Postpartum Depression

In 2004, the World Health Organisation estimated that over 150 million people were living with depressive disorders, with about 10% of these being in Africa (1). Depression is the third leading cause of the global burden of disease as measured using the Disability-Adjusted Life Years (DALYs), contributing to upto 4.3% of the DALYs. In the high and middle-income countries, it is the leading cause of the burden of disease while in low income countries it is the 8th leading cause. It is estimated that in 2030, depressive disorders will be the leading cause of the global burden of disease (1).

Among women in the reproductive age-group, depressive disorders are the leading cause of the global burden of disease (1). This is due to the greater prevalence of depression among women compared to men in the general population, and the chronic nature of the illness. For various reasons, including the reproductive cycle, it is highly probable that women suffer a greater burden of depression than men.

The Diagnostic and Statistical Manual for Mental Disorders, DSM IV TR (2) does not define postpartum depression as a distinct category of illness. However, under the classification for major depressive disorders, a specifier for 'postpartum onset' is included. Although the postpartum period in this case covers the period upto four weeks postpartum, in most research and clinical settings a period of upto one year is considered postpartum.

The clinical presentation of postpartum depression is the same as that of depression outside of this period, although additional symptoms such as mood lability and over-concern with the infant are commonly reported (2). This disorder should be distinguished from postpartum blues, a syndrome characterised by mood symptoms that are common in the first seven to ten days after delivery and that usually resolve within a few days without any intervention. Symptoms include mood lability, irritability, interpersonal hypersensitivity, insomnia, anxiety, tearfulness, and sometimes elation (3).

Although there is no difference between the prevalence rate of postpartum depression and that of depression among women in the general population, the incidence of depression within one month of delivery rises to three times the average monthly incidence in non-childbearing women (4). Many studies suggest that the postpartum period carries a higher risk of developing depression than any other period during the reproductive life of a woman (5, 6). Depending on the criteria used to diagnose postpartum depression, prevalence rates range from 7% to 20% (3, 4) but can go as high as 63% as was found in a review of Asian studies (7).

In this issue of the journal, Onwere *et al* (8) reports the findings of a study using the Edinburgh Postnatal Depression Scale to determine the prevalence and possible risk factors for postpartum depression in Nigeria. This study yielded a relatively high prevalence of screen-positive postpartum depression of 23.5%. Comparable studies from African settings are few, but the results are comparable to those reported by Onwere *et al*(8) in this issue of the journal.

A 2005 study in Nigeria reported a postpartum depression prevalence rate of 14.6% (9), while in a Zimbabwean random sample of postpartum women 33% of them met the DSM IV criteria for depression (10). A South African study similarly found a high prevalence rate of 34.7% among mothers in a peri-urban settlement (11). Obviously, then, postpartum depression is a serious problem among women in Africa, and it is possible that further research will yield the true burden of this disabling disorder.

Among the identified risk factors for the development of postpartum depression are: history of any psychopathology (including history of previous postpartum depression), low social support, poor marital relationship, recent life events and unwanted pregnancy (4,7). Studies from African countries have identified further risk factors including hospital admissions during the pregnancy, female sex of the baby, preterm delivery, instrumental delivery, Caesarean section and being single (9).

The importance of onwere *et al's*(8) study lies in two areas. Firstly, it adds to the small but growing body of knowledge originating from Africa and other low-income regions on postpartum depression and mental disorders in general. In this regard, more cross-

disciplinary research of this nature is to be encouraged due to the potential saving in costs and the benefit of pooling expertise.

Secondly, the study highlights the magnitude of the problem, raising the need for screening and treatment of depression during the postnatal clinic visits. Due to the limited amount of research in this area, it has remained difficult for policy-makers to design interventions targeting depression and other mental disorders among women in this category, and one hopes that studies such as these will provide the necessary evidence base for action.

Questions may be raised concerning the need to screen for depression, and whether management of postpartum depression has any public health importance beyond relieving the patient's symptoms. The evidence overwhelmingly supports an aggressive approach to management of this disorder in order to reduce the risk of multiple socio-economic and psychological complications.

Many studies have demonstrated a link between postpartum depression and problems with child-rearing and family dynamics, resulting in multiple negative effects including slow infant growth and malnutrition, multiple infections, poor family dynamics and increased risk of current and future behavioural and psychological problems in the child (11-15). Evidently, then, it follows that proper management of postpartum depression has the potential to improve not only the mother's overall health, but also that of the infant and the family as a whole.

Based on these observations, it is evident that postpartum depression is a global public health priority that needs more research and interventions than is currently the case. As in the paper by onwere *et al* (8) in the current issue of the journal, it is recommended that routine screening for depression be carried out during visits by pregnant and postnatal women in order to identify the problem early and institute corrective measures.

In conclusion, there is little doubt that depression among women of reproductive age, including syndromes such as postpartum depression, is a major public health issue and interventions should be integrated into the routine care of women in reproductive health services. It is my conviction that this integration is the only approach that will have significant impact towards improving both maternal and child health in Africa.

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