AFRICA CENTRE FOR HEALTH SYSTEMS AND GENDER JUSTICE

A Scoping Literature Review

Postpartum Depression in Kenya

Examining burden, recognition, systems readiness, and pathways to response

A social-sciences review of postpartum depression in maternal health systems

1. Introduction

Maternal depression during pregnancy and the postnatal period is not only a clinical condition, but also a significant psychosocial and public health issue shaped by the interaction between individual vulnerability, social relationships, gendered expectations, and health-system capacity. Postpartum depression is recognised within the broader spectrum of perinatal mental health disorders and may emerge during pregnancy, around childbirth, or within the first year after delivery (APA, 2022; Dennis et al., 2024). Globally, approximately one in seven women experience postpartum depression, highlighting its importance as both a maternal health concern and a wider social issue affecting families, caregiving systems, and child wellbeing (Amer et al., 2024; Saharoy et al., 2023).

The risk and experience of postpartum depression are shaped by multiple intersecting determinants. Biological changes may contribute to vulnerability, but psychological history, socioeconomic insecurity, intimate and family relationships, social support, gendered caregiving expectations, stigma, and access to responsive health services are equally important in shaping women's experiences and pathways to care (Nigatu et al., 2026; Wainaina et al., 2025). Maternal depression has also been associated with adverse pregnancy and infant outcomes, including preterm birth, low birth weight, gestational diabetes, preeclampsia, and increased likelihood of caesarean delivery. It may further influence maternal health behaviours and pregnancy experiences, including gestational weight gain, substance use, ambivalence toward pregnancy, health-seeking practices, and overall wellbeing.

Despite growing evidence on its prevalence and consequences, postpartum depression remains under-recognised and undertreated. Many cases are likely missed because women may normalise distress, fear judgement, lack awareness of symptoms, or encounter health services that are insufficiently prepared to identify and respond to perinatal mental health needs (Stewart & Vigod, 2019). In low- and middle-income countries such as Kenya, these barriers are further intensified by structural and systemic constraints, including limited integration of mental health into maternal health services, workforce shortages, weak referral pathways, and unequal access to timely and acceptable care (Kahiga et al., 2025).

Although existing literature has documented the prevalence, risk factors, and consequences of postpartum depression, less attention has been given to how women's lived experiences intersect with health-system readiness, sociocultural expectations, stigma, and policy environments. This gap limits understanding of how postpartum depression is recognised, interpreted, and managed in practice. This review therefore examines postpartum depression in Kenya through a social sciences lens, focusing on its burden and recognition, the preparedness of maternal health systems to respond, and the ways in which social norms, stigma, and policy contexts shape its identification and management.

2. Burden, Recognition, and Care-Seeking

In Kenya, earlier studies estimated prevalence at approximately 11% to 13% (Tuitoek, 2019), while more recent evidence suggests rates as high as 18% (Kurui et al., 2024). These variations point not only to differences in study design, screening tools, and populations sampled, but also to the likelihood that postpartum depression remains under-recognised and underreported. The true burden may therefore be greater than existing estimates suggest.

What the Evidence Suggests

Dimension	What the Literature Indicates
Prevalence in Kenya	Earlier studies estimated rates of approximately 11% to 13%, while more recent evidence suggests prevalence as high as 18%.
Global comparison	Globally, approximately one in seven women experience postpartum depression.
Recognition	Postpartum depression remains under-recognised and underreported, with the true burden likely greater than existing estimates suggest.
Common manifestations	Prolonged sadness, anxiety, sleep disturbances, low self-esteem, emotional withdrawal, and difficulties in mother–infant bonding.
Associated outcomes	Preterm birth, low birth weight, gestational diabetes, preeclampsia, increased likelihood of caesarean delivery, and disrupted caregiving and early child development.

However, prevalence data alone does not fully capture how postpartum depression is experienced, interpreted, and identified in everyday life. Depressive symptoms may begin during pregnancy and continue into the postnatal period, yet recognition often remains limited. At the individual level, women may struggle to name their distress as a mental health concern. At the household and community levels, emotional suffering may be normalised as part of mother

hood, dismissed as temporary adjustment, or interpreted through moralised narratives of personal weakness, poor coping, or failure to meet expected maternal roles, rather than understood as an undiagnosed mental health condition (Iancu et al., 2023). This social framing shapes whether symptoms are acknowledged, concealed, or acted upon.

Health-system factors further influence whether postpartum depression is identified and managed. Evidence suggests that frontline health workers, including community health workers, midwives, and nurses, often have limited training in recognising and responding to maternal mental health conditions (Ravaldi et al., 2024; Wang et al., 2025). In addition, routine screening for postpartum depression has not been consistently integrated into maternal and child health services (Oladeji et al., 2025). As a result, key points of contact with the health system, including antenatal care, postnatal care, and child immunisation visits, may fail to function as opportunities for early detection and referral. This creates a persistent gap between the documented prevalence of postpartum depression and its actual recognition within clinical and community health settings.

The relationship between recognition and care-seeking is therefore central. Where symptoms are not recognised, are minimised, or are framed as a normal part of motherhood, women are less likely to seek formal support. Many may delay care in the hope that symptoms will resolve on their own, particularly where maternal distress is socially expected or endured in silence (Manso-Córdoba et al., 2020; Place et al., 2024). Informal support systems, including partners, relatives, friends, and community networks, often serve as the first line of response. While these networks may provide emotional and practical support, they may not always facilitate access to appropriate mental health care, especially where symptoms are poorly understood or stigma remains high.

Barriers to care-seeking are therefore both social and structural. Limited awareness of postpartum depression, inadequate training in screening and diagnostic tools among health workers, stigma attached to mental health conditions, and the normalisation of emotional distress within maternal health all shape women's pathways into care (Ravaldi et al., 2024; Wakoli, 2024). These barriers are compounded by broader health-system constraints, including costs, limited mental health personnel, weak referral systems, and low mental health capacity within primary and community healthcare settings (Cirban Ekrem et al., 2025; Place et al., 2024). Women may also be discouraged from seeking support where they anticipate that their concerns will be dismissed, minimised, or treated as less legitimate within healthcare settings (Pinar et al., 2022).

When postpartum depression remains untreated, its effects extend beyond individual psychological distress. It may worsen maternal mental health over time and reduce a mother's capacity to provide consistent, emotionally responsive, and developmentally supportive care (Saharoy et al., 2023). This has implications for infant wellbeing, particularly in relation to bonding, attachment, early stimulation, and socio-emotional development. In severe cases, untreated perinatal mental health conditions may escalate into more serious psychiatric states, including postpartum psychosis (Raza & Raza, 2026). Understanding postpartum depression therefore requires attention not only to prevalence and clinical symptoms, but also to the social meanings, household dynamics, health-system gaps, and structural conditions that determine whether women's distress is recognised and responded to in time.

3. Systems Readiness and Response Gaps

The response to postpartum depression cannot be understood through the health sector alone. While healthcare facilities are important sites for identification and referral, women's experiences of postpartum depression are shaped by a wider system of care that includes households, communities, social protection structures, cultural norms, financing arrangements, workforce capacity, data systems, and policy implementation. A systems response therefore requires attention not only to whether women are screened in clinics, but also to whether the broader maternal care ecosystem is organised to recognise distress, reduce stigma, support care-seeking, and connect women to timely, affordable, and acceptable services.

A systems response to postpartum depression must also account for the social and gendered conditions that shape whether women's distress becomes visible in the first place. Cultural expectations of motherhood often frame women as naturally resilient, self-sacrificing, and emotionally fulfilled after childbirth, leaving limited space for sadness, ambivalence, anxiety, or exhaustion to be recognised as legitimate health concerns. Within households and communities, postpartum distress may therefore be normalised, moralised, or interpreted through social and spiritual explanations rather than understood as a mental health condition requiring support. These norms influence whether women disclose symptoms, whether families validate their experiences, and whether care-seeking is encouraged or delayed.

Gendered power relations further shape the pathway from recognition to care. Women's ability to seek support may depend on partner involvement, household decision-making power, control over financial resources, exposure to intimate partner violence, and the extent to which reproductive and caregiving responsibilities are shared. Where men are primary decision-makers, emotional distress may be dismissed as less urgent than physical illness, limiting women's access to care. These social dynamics also affect data visibility: when postpartum depression is hidden, minimised, or unreported, it is less likely to appear in health records, programme data, or policy priorities. In this way, stigma and gender norms become part of the system itself, shaping not only individual care-seeking but also institutional recognition, resource allocation, and

policy uptake.

4. Barriers

The barriers to recognising and responding to postpartum depression are not only clinical. They are social, institutional, economic, gendered, and structural.

- **Weak integration of mental health into maternal and child health services:** Although women interact with the health system at multiple points, these encounters are not consistently used for psychosocial assessment or mental health support. Postpartum depression is therefore often treated as peripheral to maternal health, rather than as part of the continuum of maternal care.
- **Dominance of a biomedical approach to maternal health:** Facilities often focus on physical indicators such as bleeding, infection, breastfeeding, infant weight, and immunisation, while emotional distress, anxiety, trauma, relational strain, and maternal coping receive less attention. This limits the ability of services to identify forms of suffering that are social, emotional, and relational rather than purely physical.
- **Gendered power relations:** Women's ability to seek support may depend on partner involvement, household decision-making power, control over financial resources, exposure to intimate partner violence, and the extent to which caregiving responsibilities are shared. Where men control household decisions or where emotional distress is dismissed as less urgent than physical illness, women may face additional barriers to accessing care.
- **Inconsistent screening:** Although screening tools exist, they are not routinely or uniformly applied across facilities. This means that identification often depends on the awareness, discretion, workload, and capacity of individual providers, rather than being embedded in the system as a standard practice.
- **Limited workforce capacity:** Many frontline providers have limited training in maternal mental health, particularly in recognising, screening, and responding to postpartum depression. As a result, symptoms may be overlooked, normalised, or misinterpreted, especially in rural and underserved areas where specialist support is limited.
- **Weak referral systems.** Even where women are identified as needing support, pathways to counselling, psychosocial care, peer support, psychiatric services, or community follow-up are often unclear or underdeveloped. Specialist mental health services are limited, unevenly distributed, and concentrated in urban areas, which restricts access for women in rural and low-resource settings.
- **Cost:** For women with limited financial resources, seeking mental healthcare may involve transport costs, consultation fees, medication costs, and repeated follow-up. This makes care-seeking dependent not only on recognition of symptoms, but also on women's economic position and household decision-making power.
- **Restrictive social norms:** Expectations of motherhood often frame women as naturally resilient, self-sacrificing, and emotionally fulfilled after childbirth. This leaves little space for sadness, exhaustion, anxiety, ambivalence, or emotional withdrawal to be recognised as legitimate distress. Women may therefore suppress symptoms because they fear being judged as weak, ungrateful, or failing in the role of the "good mother".
- **Weak data systems and low policy visibility:** When postpartum depression is hidden, minimised, or unreported, it is less likely to appear in health records, programme data, or policy priorities. This weakens planning, resource allocation, monitoring, and accountability.

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5. Enablers

Despite these barriers, existing structures, relationships, and platforms can support earlier recognition and response to postpartum depression.

- **Existing maternal and child health contact points.** Kenya's maternal and child health system already provides repeated contact points with women during pregnancy and after childbirth. Antenatal care, delivery services, postnatal check-ups, immunisation visits, and community health contacts all create opportunities to observe women's wellbeing over time and identify distress early. The basic service infrastructure for reaching women already exists, even if it is not yet fully used for maternal mental health.
- **Frontline providers close to communities.** Nurses, midwives, clinical officers, and community health workers often serve as the first point of contact during pregnancy and postpartum. With appropriate training, supervision, and referral support, they could become critical actors in screening, psychoeducation, early psychosocial support, and linkage to care.
- **Available screening tools.** Existing screening tools, including the Edinburgh Postnatal Depression Scale and the City Birth Trauma Scale, can support structured identification of depressive symptoms and birth-related trauma. Their presence is an enabler because the challenge is not the absence of tools, but their inconsistent use and weak integration into routine care.
- **Informal and community-based support systems.** Partners, relatives, friends, and community networks often serve as the first response system when women experience distress. Although these networks may not always connect women to formal care, they can provide emotional support, practical help, and validation when they are equipped with mental health literacy and stigma-reduction messages.
- **A receptive policy environment.** If postpartum depression is explicitly included in maternal health policy, budget lines, health information systems, and community health strategies, it can become more visible within planning, financing, service delivery, and monitoring systems.

6. Support Mechanisms

The support needed must go beyond clinical treatment. It should include household, community, health-service, and policy-level responses.

- **Individual level:** Women need accessible information on postpartum depression, including how symptoms may present, when to seek help, and where support can be found. This is important because many women may not recognise their distress as a mental health concern and may instead interpret it as ordinary exhaustion, personal weakness, or failure to cope.
- **Household level.** Partners and family members need to be engaged as part of the support system. Emotional, physical, and financial support from partners and relatives can influence women's vulnerability, disclosure, and recovery. Male involvement is especially important where gender norms place the burden of caregiving on women while excluding men from maternal care.
- **Community level:** Support should include mental health literacy, stigma reduction, peer support, and community-based referral. Community health workers and trusted community actors can help normalise conversations about maternal mental health, encourage women to disclose distress, and support timely linkage to care.
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- **Service-delivery level:** Support requires routine screening, clear protocols, provider training, supervision, and referral pathways. Screening should be embedded into antenatal care, postnatal care, immunisation visits, and community health contacts, rather than left to individual provider discretion. Providers also need practical guidance on what to do when symptoms are identified.
- **Systems level:** Support requires stronger integration of postpartum depression into maternal health policy, financing, health information systems, and community health strategies. Without budget lines, data capture, and accountability mechanisms, postpartum depression will remain under-prioritised despite its impact on women, infants, families, and communities.

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