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Exploring Sociocultural and Familial Dimensions of Postnatal Depression in Southwestern Nigeria: A Mixed-Methods Perspective

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Abstract

Postnatal depression (PND) has emerged as a significant public health issue, affecting individual health, family cohesion, and child development. This study investigated the societal and familial dimensions of postpartum depression among parents in Southwestern Nigeria through a mixed-methods approach. Quantitative data were collected from 200 respondents (113 women and 87 men) using stratified random sampling, while qualitative insights were derived from 8 focus group discussions, 4 for men and 4 for women. The Edinburgh Postnatal Depression Scale (EPDS) was utilised for screening, and thematic analysis guided the qualitative interpretation. Quantitative findings revealed that 29.6% of participants met the criteria for probable depression with a higher frequency in females (34.5%) than in males (24.1%). The qualitative findings revealed four primary themes: cultural stigma and emotional silence, maternal guilt and unrealistic expectations, family-role conflict, and inadequate social support. The integration of data indicated that patriarchal norms, gendered expectations, and insufficient mental health literacy intensify vulnerability to depression. The study shows that gender-sensitivity and family-centred interventions are essential for the prompt recognition and treatment of postpartum depression within Nigeria's postnatal care system.

Keywords: *Family Dynamics, Gender, Mixed Methods, Nigeria, Postnatal Depression, Sociocultural Factors.*

Introduction

Global and African Context

Postnatal depression (PND) is a prevalent, although frequently neglected, mood illness that manifests within the initial year following childbirth. It affects about one in five moms around the world, but new research shows that fathers are equally at risk [1]. The World Health Organisation (WHO) now identifies mother and paternal depression as key determinants impacting family and child health, leading to repercussions such as disturbed bonding and worse cognitive outcomes for children [2, 3]. In high-income nations, improvements in screening and psychosocial support have led to earlier detection. However, in low- and middle-income countries (LMICs), the burden remains disproportionately high, with prevalence rates of 25%-40% [4, 5]. Poverty, poor access to healthcare, gender inequity, and cultural stigma

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together exacerbate risk and impede the pursuit of care—gender and Sociocultural Aspects.

Gender and Sociocultural Dimensions

Gender norms significantly influence the manifestation and management of postpartum depression (PND). In the context of parenthood, women's depressive symptoms are frequently normalised, but men's emotional challenges are generally suppressed due to cultural norms that emphasise strength and stoicism [6, 7]. Research conducted in Asia and Africa indicates that men's postnatal depression, although frequently overlooked, can profoundly affect familial relationships and child development [4]. Sociocultural conceptions and familial roles significantly shape African contexts, where delivery is a collective event linked to social status and religious obligations. Emotional difficulties are often ascribed to spiritual factor, hence reducing psychological interpretations [8]. Stigma hinders transparent communication and obstructs the pursuit of assistance.

The Nigerian Perspective

In Nigeria, PND is still not being identified or reported enough, even though there is a lot of evidence that it happens more often than it should. Public health services primarily focus on physical and obstetric outcomes, significantly neglecting psychological dimensions. Prior studies have established a connection between maternal anxiety and factors such as low income, marital discord, and inadequate social support [10, 17]. Nevertheless, there is a lack of comprehensive information elucidating how cultural and familial factors exacerbate these experiences for both mothers and fathers.

Theoretical Framework

This research is based on Family Systems Theory, which asserts that individuals function as interdependent entities within a family; distress in one person influences the entire system [11]. Social Relations Theory elucidates how power dynamics and role expectations shape coping techniques. They view PND as a relational phenomenon situated within gendered societal frameworks rather than as an individual disorder.

Objectives of the Study

The study sought to investigate the sociocultural and familial determinants affecting postpartum depression (PND) in Southwestern Nigeria through a mixed-methods framework to:

1. Quantitatively assess the gender-specific prevalence of PND.
2. Qualitatively discern sociocultural and familial influences on depressive experiences.
3. Synthesise both aspects to recommend culturally appropriate strategies for prevention and care.

Materials and Methods

Study Design

A sequential explanatory mixed-methods design was utilised. Quantitative data collection occurred before qualitative analysis to enhance the contextualisation and comprehension of statistical results.

Research Setting

The research took place in Adeoyo maternity teaching hospital in Ibadan, Oyo State, Nigeria, which is a city with a wide range of socioeconomic status. This teaching hospital provides postnatal care, family planning services, and vaccination services.

Sampling and Respondent Selection

The quantitative phase utilised a stratified random sampling method to guarantee fair gender representation. We identified the parents of babies aged 0-6 months from the clinic records and sorted them by gender. Balloting was used to choose participants from each stratum until 113 mothers and 87 fathers had signed up.

Inclusion criteria: people must be biological parents of babies aged 0-6 months, living in Ibadan, and fluent in either English or Yoruba.

Exclusion criteria: Parents with diagnosed psychiatric illnesses or recent child loss were excluded.

During the qualitative phase, purposive sampling facilitated the selection of participants for eight focus group discussions (FGDs); 4 with males and 4 with females. Sampling persisted until topic saturation was attained.

Data Collection Instruments

The Edinburgh Postnatal Depression Scale (EPDS) was employed to assess depressive symptoms. The EPDS has been validated in Nigeria and internationally with cut-off scores above 13 signifying probable depression [12]. The instrument underwent translation and subsequent back-translation into Yoruba to guarantee linguistic precision. We used semi-structured guides to acquire qualitative data on views of depression, cultural beliefs, family ties, and ways of coping. Interviews were audio-recorded with consent and conducted in secluded settings to maintain confidentiality.

Data Collection Procedures

Three days of instruction on ethical conduct, relationship-building, and neutrality in interviews were provided to research assistants who spoke both English and Yoruba. To clarify, the interviewers and participants were the same gender. The data collection phase lasted eight weeks. Transcripts were made word-for-word, checked for accuracy, and, as needed, translated into English.

Data Analysis

We used SPSS v25 to analyze quantitative data using descriptive and inferential statistics (χ^2 and t-tests). Qualitative data were processed manually with Braun and Clarke's six-phase theme analysis framework [13].

Coding utilised both inductive and deductive reasoning. A composite display matrix was used to combine quantitative and qualitative results. It showed where data threads converged and diverged.

Reliability and Precision

Data source triangulation, longer interaction, and member validation all helped to make the information more credible. Maintaining an audit trail of field notes and coding decisions ensured the work was reliable. Peer debriefing with a qualitative research mentor facilitated confirmability.

Ethical Approval

The study was conducted in accordance with the most stringent ethical standards to guarantee the respect, dignity, and protection of all participants. In accordance with the Universal Declaration of Human Rights, the International Code of Medical Ethics, and the WHO Ethical Guidelines for Health Research, ethical sanction was obtained from the Oyo State Ministry of Health Ethical Review Committee (Ref No: MOH/OY/2024/071). The purpose, procedures, potential hazards, and benefits of the study were fully disclosed to all participants. Prior to participation, written informed assent was obtained, and information sheets were distributed in both English and Yoruba to guarantee comprehension. Respondents were guaranteed the right to withdraw at any point without incurring any penalties, and participation was entirely voluntary. Anonymity and confidentiality were rigorously upheld. All identifiable data was eliminated from the records and substituted with codes. Hard copies were securely stored, and all electronic data was password-protected. To prevent identification, transcripts and quotations were anonymised. Participants were treated with empathy, and those who demonstrated distress were informed about available counselling and referral services, as postnatal depression is an emotionally sensitive condition. The investigation refrained from employing any form of coercion, deception, or

undue influence. Data security and integrity were prioritised throughout the research process. After completion, all materials will be securely stored and kept confidential. The study was in accordance with the National Health Research Ethics Code of Nigeria (NHREC, 2011) and the Research Ethics Policy of Texila American University.

Results

Quantitative Overview

Of the 200 responses, 56.5% were from women and 43.5% were from men. The average age was 31.6 years, with a range of 6.4 years. A majority of the participants were married (93%), self-employed (57%), and resided in urban regions (67%). About one-third (29.6%) showed positive screening results for possible postpartum depression (EPDS > 13). There were more women (34.5%) than men (24.1%) who had it. There were essential links between depression and education (p = 0.041), work (p = 0.034), and social support (p = 0.009).

Table 1. Sociodemographic Characteristics of Respondents (n=200)

Variables		**Gender**		**Total n(%)**	**p**
		Male n(%)	**Female n(%)**		
Age	18–25	13(14.9)	36(31.9)	49 (24.5)	0.002
	26–35	40(46.0)	59(52.2)	99 (49.5)	
	36–45	29(33.3)	13(11.5)	42 (21.0)	
	46–55	3(3.4)	3(2.7)	6 (3.0)	
	56+	2(2.3)	2(1.8)	4 (2.0)	
Marital Status	Single	4(4.6)	3(2.7)	7 (3.5)	0.488
	Married	82(94.3)	105(92.9)	187 (93.5)	
	Separated	1(1.1)	4(3.5)	5 (2.5)	
	Widowed	0(0)	1(0.9)	1 (0.5)	
Educational Level	No formal education	0(0)	4(3.5)	4 (2.0)	0.217
	Primary	6(6.9)	3(2.7)	9 (4.5)	
	Secondary	34(39.1)	49(43.4)	83 (41.5)	
	Tertiary	43(49.4)	50(44.2)	93 (46.5)	
	Others	4(4.6)	7(6.2)	11 (5.5)	
Employment Status	Full time	32(36.8)	19(16.8)	51 (25.5)	0.012
	Part time	7(8.0)	9(8.0)	16 (8.0)	
	Self-employed	44(50.6)	71(62.8)	115 (57.5)	
	Unemployed	3(3.4)	7(6.2)	10 (5.0)	
	Student	1(1.1)	7(6.2)	8 (4.0)	
Household Income	< 50,000	3(3.4)	37(32.7)	40 (20.0)	0.000
	50,000 – 100,000	30(34.5)	42(37.2)	72 (36.0)	
	100,000 – 200,000	25(28.7)	22(19.5)	47 (23.5)	
	200,000 – 500,000	25(28.7)	11(9.7)	36 (18.0)	
	> 500,000	4(4.6)	1(0.9)	5 (2.5)	
Residential Area	Urban	68(78.2)	65(57.5)	133(66.5)	0.007
	Semi-urban	13(14.9)	37(32.7)	50(25.0)	
	Rural	6(6.9)	11(9.7)	17(8.5)	

Ethnicity	Yoruba	77(88.5)	106(93.8)	183(91.5)	0.237
	Hausa	2(2.3)	4(3.5)	6(3.0)	
	Igbo	5(5.7)	2(1.8)	7(3.5)	
	Others	3(3.4)	1(0.9)	4(2.0)	

Source: (Field Survey, 2025)

Table 1 presents the sociodemographic characteristics of the respondents; with respect to the age of the participant, more than half 113 (56.5%) were female. The age distribution showed that the largest group of respondents was aged 26–35 years, representing about half 99 (49.5%). In terms of marital status, the majority of respondents were married 187, 93.5%). Regarding educational attainment, approximately half of the respondents had attained tertiary education 93 (46.5%). Employment status revealed that self-employment was the most common, accounting for more than half 115 (57.5%) of the respondents. Household income distribution indicated that over one-third, 72 (36.0%), earned between ₦50,000–₦100,000. With respect to residential location, the majority resided in urban areas 133 (66.5%). The ethnic distribution showed that the Yoruba ethnic group predominated, accounting for 183 (91.5%) respondents.

The majority of respondents in both genders were aged 26–35 years, though females had a slightly higher proportion in the 18–25 age group compared to males (31.9% vs. 14.9%, $p = 0.002$). Most participants were married, with no significant gender difference in marital status ($p = 0.488$). Educational attainment was generally high, with tertiary education being most common; however, differences by gender were not statistically significant ($p = 0.217$). Employment status showed a significant association with gender ($p = 0.012$), with males more likely to be in full-time work and females more likely to be in self-employment or student categories. Household income also differed significantly by gender ($p < 0.001$), with males more frequently in higher income brackets (≥ 200,000) and females more concentrated in the lowest category (< 50,000). Residential area was significantly related to gender ($p = 0.007$), with males more often living in urban settings and females more often in semi-urban areas. Ethnicity distribution showed no significant gender difference ($p = 0.237$), with Yoruba being the predominant ethnic group among both males and females.

Table 2. Edinburgh Postnatal Depression Scale (EPDS)

Variables		**Gender**		**Total n(%)**	**P**
		Male n(%)	**Female n(%)**		
Able to laugh and see the funny side of things	As much as always	67(77.0%)	85(75.2%)	152 (76.0%)	0.868
	Not quite so much	10(11.5%)	17(15.0%)	27 (13.5%)	
	Definitely less	7(8.0%)	7(6.2%)	14 (7.0%)	
	Not at all	3(3.4%)	4(3.5%)	7 (3.5%)	
Looked forward with enjoyment to things	As much as always	72(82.8%)	88(77.9%)	160 (80.0%)	0.510
	Less than usual	8(9.2%)	14(12.4%)	22 (11.0%)	
	Definitely less	3(3.4%)	8(7.1%)	11 (5.5%)	
	Hardly at all	4(4.6%)	3(2.7%)	7 (3.5%)	
Blamed self unnecessarily when things went wrong	Yes, most of the time	4(4.6%)	21(18.6%)	25 (12.5%)	0.000
	Sometimes	12(13.8%)	36(31.9%)	48 (24.0%)	
	Not often	26(29.9%)	39(34.5%)	65 (32.5%)	
	No, never	45(51.7%)	17(15.0%)	62 (31.0%)	

Felt anxious or worried for no good reason	No	47(54.0%)	37(32.7%)	84 (42.0%)	0.001
	Hardly ever	11(2.6%)	8(7.1%)	19 (9.5%)	
	Yes, sometimes	26(9.9%)	54(47.8%)	80 (40.0%)	
	Yes, very often	3(3.4%)	14(12.4%)	17 (8.5%)	
Felt scared or panicky for no very good reason	Yes, quite a lot	8(9.2%)	18(15.9%)	26 (13.0%)	0.001
	Yes, sometimes	12(13.8%)	35(31.0%)	47 (23.5%)	
	No, not much	17(19.5%)	26(23.0%)	43 (21.5%)	
	No, not at all	50(57.5%)	34(30.1%)	84 (42.0%)	
Things have been getting on top of me	Yes, most of the time	11(12.6%)	21(18.6%)	32 (16.0%)	0.004
	Yes, sometimes	15(17.2%)	36(31.9%)	51 (25.5%)	
	No, I have coped well	22(25.3%)	31(27.4%)	53 (26.5%)	
	No, as well as ever	39(44.8%)	25(22.1%)	64 (32.0%)	
Been so unhappy that I have had difficulty sleeping	Yes, most of the time	16(18.4%)	21(18.6%)	37 (18.5%)	0.117
	Sometimes	8(9.2%)	21(18.6%)	29 (14.5%)	
	Not often	18(20.7%)	29(25.7%)	47 (23.5%)	
	No, not at all	45(51.7%)	42(37.2%)	87 (43.5%)	
Felt sad or miserable	Yes, most of the time	2(2.3%)	18(15.9%)	20 (10.0%)	0.002
	Quite often	7(8.0%)	15(13.3%)	22 (11.0%)	
	Not often	25(28.7%)	35(31.0%)	60 (30.0%)	
	No, not at all	53(60.9%)	45(39.8%)	98 (49.0%)	
Been so unhappy that I have been crying	Yes, most of the time	6(6.9%)	20(17.7%)	26 (13.0%)	0.001
	Quite often	3(3.4%)	13(11.5%)	16 (8.0%)	
	Occasionally	6(6.9%)	16(14.2%)	22 (11.0%)	
	No, never	72(82.8%)	64(56.6%)	136 (68.0%)	
The thought of harming myself has occurred to me	Yes, quite often	2(2.3%)	15(13.3%)	17 (8.5%)	0.009
	Sometimes	7(8.0%)	16(4.2%)	23 (11.5%)	
	Hardly ever	2(2.3%)	5(4.4%)	7 (3.5%)	
	Never	76(87.4%)	77(68.1%)	153 (76.5%)	

Table 2 presents the Edinburgh Postnatal Depression scale of the respondents; majority 152(76.0%) were able to laugh and see the funny side of things as much as always. Similarly, majority160(80.0%) looked forward to things as much as always. Regarding self-blame when things went wrong, below one-quarter 25(12.5%) reported blaming themselves most of the time. Feelings of anxiety or worry without a clear reason were reported by approximately two out of five 80(40.0%), sometimes. In terms of feeling scared or panicky for no good reason, about half 84(42.0%) were not experiencing it at all. Sleep disturbances due to unhappiness were reported most of the time by less than one-quarter 37(18.5%), and not at all by about half 87(43.5%). Feelings of sadness or misery were experienced most of the time by below one-quarter20(10.0%), and not at all by about half 98(49.0%).

Episodes of crying due to unhappiness occurred most of the time in less than one-quarter 26(13.0%), while more than two-third 136(68.0%) never experienced it. Concerning thoughts of self-harm, few 17(8.5%) reported this quite often, while the majority, 153(76.5%), had never experienced such thoughts. Cross-tabulation of Edinburgh Postnatal Depression Scale (EPDS) items by gender showed several significant differences. Female respondents were

significantly more likely than males to report blaming themselves unnecessarily ($p < .001$), feeling anxious or worried without reason ($p = .001$), feeling scared or panicky ($p = .001$), and feeling overwhelmed by problems ($p = .004$). Females were also more likely to report feeling sad or miserable ($p = .002$), crying more often ($p = .001$), and having thoughts of self-harm ($p = .009$).

No significant gender differences were found in the ability to laugh, enjoyment of activities, difficulty sleeping, or most other emotional symptoms. However, females tended to report higher frequencies of distress in these areas.

About two-thirds (80.0%) were not depressed,53(26.6%) were probably depressed, while 23(11.5%) were possibly depressed.

Participants' overall postnatal depression was determined based on their responses to 10 Edinburgh Postnatal Depression questions with questions 1, 2, and 4 scored 0 – 3 and 3, 5-10 scored 3 - 0; participants with total scores between (0 - 9), (10 - 12) and (13 - 30) were adjudged to have no depression, possible and probable depression respectively.

Table 3. Sociocultural Factors Affecting Postnatal Depression

Variables	**Categories**	**Gender**		**n(%)**	**p**
		Male	**Female**		
In your community, do people believe men can experience postnatal depression?	Yes	41(47.1)	49(43.4)	90(45.0)	0.356
	No	15(17.2)	29(25.7)	44(22.0)	
	Unsure	31(35.6)	35(31.0)	66(33.0)	
Feels there is stigma around mental health issues in your community?	Yes, a lot	23(26.4)	41(36.3)	64(32.0)	0.328
	Yes, but only for severe cases	30(34.5)	35(31.0)	65(32.5)	
	No	34(39.1)	37(32.7)	71(35.5)	
Ever sought help for emotional distress or mental health issues	Yes	15(17.2)	37(32.7)	52(26.0)	0.015
	No	72(82.8)	76(67.3)	148(74)	
Factors preventing people from seeking help for depression in community *	Stigma	x	x	28(11.6)	
	Lack of awareness	x	x	100(41.3)	
	High cost	x	x	48(19.8)	
	Lack of trust	x	x	58(24.0)	
	Other	x	x	8(3.3)	
Typically discuss emotional challenges with *	No one	x	x	18(8.7)	
	Partner	x	x	103(49.8)	
	Family	x	x	40(19.3)	
	Friends	x	x	15(7.2)	
	Religious leader	x	x	13(6.3)	
	Therapist	x	x	17(8.2)	
	Elderly people	x	x	1(0.5)	
Believe men and women experience depression differently?	Yes	72(82.8)	89(8.8)	161(80.5)	0.053
	No	1(.1)	10(8.8)	11(5.5)	
	Unsure	14(16.1)	14(12.4)	28(14.0)	

** Multiple responses allowed*

Table 3 presents sociocultural factors affecting postnatal Depression; when respondents were asked whether people in their community believe men can experience postnatal depression, about half 90, 45.0%) indicated yes. Regarding the presence of stigma around mental health issues in their community, about one-third 64, 32.0%) believed there is a lot of stigma. When asked about help-seeking behavior, more than one-quarter , 52(26.0%), had ever sought help for emotional distress or mental health issues, while the majority , 148(74.0%), reported never seeking help. In terms of barriers preventing people from seeking help for depression, lack of awareness was the most reported factor 100(41.3%). Concerning who respondents typically discuss emotional challenges with, partners were the most common option, 103(49.8%). Finally, a large majority 161(80.5%) believed that men and women experience depression differently.

Analysis of sociocultural factors showed that beliefs about men experiencing postnatal depression and perceptions of mental health stigma did not differ significantly by gender ($p > .05$). However, females were significantly more likely than males to have sought help for emotional distress or mental health issues ($p = .015$). A higher proportion of both genders believed men and women experience depression differently, though this difference approached but did not reach statistical significance ($p = .053$).

Table 4. Coping Mechanisms & Support Systems

Variables	**Categories**	**n(%)**
Coping mechanism with stress or sadness*	Talking to friends/family	97(46.9)
	Religious activities	31(15.0)
	Exercise	30(14.5)
	Alcohol/substances	11(5.3)
	Professional help	13(6.3)
	Others	25(12.1)
Support received post-childbirth*	Family support	148(62.2)
	Healthcare support	43(18.1)
	Religious support	28(11.8)
	No support	19(8.0)
Most helpful interventions for parents struggling with postnatal depression*	Awareness programs	105(43.4)
	Mental health services	54(22.3)
	Family involvement	46(19.0)
	Support groups	30(12.4)
	Others	7(2.9)
	No	11 (5.5)
	Unsure	28 (14.0)

** Multiple responses allowed*

Table 4 presents respondents' coping mechanisms and support systems; nearly half 97 (46.9%) relied on talking to friends or family when coping with stress or sadness. In terms of support received after childbirth, the majority, 148 (62.2%), reported receiving support from family members. When asked about the most helpful interventions for parents struggling with postnatal depression, awareness programs were identified by about half 105 (43.4%) as being most beneficial.

Qualitative Findings

Four main themes came up:

1. Cultural Stigma and Emotional Suppression in Men; A lot of fathers said they felt like

they could not show their sadness or worry. One person said, "In our culture, a man who says he's unhappy is seen as weak." One must act as if everything is well. This quietness made it even harder to identify the internal struggle that was already there. This theme demonstrates the gendered stigma associated with men's emotions, reflecting previous research that masculine ideals inhibit vulnerability and postpone the acknowledgement of paternal postpartum depression (6,8,10).

2. . Maternal Regret and Unrealistic Expectations; Mothers expressed the difficulty of maintaining a cheery demeanour and nurturing behaviour despite their fatigue. A mother said, "One should thank God; so, when one cries, others may think they are ungrateful." This shows how stigma and unrealistic expectations from mothers make emotional pain seem normal. This guilt-induced silence reflects findings from African studies that indicate postpartum sadness is spiritualised and inadequately reported (4,5,9).
3. Family Role Conflict and Ineffective Communication Among Spouses; Both men and women said that their relationships were strained because of money problems and unequal childcare duties. Husbands expressed emotional detachment, whereas wives conveyed dissatisfaction with insufficient assistance. This theme corroborates that financial difficulties and inequitable caregiving exacerbate emotional stress within families, aligning with Family Systems Theory (12).
4. Little awareness and community support; from the community Participants observed that sorrow was infrequently recognised in familial or religious contexts. Many people went to pastors or traditional healers for help before seeing a doctor. These accounts demonstrate that the spiritualization of mental illness persists, hindering access to formal treatment and perpetuating stigma (7,9,11).

The qualitative findings suggest that postnatal depression is a socially ingrained phenomenon influenced by gender, culture, and familial relationships. Men's emotional repression and women's guilt exemplify gendered societal roles. Financial stress and poor communication exacerbate family tension, highlighting the interconnectedness of emotional well-being. The results support Family Systems and Social Relations Theories, showing that PND is both relational and sociocultural.

Integration of Quantitative and Qualitative Results

Quantitative studies indicated a considerable predominance of females and notable associations with social support, corroborated by qualitative narratives highlighting relational tension and cultural silence. The integration matrix showed that stigma made men less likely to talk about their problems whereas unrealistic social expectations made women feel more pain.

Discussion

Interpretation of Findings

This study demonstrates that postpartum depression affects both genders in Nigeria, with women experiencing a greater burden. The results corroborate studies from Ethiopia [14] and Ghana [15], which exhibited similar gender disparities. Patriarchal standards, financial stress, and insufficient spousal communication were identified as persistent factors. Comparable community-based research in Ethiopia indicates heightened depression symptoms in both mothers and fathers, influenced by economic hardship and limited access to mental health services [19, 20]. The combination of EPDS scores and qualitative narratives gave a full picture of how cultural scripts affect emotional experiences. Mothers internalised shame or guilt whereas males externalised sadness through withdrawal adhering to gendered emotional standards.

Theoretical Implications

The findings corroborate Family Systems Theory, illustrating that distress in one parent influences the entire home, affecting marital peace and caregiving practices. Social Relations Theory elucidates how gender roles and societal systems generate varying emotional loads. These concepts indicate that interventions ought to focus on relational dynamics rather than solely on individuals.

Policy Implications

As Nigeria does not have enough mental health infrastructure, it is important to include regular depression screenings to the current postnatal care plans. Teaching nurses and other community health workers to use the EPDS can facilitate early detection. Counselling programs that focus on couples can assist in easing stress in marriages, and public awareness campaigns can help break the taboo around men revealing their feelings.

At the policy level, including perinatal mental health in Nigeria's National Primary Health-Care Development Policy is in line with Sustainable Development Goal 3, which is about promoting mental health. Working together with the ministries of health, women's affairs, and social welfare can make family-support programs more effective.

Comparison with Global Literature

The reported frequency of 29.6% aligns with pooled estimates from African LMICs (25–35%) [4, 5] and exceeds rates observed in Europe (10–15%) [16, 18]. This difference shows that there are bigger problems with how easy it is to get healthcare and how people accept mental illness in different cultures. Shorey et al. [4] and Paulson & Bazemore [9] documented similar global prevalence rates of father postnatal depression, underscoring that postnatal mental illness is a universal occurrence, albeit influenced by cultural factors.

Research Limitations

The mixed-methods approach enhanced validity; however, several drawbacks remain. The final sample size (n = 200) fell short of the expected 236 due to difficulties in recruiting fathers which may diminish the statistical power for subgroup analysis. Self-reported EPDS data could be affected by social desirability bias. Qualitative findings were confined to urban Ibadan; rural viewpoints may vary. The cross-sectional design ultimately inhibits causal inference. Future longitudinal studies are advised to evaluate temporal variations.

Conclusion

In Southwestern Nigeria, sociocultural norms, gender expectations, and a lack of familial support have a significant effect on how people suffer postnatal depression. Both mothers and fathers experience emotional vulnerability; yet cultural stigma and shame impede transparency and support. Enhancing postnatal care through gender-inclusive mental health assessments, spouse counselling, and community awareness initiatives can promote family welfare and facilitate equitable mental health outcomes.

Conflict of Interest

There is no conflict of interest in this study.

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Data Availability Statement

The datasets produced and examined in this investigation are available and can be obtained

from the corresponding author upon a reasonable request.

Author's Contribution

Adeola Oluwatobi Aminu conceived and designed the project, coordinated fieldwork, supervised data collecting, and wrote the initial manuscript draft. Wakili Adelani Tijani provided overall supervision, technical mentorship, and guidance on study design and analysis. Fatimah Omobolanle Azeez facilitated training for research assistants and oversaw field data collection. Olalekan Amos Oladejo, Michael Oloyede Oladeji and Doubra Aanuoluwapo Onoviron collaboratively engaged in the review, editing, and proofreading of the final text draft to ensure intellectual clarity and consistency. All authors reviewed and sanctioned the final version of the text.

References

[1]. Fisher, J., Cabral de Mello, M., Patel, V., Rahman, A., Tran, T., Holton, S., and Holmes, W., 2012, The global prevalence of perinatal depression: A systematic review. *Bulletin of the World Health Organization*, 90(2), 139–149.

[2]. Dadi, A. F., Akalu, T. Y., Baraki, A. G., and Wolde, H. F., 2020, Epidemiology of postnatal depression and its associated factors in Africa: A systematic review and meta-analysis. *PLoS ONE*, 15(4), e0231940.

[3]. World Health Organization, 2022, Mental Health Gap Action Programme: Maternal and Perinatal Guidelines. *Geneva: WHO*.

[4]. Shorey, S., Chee, C. Y. I., Ng, E. D., Chan, Y. H., Tam, W. W. S., and Chong, Y. S., 2018, Prevalence and incidence of paternal perinatal depression: A systematic review and meta-analysis. *Journal of Affective Disorders*, 235, 75–84.

[5]. Gelaye, B., Rondon, M. B., Araya, R., and Williams, M. A., 2016, Epidemiology of maternal depression, risk factors, and child outcomes in low-income and middle-income countries. *Current Opinion in Psychiatry*, 29(5), 372–379.

[6]. Hyde, J. S., and Mezulis, A. H., 2020, Gender differences in depression: Biological, cognitive, and sociocultural factors. *Current Opinion in Psychology*, 32, 17–22.

[7]. Odufuwa, B., Adebayo, A., and Alade, M., 2022, Socio-cultural beliefs and stigma surrounding mental illness in Nigeria. *African Journal of Social Sciences*, 13(2), 45–57.

[8]. Esan, O., Esan, A., Adeoye, A., and Amoo, G., 2022, Perinatal mental-health services in Nigeria: Current status and challenges. *Nigerian Journal of Clinical Practice*, 25(8), 1025–1032.

[9]. Paulson, J. F., and Bazemore, S. D., 2010, Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis. *Journal of the American Medical Association (JAMA)*, 303(19), 1961–1969.

[10]. Oppong, S., 2023, Paternal postpartum depression in Africa: A systematic review. *BMC Public Health*, 23, 459.

[11]. Connell, R., 2021, Gender. Cambridge: *Polity Press*.

[12]. Cox, J. L., Holden, J. M., and Sagovsky, R., 1987, Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782–786.

[13]. Braun, V., and Clarke, V., 2006, Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.

[14]. Duko, B., Ayano, G., and Bedaso, A., 2020, Postpartum depression among Ethiopian mothers: A systematic review and meta-analysis. *BMC Pregnancy and Childbirth*, 20, 290.

[15]. Were, F. N., Bukusi, D., Wambui, E., and Mwangi, P., 2021, Prevalence and correlates of postpartum depression in Kenya: A cross-sectional study. *BMC Public Health*, 21, 1612.

[16]. Moulds, M. L., Cheung, M. S. P., and Wong, Q. J. J., 2022, Postpartum depression and cognitive bias in parents: A meta-analytic review. *Clinical Psychological Science*, 10(2), 355–369.

[17]. Adewuyi, E. O., Akinloye, O. A., Musa, T. H., 2023, Sociodemographic and health predictors of postpartum depression among Nigerian women: A

cross-sectional analysis. *Int J Ment Health Syst,* 17:65.

[18]. Pan, Y., Zhang, Q., Wang, C., et al., 2024, Global prevalence of perinatal depression and associated factors: A systematic review and meta-analysis. *J Clin Med,* 13(2):112–128.

[19]. Hanlon, C., Alem, A., Tesfaye, F., Lakew, Z., Worku, B., Dewey, M., et al., 2023, Perinatal mental health in Ethiopia: A population-based study. *Lancet Glob Health.* 11(1):e45–e56

[20]. Duko, B., Ayano, G., Bedaso, A., 2020, Postpartum depression and associated factors among Ethiopian mothers: A systematic review and meta-analysis. *BMC Pregnancy Childbirth.* 20:290.