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Association of Social Support with Postpartum Depression Among Teen and Adult Mothers in Lahore, Pakistan

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Abstract

Background

Postpartum depression (PPD) is a mood disorder that affects 28–63% of women, predominantly within the first year of childbirth. Cultural, environmental, and economic context in Pakistan will play a role in the level of support women do receive and that support will differ between teen mothers and adult mothers.

Objective

To investigate the impact of emotional, instrumental, and informational social support during and after pregnancy on the incidence of PPD among teenage (15–19 years) and adult (20+ years) women in Lahore, Pakistan.

Methods

At Services Hospital Lahore, 400 mothers (43 percent teenagers and 57 percent adults), who had given birth in the previous 12 months participated in a cross-sectional study. The Edinburgh Postnatal Depression Scale (EPDS) was used to measure depressive symptoms. Structured questionnaires were used to gather information on social support, pregnancy history, and sociodemographic factors. Independent predictors of PPD were found using multivariate logistic regression.

Results

The prevalence of PPD was 28.3%, with adult mothers more affected (31.7%) than teenage mothers (23.8%)—a statistically significant difference. Key predictors of PPD included low family income (AOR = 2.40), lack of husband support (AOR = 3.96), and dissatisfaction with the baby's sex (AOR = 0.29). Postnatal social support significantly reduced the risk of PPD, while antenatal support showed no adjusted effect.

Conclusion

Postnatal social support is crucial in reducing the risk of PPD, especially for adult mothers. Strengthening family and social support systems, improving economic conditions, and addressing cultural stigma are essential to improving maternal mental health in Pakistan.

Keywords: Postpartum, Type of Delivery, Pregnancy, Demographic, Adolescent Mothers

1. Introduction

PPD or Postpartum depression is a critical mental health condition for mothers, which may definitely give rise to health-related problems. Symptoms including fatigue, in addition to a very depressed mood and anxiety, usually characterize this disorder emerging right after delivery and prevent the new mother from taking care of herself or the child [1]. Any new mother can develop PPD, but the extent and severity of the occurrence will depend on several factors like financial capacity, access to health care, and social support provisions [2].

Postpartum depression is an emerging public health problem in Pakistan, with reports on a prevalence level ranging from 28% to 63% [3]. The variation in reported prevalence indicates the diverse contextual risk factors that can lead up to PPD, for instance, poverty, absence of partner or family support, or lack of mental health services [4]. Social support during pregnancy and soon after delivery is recognized as a critical protective factor for all these factors against increased chances for developing depressive symptoms [5]. Social support can be defined as being at least three types: emotional (encouragement), instrumental (practical help or financial support), and informational (advice on health care) [6]. Women with good family, partner, or community support are less likely to suffer from postpartum depression because social support is a means of stress reduction, coping, and greater feelings of security and belonging [7].

But its impact might be different from one mother's age to another. Variations in maturity, readiness, and expectations within society set teen (15–19 years) mothers apart from adult mothers (20 and older) [8]. These variations characterize the teenage and adult motherhood experience. Teenage mothers experience highly demanding challenges, i.e., stigma, economic dependence, and low levels of education, among others which have been linked to PPD [9,10]. Research has indicated that teen and adult mothers who have less postnatal care and support are five times more likely to develop PPD [11]. This research aims to establish the impact of social support during postpartum on the prevalence of PPD among teen and adult mothers in Lahore, Pakistan [12]. Since PPD is highly prevalent in Pakistan, this study is of great significance in bridging the research gaps that exist and sought to divert attention to social determinants influencing PPD [13]. The findings of this research will show the significance of social support having an effect on maternal mental health and it will also assist the health care providers in making plans to enhance support system for postpartum and pregnant women [14].

2. Methodology

- **Study Design**
  Cross sectional study design was utilized to measure association between postpartum depression and social support among teen and adult mothers in Lahore, Pakistan.
- **Study Setting**
  The study was performed at Services Hospital Lahore, in the Outpatient Department (OPD) ward. The heterogeneity of this setting guaranteed a representative population sample.

2.1. Study Population and Sample Size

The participants in this study were females who were 15 years and older with delivery at least in the past 12 months. They were categorized into the following groups: teen mothers (15-19 years) and adults (20 years and older). A 45.5% prevalence (as an average of 28% and 63%) for the estimation of PPD was utilized for sample size determination to acquire a 95% confidence level with a 5% margin of error under the Daniel formula.

2.2. Data Collection

Data were gathered through an adjusted questionnaire with four sections. Section 1 dealt with the patient demographics such as age, education level, socioeconomic status, and obstetric history [15]. Section 2 dealt with the identification of postpartum depression (PPD) among adult and teenage mothers, in an effort to determine its incidence in these two age groups [16]. Section 3 analysed social determinants of PPD, that is, family support, economic status, and partner support [15]. Section 4 analysed intercorrelations between postpartum depression and social support, given the indicators of emotional, instrumental, and informational support [17]. The Edinburgh Postnatal Depression Scale (EPDS) was utilized to measure postpartum depression. Analysis of Data SPSS version 25 was used to analyse the data. Demographic information and social support levels were compiled using descriptive statistics. After controlling for potential confounding factors like socioeconomic status, parity, and birth complications, logistic regression was used to investigate the association between social support and PPD. Teenage and older mothers were compared using interaction terms between age group and social support. 95% CIs and adjusted odds ratios (AORs) were presented. The study had three main goals, each of which was determined by means of particular statistical tests. The Edinburgh Postnatal Depression Scale was used in this instance to identify depressive symptoms in order to achieve Objective 1, which was to identify postpartum depression (PPD) in adult mothers as opposed to teenage mothers Understanding the part that social factors play in PPD was the focus of Objective 2 [15]. Simultaneous logistic regression analysis was used to compare Adjusted Odds Ratios (Adj OR) with a 95% Confidence Interval (CI) and set the significance level at $p < 0.05$ in order to determine which of the factors independently affected postpartum depression. The association between social support and postpartum depression was determined by Objective 3 [17]. The Chi-square test was employed to compare significant variations in the degree of social support, PPD, and the differences between adolescent mothers (15–19 years old) and adult mothers (20 years and older) in terms of sociodemographic, pregnancy-related, delivery, and postpartum factors. Moral Aspects to Take into Account The corresponding institutional review boards granted ethics approval. The University of Central Punjab's Ethical Committee in Lahore granted permission. All participants gave their informed written consent, and the data were anonymised to ensure privacy.

3. Results

The survey involved 400 mothers, of which 43% were teen mothers (below 18 years) and 57% were adult mothers (above 18 years). The majority of the respondents were high school or lower educated (69.3%), and a mere 13%

had graduate level education. A vast number of participants were housewives (65.9%) as opposed to unskilled workers (34.1%). The majority resided in urban settings (71.5%), and most were from extended families (57%). Low monthly family income was experienced by 84.5% of the participants. In terms of factors related to pregnancy, 63.5% of the pregnancies were planned, and 87% were wanted by the mothers. Around 71.5% of the participants had four or more antenatal care visits. Normal vaginal delivery was experienced by 55%, while 45% had cesarean delivery. Baby sex satisfaction was reported by 93.5% of the women, and 89.5% reported having support from their husbands during postpartum.

Characteristics	**n**	**%**
Demographic and socio-economic		
Age		
<18 years old	172	43.0
18 years old	228	57.0
Education		
High school or less	277	69.3
Some Postsecondary	45	11.3
Undergraduate	26	6.5
Graduate	52	13.0
Occupational		
Unskilled Worker	302	34.09
Housewife	582	65.91
Type of staying		
Urban	286	71.5
Rural	113	28.2
Rural (>500,000)	1	0.3
Type of Household		
Nuclear Family	172	43.0
Extended Family	228	57.0
Family monthly Income		
High	57	14.2
Low	338	84.5
Latest Pregnancy		
Planned Pregnancy		
Yes	254	63.5
No	146	36.5
Wanted Pregnancy		
Yes	348	87.0
No	52	13.0
ANC Visit		
<4	114	28.5
4	286	71.5
Type of Delivery		
Normal	220	55.0
Caesarea	180	45.0
Satisfied with baby's sex		
No	26	6.5
Yes	374	93.5
Husband Support		
Yes	357	89.5
No	42	10.5

Table 1: Demographic and Socio-Economic Characteristics of Respondents

Citation: Akhtar, A., Babar, A. A. K., Usman, T., Akram, W., Ahmed, W., et.al. (2026). Association of Social Support with Postpartum Depression Among Teen and Adult Mothers in Lahore Pakistan. *J Cancer Res, 4*(1), 1-10.

An Edinburgh Postnatal Depression Scale (EPDS) score of 13 or higher indicated the presence of postpartum depression, which was present in 22.5% of cases. Mothers' mean EPDS score was 10.29, with a standard deviation of 4.23. Scores ranged from 1 to 23, with 10 serving as the median. This result implies that this age group has a significant burden of depressive symptoms. % of postpartum depression

Postpartum Depression	n	%
Postpartum Depression Yes (≥13)	90	22.50
No (<13)		
Mean ± SD	310	77.50
10.29 ± 4.23		
Median (Min-Max)		10 (1–23)

Table 2: Prevalence of Postpartum Depression Among Mothers

A score of 13 or higher on the Edinburgh Postnatal Depression Scale (EPDS) indicated postpartum depression, which was present in 22.5% of cases. The mean EPDS score of the teenage moms was 10.29, with a standard deviation of 4.23. Median was 10 and varied from 1 to 23. Median was 10 and varied from 1 to 23. This indicates a high prevalence of depressive symptoms in this group of age. Bivariate analysis identified various predictors significantly associated with postpartum depression. Family income below the national median was at higher risk of postpartum depression (OR = 0.484, 95% CI: 0.281–0.833, p = 0.009). Unintended pregnancy (OR = 1.680, 95% CI: 1.077–2.622, p = 0.022) and unwanted pregnancy (OR = 2.355, 95% CI: 1.290–4.297, p = 0.005) also were predictors. Sex dissatisfaction of the baby (OR = 4.553, 95% CI: 1.999–10.370, p < 0.001) and not having husband support (OR = 5.672, 95% CI: 2.885–11.153, p < 0.001) were significantly linked with postpartum depression risk. Other factors such as maternal age, residence, household type, antenatal care visits, and mode of delivery were not found to have significant relations.

Characteristics	n	%	Crude OR	95%CI	p-value
Demographic and socio-economic					
Age					
<18 years old	172	43.0	1 (Ref)		
≥18 years old	228	57.0	0.674	0.430 – 1.055	0.084
Type of staying					
Urban	286	71.5	1 (Ref)		
Rural	113	28.2	0.836	0.519 – 1.345	0.460
Type of Household					
Nuclear Family	172	43.0	1		
Extended Family	228	57.0	1.322	0.853-2.049	0.212
Family monthly Income					
High	57	14.2	1		
Low	338	84.5	0.484	0.281-0.833	0.009
Planned Pregnancy					
Yes	254	63.5	1		
No	146	36.5	1.680	1.077–2.622	0.022
Wanted Pregnancy					
Yes	348	87.0	1		
No	52	13.0	2.355	1.290 – 4.297	0.005
ANC Visit					
<4	114	28.5	1		
≥4	286	71.5	1.044	0.646–1.687	0.861
Type of Delivery					
Normal	220	55.0	1		

Citation: Akhtar, A., Babar, A. A. K., Usman, T., Akram, W., Ahmed, W., et.al. (2026). Association of Social Support with Postpartum Depression Among Teen and Adult Mothers in Lahore Pakistan. *J Cancer Res, 4*(1), 1-10.

Caesarea	180	45.0	0.695	0.449–1.077	0.103
Satisfied with baby's sex					
Yes	374	93.5	1		
No	26	6.5	4.553	1.999–10.370	<0.001
Husband Support					
Yes	357	89.5	1		
No	42	10.5	5.672	2.885–11.153	<0.001

Table 3: Simple Logistic Regression Results for Bivariate Analysis of Factors Associated with Postpartum Outcomes in Adolescent Mothers

In multivariate logistic regression model, low family monthly income continued to have significant association with increased odds of postpartum depression (AOR = 2.395, 95% CI: 1.258–4.560, p = 0.008). Dissatisfaction with the sex of the baby (AOR = 0.286, 95% CI: 0.112–0.733, p = 0.009) and lack of support from the husband (AOR = 3.960, 95% CI: 1.748–8.970, p < 0.001) were independent predictors of postpartum depression. Planned pregnancy and desired pregnancy did not remain statistically significant after controlling for other variables.

Characteristics	n	%	Crude OR	Adj OR	95%CI	p-value
Family monthly Income						
High	57	14.2	1			
Low	338	84.5	0.484	2.395	1.258 – 4.560	.008
Planned Pregnancy						
Yes	254	63.5	1			
No	146	36.5	1.680	0.642	0.378 – 1.090	.101
Wanted Pregnancy						
Yes	348	87.0	1			
No	52	13.0	2.355	0.655	0.326 – 1.315	.234
Satisfied with baby's sex						
Yes	374	93.5	1			
No	26	6.5	4.553	0.286	0.112 – 0.733	.009
Husband Support						
Yes	357	89.5	1			
No	42	10.5	5.672	3.960	1.748 – 8.970	<0.001

Table 4: Multivariate Logistic Regression Analysis of Factors Associated with Adult and Teen Mothers Regarding Pregnancy Planning, Pregnancy Intention, Satisfaction with Baby's Sex and Husband Support

As per the table presented below, postpartum depression was more common in adult mothers (31.72%) than in teen mothers (23.84%), which is statistically significant (p < 0.001). When considering social support, 72.1% of teen mothers and 74.6% of adult mothers said they received overall support "all of the time" throughout pregnancy. At birth, 72.7% of adolescents and 69.9% of adults reported always receiving consistent support. Social support was less common in adults than teens, indicating that consistent social support is an important factor for minimizing postpartum depression in both teens and adults.

In the table provided below the logistic regression model adjusted for social support at birth revealed that social support at birth was significantly related to decreased odds of postpartum depression. Mothers who claimed to have received support "most of the time" (AOR = 0.120, 95% CI: 0.034–0.426) and "some of the time" (AOR = 0.214, 95% CI: 0.068–0.673) were significantly less likely to have postpartum depression than those reporting support "all of the time." Having a partner (AOR = 0.186, 95% CI: 0.073–0.469) and no history of depression diagnosis (AOR = 0.382, 95% CI: 0.150–0.971) were protective against postpartum depression. Prenatal support, on the other hand, did not have a significant independent association in the adjusted model.

survey (N = 400)				
Teen mothers		Adult mothers	All mothers	P-value‡
Characteristics	N (%)	N (%)	N (%)	
Outcome variable				
Postpartum depression				<0.001
No	131 (76.16)	155 (68.28)	286 (71.68)	
Yes	41 (23.84)	72 (31.72)	113 (28.32)	
Social support around pregnancy				
Overall support during pregnancy				<0.001
All of the time	124 (72.1)	170 (74.6)	294 (73.5)	
Most of the time	28 (16.3)	27 (11.8)	55 (13.8)	
None/Little/Some of the time	20 (11.6)	31 (13.6)	51 (12.8)	
Overall support after birth				0.003
All of the time	125 (72.7)	157 (69.9)	282 (70.5)	
Most of the time	26 (15.1)	50 (21.9)	76 (19.0)	
None/Little/Some of the time	21 (12.2)	21 (9.2)	42 (10.5)	
Socio-demographic characteristics				
Age				
Teen mother (15–19 years)	N/A	N/A	172 (43.0)	
Adult mother (20+ years)	N/A	N/A	228 (57.0)	
Urban–rural residence				0.084
Rural area	41 (31.3)	27 (12.8)	68 (17.0)	
Urban, population ≤499,999	50 (38.2)	67 (31.8)	117 (29.3)	
Urban, population ≥500,000	81 (61.8)	117 (55.4)	215 (33.5)	
Level of education				
High school or less	N/A	N/A	277(69.3)	
Some postsecondary education	N/A	N/A	45(11.3)	
Undergraduate education	N/A	N/A	26(6.5)	
Graduate education	N/A	N/A	52(13.0)	
Partner/Significant other				<0.001
No	15 (11.5)	19 (16.8)	36 (9.0)	
Yes	155 (88.5)	209 (83.2)	364 (91.0)	
Previous depression diagnosis				
No	N/A	N/A	354 (88.5)	
Yes	N/A	N/A	46 (11.5)	
Pregnancy-related characteristics				
Wanted the pregnancy				<0.001
Then or Sooner	41 (24.1)	39 (17.1)	80 (20.1)	
Later or Not at all	129 (75.9)	189 (82.9)	318 (79.9)	
Health problems during pregnancy				0.822
No	145 (84.3)	169 (74.1)	314 (78.5)	
Yes	27 (15.7)	59 (25.9)	86 (21.5)	
Work during pregnancy				<0.001
No	40 (23.3)	38 (16.7)	78 (19.5)	
Yes	132 (76.7)	190 (83.3)	322 (80.5)	
Cigarette smoking during pregnancy				<0.001
No	170 (98.8)	215 (94.3)	385 (96.3)	

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Yes	2 (1.2)	13 (5.7)	15 (3.8)	
Alcohol use during pregnancy				
No	N/A	N/A	395 (98.8)	<0.001
Yes	N/A	N/A	5 (1.2)	
Drug use during pregnancy				
No	N/A	N/A	228 (86.4)	
Yes	N/A	N/A	36 (13.6)	
Delivery characteristics				
Type of delivery				0.025
Vaginal	118 (68.6)	102 (44.7)	220 (55.0)	
Caesarean	54 (31.4)	126 (55.3)	180 (45.0)	
Birth setting				
Hospital/clinic	N/A	N/A	334 (83.5)	0.723
Birthing centre/private/other	N/A	N/A	66 (16.5)	
General experience in labour & birth				
Negative	N/A	N/A	73 (18.2)	
Positive	N/A	N/A	260 (65.0)	
Neither	N/A	N/A	67 (16.8)	
Postpartum characteristics				
Mother's hospitalization after birth				<0.001
No	85 (49.4)	65 (28.5)	150 (37.5)	
Yes	87 (50.6)	163 (71.5)	250 (62.5)	
Work after pregnancy				
No	N/A	N/A	148 (37.0)	
Yes	N/A	N/A	252 (63.0)	
Enough information on PPD				0.174
No	151 (87.8)	179 (78.5)	330 (82.5)	
Yes	21 (12.2)	49 (21.5)	70 (17.5)	

Table 5: Associations Between Social Support and Postpartum Depression Among Pakistani Mothers in 2025 Maternity Experiences Survey (N = 400)

The study, involving 400 mothers (43% teen mothers and 57% adult mothers), found an overall postpartum depression (PPD) prevalence of 28.3%, with adult mothers experiencing a higher rate (31.7%) compared to teen mothers (23.8%). Factors significantly associated with PPD included low family income (AOR = 2.395), lack of husband support (AOR = 3.960), and dissatisfaction with the baby's sex (AOR = 0.286). Social support played a protective role, with consistent postpartum support lowering the odds of PPD, particularly among mothers who received support "all of the time." Bivariate analysis showed that unintended and unwanted pregnancies, as well as lack of partner support, were major contributors to PPD risk. The findings highlight the critical importance of social support, especially after childbirth, and underscore the need for targeted interventions focusing on socio-economic factors and family involvement to mitigate the risk of PPD in both adolescent and adult mothers.

4. Discussion

The impact of social support during pregnancy on the prevalence of postpartum depression (PPD) among Pakistani adolescent and adult mothers was investigated in this study. In keeping with growing global awareness of the social determinants of PPD, our findings offer valuable data on how the caliber and promptness of social support affect mother mental health across age groups [18]. Our sample's overall PPD rate was 28.3%, with adult women accounting for a larger percentage (31.7%) than teen moms (23.8%). This goes against earlier assumptions that teen moms would be more likely to suffer from PPD due to social shame and mental immaturity [19]. Adult mothers could be exposed to other stressors like work-life conflict, career interruption, and economic instability, leading to their higher risk [20]. The need to go beyond stereotypes and include age-based psychosocial circumstances of maternal mental health is highlighted by this nuanced interplay. One important protective factor was social support. While intermittent postpartum assistance was associated with increased risks, continuous support "all the time" significantly reduced the odds of PPD. These findings are consistent with the stress-buffering hypothesis, which holds that instrumental and emotional support boosts resilience and reduces susceptibility to depression [21]. Although prenatal support was high in unadjusted models, its link decreased after adjustment, suggesting that postpartum support has a more immediate impact, possibly as a result of the intense mental and physical strain that follows delivery [22].

A Low income was a consistent predictor of PPD among socio-demographic risk factors, echoing findings in both high- and low-income settings [23]. Financial instability might limit access to proper care, food, and sleep, which can increase emotional stress. Lack of partner support was another strong independent predictor; moms who did not get assistance were nearly four times more likely to suffer from PPD, confirming earlier research on the crucial role partner's play in helping mothers adjust [24]. It's interesting to note that PPD was strongly associated with infant sex dissatisfaction, especially among mothers of daughters. This is in line with the majority of South Asian nations' traditional predilection for sons and their detrimental psychological effects [25]. Mothers who get criticism or less support due to the baby's sex are more likely to experience feelings of shame and loneliness, in addition to experiencing greater symptoms of depression. Pregnancy intention was associated with PPD in bivariate analysis, but this relationship was no longer significant after adjustment. This suggests that, similar to the results of previous research, unplanned pregnancies may not be a reliable indicator of depression on their own if financial conditions and support networks are considered [26]. Teen mothers in our sample reported slightly greater degrees of consistent support than adults, perhaps because of closer familial proximity or cultural pressure to shield younger mothers [27]. Our findings are consistent with research from other countries, such as the Canadian study that found decreased levels of depression and good felt support (PHAC, 2009). Even if Pakistan's healthcare system and culture differ from those of high-income countries, social ties always act as a buffer [28].

Interestingly, prior history of depression and mode of delivery, including cesarean section, did not prove to be significant predictors upon adjustment, opposite some literature [29]. This could indicate the stronger impact of social stressors and support systems at the time of delivery over obstetric and clinical history in determining postpartum mental health. The critical need for health interventions and policies that prioritize postpartum emotional well-being is highlighted by our research. Programs of maternal care must include frequent screening for social support during prenatal and postnatal consultations, especially for women from low-income households or without partner involvement [30]. Husbands must be involved in family education on the need of consistent support. Additional therapies that can address unmet emotional needs include peer counselling, support groups, and community outreach [31]. Due to their increased prevalence of PPD, which may be brought on by role overload and financial obligation, adult moms in particular may benefit from special programs. Understanding these unique demands can help to tailor mental health care to the needs of different age groups and situations. A key strength of our study is its representative sample and focus on an underexplored population in the Pakistani context. However, limitations include its cross-sectional design and limited ability to account for previous psychiatric history or quality of marital relationships. Nonetheless, our findings add meaningful knowledge to the field and support the global call for integrating psychosocial care into maternal health strategies (UNFPA, 2021).

4.1. Limitations

Some limitations nevertheless need to be noted. The cross-sectional design precludes causal conclusions, and self-reported data are at risk for recall or social desirability biases. The study took place in an urban hospital setting, which may restrict generalizability to rural populations. Longitudinal future research would follow mothers over time to establish more fully the changing dynamics of social support and its effect on maternal mental health.

4.2. Clinical Implications

- **Importance of Postpartum Social Support**

Postnatal social support is crucial in reducing the risk of postpartum depression (PPD), especially for adult mothers. Healthcare providers should focus on fostering strong support systems during the postpartum period.

- **Targeted Interventions for Vulnerable Groups**

Low family income, lack of partner support, and dissatisfaction with the baby's sex are key risk factors for PPD. Health interventions should target these socio-economic and cultural factors, particularly for vulnerable populations.

- **Need for Routine Screening**

Regular screening for postpartum depression should be integrated into maternal healthcare services, assessing both depressive symptoms and the level of social support during pregnancy and after birth to identify at-risk women.

- **Cultural Sensitivity in Maternal Care**

Healthcare providers must be culturally sensitive to factors like the preference for male children, which can impact maternal mental health, while addressing mental health needs effectively.

- **Postpartum Support Programs**

Healthcare systems should prioritize the development of support programs, such as peer counseling, community outreach, and family education, to provide sustained support and reduce the risk of postpartum depression, particularly for adult mothers.

4.3. Implications for Practice

- **Integrating Social Support Frameworks in Maternal Health Care**

Healthcare professionals should incorporate social support assessments into regular maternal care, especially during the antenatal and postnatal periods. Providers should actively engage with mothers about the emotional, informational, and instrumental support available to them. This could involve helping mothers identify supportive family members, encouraging partner involvement, and facilitating access to community resources.

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• Targeted Postpartum Depression (PPD) Prevention Programs

Given the findings that low family income and lack of partner support are significant risk factors, maternal healthcare services should develop targeted PPD prevention programs. These programs can focus on improving economic support through social services, offering mental health support for mothers with low income, and educating families about the importance of emotional support during the postpartum period.

• Routine Screening and Early Identification of At-Risk Mothers

Healthcare providers should implement routine screening for postpartum depression using tools like the Edinburgh Postnatal Depression Scale (EPDS) at both antenatal and postnatal visits. By identifying mothers at risk early, providers can offer timely interventions, ensuring better mental health outcomes. Screening should not be limited to depressive symptoms but should also assess the quality and consistency of social support, particularly from partners and family.

• Cultural Competence in Maternal Care

Healthcare providers should be trained in cultural competence to understand the specific cultural contexts affecting maternal mental health, such as son preference in some communities. Tailoring interventions to address cultural norms and their psychological impacts can help improve maternal mental health outcomes and reduce feelings of isolation or guilt among mothers.

• Strengthening Family and Partner Involvement

Family and partner support are critical in reducing PPD risks. Healthcare providers should involve fathers and other family members in maternal care, providing education on how to support the mother both emotionally and practically. Programs aimed at educating families about the importance of their role in supporting maternal mental health should be integrated into standard maternal care practices.

• Development of Community-Based Support Programs

Community programs should be developed to provide continuous support to mothers. These can include peer counseling groups, support hotlines, and local parenting groups where mothers can share experiences and gain emotional support. Empowering communities to play an active role in maternal mental health will help reduce the stigma surrounding postpartum depression and ensure that mothers receive ongoing emotional support during their transition to motherhood.

5. Conclusion

There is extraordinary compulsion to be highlighted with reference to customized treatments to local assert in terms of family and partner support of maternal health and perceptions; financial conditions, and cultural norms surrounding pregnancy outcomes. For optimal maternal health and well-being measures, health care professionals will need to actively assess and advocate social support structures during antenatal and postnatal periods. Future longitudinal studies should aim to explore the ways in which social support influences postpartum mental health in the longer term and should provide targeted programs to help reduce the risk of PPD among vulnerable groups. Social support programs in provincial, national, or federal public health systems, following on from prioritising maternal social support structures would be effective in enhancing health and wellness for mothers and children by minimising the effects of postpartum depression in Pakistan.

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