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Paternal Postnatal Depression in Sub-Saharan Africa: A Narrative Synthesis of Clinical Burden, Impact on Men's Health and Implications for Maternal–Child Health Integration

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Abstract

Objective: This review synthesises and critically evaluates evidence on paternal postnatal depression in sub-Saharan Africa, with specific attention to prevalence, associated factors, recognition, screening practices, health-system responses, and priorities for future research. **Background:** Paternal postnatal depression is an under-recognised aspect of perinatal mental health in sub-Saharan Africa. Although emerging studies highlight its relevance to family wellbeing, fathers remain underrepresented in regional research, policy, and service delivery. **Method:** We conducted a narrative synthesis of quantitative and qualitative studies to examine prevalence patterns, correlates, screening approaches, and health-system engagement. We assessed studies for methodological characteristics, measurement approaches, and contextual relevance. **Results:** Evidence is geographically concentrated, with most quantitative studies originating from Ethiopia, Nigeria, and Ghana, and qualitative implementation findings from Tanzania. Prevalence estimates vary substantially due to differences in study timing, sampling strategies, measurement instruments, cut-off thresholds, and whether depressive symptoms, psychological distress, or clinically diagnosed depression were assessed. Although findings support the inclusion of fathers in perinatal mental-health pathways, no study has yet demonstrated the effectiveness of a specific intervention in the region. Screening remains unsettled, particularly given variable Edinburgh Postnatal Depression Scale cut-offs and its limited sensitivity to culturally patterned or male-typical presentations. **Conclusion:** Paternal postnatal depression remains an under-addressed though important component of perinatal mental health in sub-Saharan Africa. Future research should employ longitudinal, culturally adapted, diagnostically anchored designs and evaluate feasible interventions integrated within routine maternal and child health services.

Keywords: Africa, Depression, Ethiopia, Fathers, Ghana, Health, Men, Mental, Nigeria, Paternal, Postnatal, Screening, Sub-Saharan, Tanzania

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INTRODUCTION

Postnatal depression (PND) is a depressive disorder that occurs following childbirth and is characterised by persistent sadness, loss of interest in usual activities, fatigue, feelings of hopelessness or guilt, and impaired maternal functioning (American Psychiatric Association, 2022; World Health Organisation [WHO], 2022). In the literature, PND is commonly used interchangeably with postpartum depression (PPD), maternal postnatal depression, and maternal postpartum depression, all of which describe the same clinical condition. By contrast, perinatal depression and peripartum depression are broader terms that encompass depressive episodes occurring during pregnancy as well as after childbirth (American Psychiatric Association, 2022; Howard & Khalifeh, 2020).

Paternal postnatal depression refers to depressive illness or clinically significant depressive symptoms occurring after the birth of a child experienced by fathers. It is related to, but distinct from, maternal postnatal depression and from broader paternal psychological distress. The condition matters at the individual father, couple, and developing family levels. Fathers experiencing paternal postnatal depression (PPND) commonly report hidden distress, low mental-health literacy, stigma-driven reluctance to disclose symptoms, and limited father-focused support, with isolation and masculinity norms shaping recognition and help-seeking (Davenport et al., 2022; Davenport & Swami, 2023 and Maharani et al., 2025). A meta-analysis by Rao et al. (2020) demonstrated that paternal depression is a prevalent but under-recognised perinatal health issue, affecting around one in twelve fathers. The study highlighted a strong association between paternal and maternal depression and emphasised the need for integrated mental health screening and support for both parents during the transition to parenthood. Yet fathers are often reached indirectly through maternal and infant services, and their symptoms may be expressed through withdrawal, irritability, substance use, anger, sleep disturbance, or reduced engagement rather than an explicit report of low mood. Another meta-review of paternal perinatal mental-health instruments found substantial variation in screening thresholds and suggested that conventional measures may miss some paternal presentations (Schöch et al., 2024).

The transition to fatherhood can combine financial responsibility, disrupted sleep, altered couple roles, uncertainty about caregiving, and concern about the health of the mother or infant. Local economic conditions, social expectations, family structures, and access to care shape these pressures. Paternal postnatal depression disrupts fathers' wellbeing, relationships, and parenting, with men reporting legitimacy concerns, exclusion from services, and multidomain risk factors shaping distress and adaptation (Darwin et al., 2017; Kennedy-Metz & Ashmore, 2022). Early intervention and culturally sensitive mental health support may help address these challenges (Paul, 2026).

METHODOLOGY

Review Design and Eligibility Criteria

A systematic review was undertaken to examine paternal postnatal depression in sub-Saharan Africa. Studies were eligible if they investigated postnatal or postpartum depression among fathers or male partners within any sub-Saharan African country and reported on prevalence, determinants, lived experiences, outcomes, or interventions. We included quantitative, qualitative, and mixed-methods design studies. Studies were excluded if they focused solely

on maternal depression, were conducted outside sub-Saharan Africa, or did not provide sufficient data on paternal mental-health outcomes. We also excluded editorials, commentaries, conference abstracts, dissertations, and review articles from the pool of primary studies.

Information Sources and Search Strategy

We conducted computer searches of major biomedical and regional databases, including PubMed/MEDLINE, PsycINFO, Scopus, Web of Science, African Journals Online, and Google Scholar, and supplemented them with manual screening of reference lists. The search spanned database inception to October 2026. The search strategy combined Medical Subject Headings (MeSH) and free-text terms relating to paternal postnatal depression in Sub-Saharan Africa. MeSH terms included "Depression, Postpartum", "Fathers", and "Africa South of the Sahara", while free-text terms included paternal postpartum depression, paternal postnatal depression, paternal depression, fatherhood-related depression, depression in fathers, and Sub-Saharan Africa. Where appropriate, we also included the names of individual Sub-Saharan African countries to improve search sensitivity. Boolean operators (AND/OR) were used to combine concepts relating to depression, fatherhood, and geographical setting, and truncation (*) was applied to capture variations in terminology.

Study Selection and Data Extraction

Figure 1 presents the evidence selection process. Of 1,250 studies identified through database searches, 930 were screened by title and abstract after removing 320 duplicates. We further excluded 888 studies after applying the exclusion criteria. We assessed the remaining 42 full-text articles and excluded 33 based on pre-agreed criteria. Thus, 9 studies that fully met the inclusion criteria were included in the final review. One study we considered for inclusion was subject to an authorship dispute and was excluded because the publishers have since withdrawn it. However, the original study was conducted as part of a postgraduate dissertation (Worku, 2019), which was identified and included. The included articles comprised 6 cross-sectional studies, 2 qualitative studies, and 1 prospective observational study. Data were extracted from the 9 eligible studies, including authorship, publication year, country, design, sample size, measurement instrument, prevalence estimate, associated factors, and principal findings.

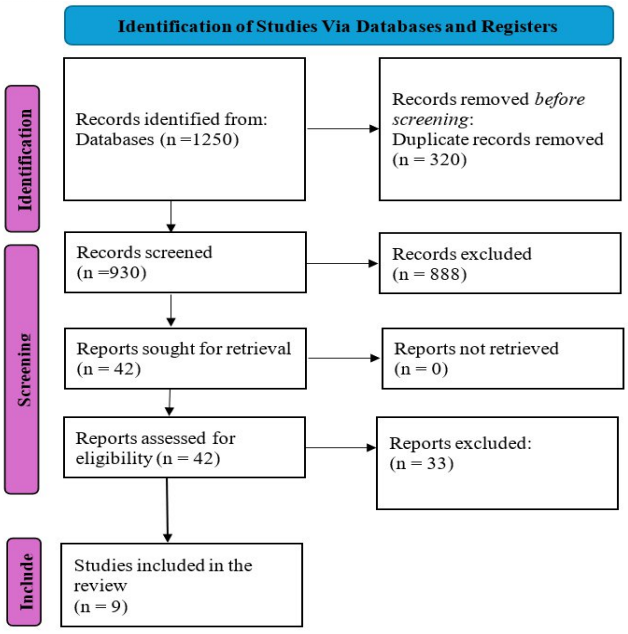

Figure 1: Study selection process

Quality Assessment and Synthesis

The narrative synthesis followed the framework of Popay et al. (2006). Consistent with Joanna Briggs Institute (JBI) guidance, findings were synthesised narratively because heterogeneity in study designs, populations, and outcome measures precluded meta-analysis (Aromataris et al., 2024). Studies were grouped into five prespecified domains: (1) geographical context and prevalence estimates, (2) socioeconomic and psychosocial correlates, (3) pregnancy-, infant-, and family-related factors, (4) clinical recognition and screening approaches, and (5) health-system responses and service delivery. Studies were compared by country, design, population characteristics, outcome measures, and key findings to identify patterns, inconsistencies, and evidence gaps. Differences in outcome definitions and measurement tools were considered during interpretation, and apparent inconsistencies were examined in relation to methodological variation rather than treated as contradictory findings. To minimise reviewer bias, a predefined data extraction framework and prespecified analytical domains were applied consistently across studies, while methodological quality was independently assessed by authors (ISM and JK) using the JBI Critical Appraisal Tools, with any discrepancies resolved through discussion and consensus. Nevertheless, narrative synthesis remains susceptible to reviewer interpretation and variation in study quality and reporting, which may limit the comparability and generalisability of findings.

Table 1: Included studies and methodological comparison (alphabetically ordered)

Study by Author	Design and setting	Sample size and measurement	Main finding	Evidence contribution
Assefa et al., 2026	A community-based cross-sectional study in Dessie Town, Northeast **Ethiopia**	610 fathers, using the Edinburgh Postnatal Depression Scale (EPDS). The authors report that 19% of fathers screened positive for PPD (EPDS ≥ 10),	The prevalence of paternal postpartum depression was 19% (95% CI 16.0 to 22.3)".	Large sample with 96.2% response rate, clear inclusion criteria, used a validated EPDS tool, multivariable regression with diagnostics, detailed operational definitions and transparent reporting of limitations
Ayinde & Lasebikan (2019).	Prospective observational study **Nigeria**	331 fathers assessed at childbirth and six weeks using structured clinical assessment	3% were depressed at baseline; 5.9% developed depression at six weeks among those without baseline	Provides temporal information, but follow-up was short and country-specific

Study by Author	Design and setting	Sample size and measurement	Main finding	Evidence contribution
			depression; 8.8% met the definition during the study period	
Dabala et al., (2024)	Community-based cross-sectional study, Seka Town **Ethiopia**	280 partners; self-report depression screening	Prevalence was 19.6%; previous depression, unintended pregnancy, alcohol use, infant sleep problems, and mode of delivery were associated	Recent evidence on correlates, but cross-sectional and instrument-dependent
Dwaah et al (2025).	Cross-sectional study with multistage cluster sampling across 10 communities (5 peri-urban, 5 rural). Sunyani West Municipality, **Ghana**	400 biological fathers living with children aged 0–17 years.	High prevalence of psychological distress, with 25% of fathers showing severe depression and 42% reporting elevated stress.	Provides strong evidence that paternal mental health is a critical determinant of parenting quality and child development in low-resource settings. Addressing fathers' psychological distress can significantly strengthen family well-being and improve child outcomes.
Shidende et al., (2025a)	Qualitative focus-group studies, Dar es Salaam, **Tanzania**	22 midwives from two hospitals	Paternal depression was recognised but overlooked; stigma,	Provides implementation perspectives, not prevalence or fathers' lived

Study by Author	Design and setting	Sample size and measurement	Main finding	Evidence contribution
			inadequate resources, and limited training constrained care	experience. They call for better training, inclusion of fathers in postnatal care, culturally sensitive counselling, community engagement, and stronger referral systems.
Shidende et al. (2025b)	Qualitative descriptive study, Dar es Salaam, **Tanzania**	22 midwives from two hospitals	Midwives in Tanzania recognise paternal postnatal depression as a real but neglected public health issue**.**	They call for better training, inclusion of fathers in postnatal care, culturally sensitive counselling, community engagement, and stronger referral systems.
Tuji et al., (2023)	Facility-based cross-sectional study **Ethiopia**	280 fathers six to eight weeks postpartum; validated Amharic K10 administered by telephone	About one-fifth (20%) reported psychological distress Lower income, unintended pregnancy, poor social support, poor infant health, and maternal distress were associated factors	Adds culturally adapted distress measurement, but does not estimate depression directly
Wedajo et al., (2023)	Community-based cross-sectional study, Mattu Town	412 fathers; interviewer-administered questionnaire	Prevalence was 29.37%; poor wealth, loneliness, poor support, income	Community evidence, but limited causal interpretation

Study by Author	Design and setting	Sample size and measurement	Main finding	Evidence contribution
	Ethiopia		stress, and adverse pregnancy outcomes were associated	
Worku (2019	Facility-based cross-sectional study, Wolaita Zone **Ethiopia**	410 male partners. EPDS cut-off ≥10	17% screened positive; income, social support, marital relation, substance use, unintended pregnancy, and infant sleep were associated	Useful regional prevalence and correlates, but screening-based and cross-sectional

FINDINGS

Characteristics and Geographical Distribution of the Included Evidence

Nine studies informed the narrative synthesis. Of the included studies, eight provided direct evidence relating to paternal postnatal depression (PPND) or paternal postpartum psychological distress, while one study provided contextual evidence on paternal mental health beyond the postpartum period. The evidence was concentrated geographically, with most studies originating from Ethiopia. Additional evidence was identified from Nigeria, Ghana, and Tanzania. Study designs included seven cross-sectional studies, two qualitative studies, and one prospective observational study.

Direct evidence on paternal postnatal depression was available primarily from Ethiopia and Nigeria. The Ethiopian studies included facility-based and community-based investigations conducted in Addis Ababa, Wolaita Zone, Mattu Town, Seka Town, and Dessie Town. The Nigerian study followed fathers prospectively during the early postpartum period. The two Tanzanian studies did not assess prevalence among fathers but explored midwives' experiences of recognising and managing paternal postnatal depression within routine care settings (Shidende et al., 2025a, 2025b). One Ghanaian study examined paternal psychological wellbeing among fathers of children aged 0–17 years. Because the study population extended well beyond the postpartum period, it was considered contextual evidence on paternal mental health rather than direct evidence of paternal postnatal depression (Dwaah et al., 2025). These patterns indicate that current evidence remains geographically limited and unevenly distributed across sub-Saharan Africa. Consequently, findings should be interpreted as representing a small number of national contexts rather than the region.

Globally, PPND prevalence varies widely across tools and contexts, with pooled estimates near 24%, and risks shaped by antenatal symptoms, partner depression, social support, economic strain, and paternal role constraints (Dhanpal & Shil, 2024; Koh et al., 2014; Philpott

& Corcoran, 2018). This review focused on detailed evidence from Ethiopia, Nigeria, Tanzania, and Ghana. The Nigerian study used a prospective design and followed fathers from childbirth to six weeks. Ethiopian studies were primarily cross-sectional and included facility-based and community-based samples from Wolaita Zone, Addis Ababa, Mattu Town, and Seka Town. The Tanzanian studies used focus groups with 22 midwives from two hospitals in Dar es Salaam and examined recognition, management, and service recommendations rather than estimating paternal depression among fathers (Shidende et al., 2025a, 2025b).

Dwaah et al. (2025) examined paternal psychological distress among fathers of children aged 0–17 years and therefore does not provide direct evidence on paternal postnatal depression. However, the study was retained as contextual evidence because it contributes to understanding paternal mental health, parenting practices, and child wellbeing within a sub-Saharan African setting.

The Ghanaian study was cross-sectional and examined 400 fathers using four different depression measurement tools. In this study, 25% of participants (men) had symptoms classified as severe depression and reported that poorer mental health was associated with reduced fathering practices and lower perceived child well-being. However, because participants had children aged 0–17 years, this is broader paternal mental-health evidence rather than a specific postpartum depression study.

This distribution creates two interpretive constraints. First, findings from Ethiopia, Nigeria and Ghana cannot be assumed to generalise to countries with different languages, health systems, family arrangements, or economic conditions. Second, provider perspectives from Tanzania help explain implementation barriers but cannot substitute for direct evidence from affected fathers. The available evidence supports concern about paternal postnatal depression across the SSA region, but it does not support a precise estimate of regional prevalence.

Prevalence and Outcome Variation

Reported prevalence estimates varied substantially across studies. This variation reflected differences in study populations, postpartum assessment periods, measurement instruments, screening thresholds, and outcome definitions. The Nigerian prospective study reported that 3% of fathers met criteria for depression at baseline, while 5.9% subsequently developed depression during the six-week follow-up period. Overall, 8.8% met the study definition of depression during the observation period (Ayinde & Lasebikan, 2019). Because this study employed prospective follow-up and structured assessment, it provides the strongest temporal evidence among the included studies.

Most Ethiopian studies used screening instruments and reported higher proportions of fathers with screen-positive depressive symptoms. In Addis Ababa, 17% of fathers screened positive using the Edinburgh Postnatal Depression Scale (EPDS) at a threshold of ≥10 (Worku, 2019). Similar studies reported prevalence estimates of 19.0% in Dessie Town (Assefa et al., 2026), 19.6% in Seka Town (Dabala et al., 2024), and 29.4% in Mattu Town (Wedajo et al., 2023).

Importantly, not all studies assessed the same outcome. Tuji et al. (2023) measured paternal postpartum psychological distress using the Kessler Psychological Distress Scale (K10) rather than depressive symptoms. Approximately one-fifth of fathers reported clinically significant psychological distress six to eight weeks after childbirth. Because psychological distress and depression represent related but distinct constructs, these findings were interpreted separately and were not treated as equivalent prevalence estimates. Overall, the evidence does not support

calculation of a single regional prevalence estimate. Instead, the studies demonstrate that paternal depression, depressive symptoms, and psychological distress occur at clinically relevant levels across multiple settings, while measurement approaches substantially influence reported prevalence.

The most consistent finding is that paternal postnatal depression or postpartum psychological distress occurs at clinically relevant levels, while reported prevalence varies considerably. In Nigeria, a prospective study of 331 fathers reported that 3% were depressed at baseline, 5.9% developed depression at six weeks after exclusion of those depressed at baseline, and 8.8% met the study definition across the assessment period (Ayinde & Lasebikan, 2019). The longitudinal design improves temporal interpretation, but the six-week follow-up limits conclusions about the longer postpartum period.

Ethiopian studies generally reported higher screening-based estimates. In Wolaita Zone, 17% of 410 male partners screened positive on the Edinburgh Postnatal Depression Scale using a cut-off of at least 10 (Worku, 2019). A community-based study in Mattu Town reported a prevalence of 29.37% among 412 fathers (Wedajo et al., 2023), while a study in Seka Town reported 19.6% among 280 partners (Dabala et al., 2024). In Addis Ababa, a facility-based study of 280 fathers assessed psychological distress rather than depression using the validated Amharic Kessler Psychological Distress Scale. Approximately one-fifth of fathers endorsed distress symptoms six to eight weeks after their partners gave birth (Tuji et al., 2023). This estimate should not be treated as equivalent to an EPDS-based depression prevalence because psychological distress and depressive disorder are different constructs.

A systematic review and meta-analysis of Ethiopian studies estimated pooled paternal postpartum depression prevalence at 20.86% (95% CI 16.43–25.29%) across five studies (Kitil et al., 2024). However, heterogeneity was very high ($I^2 = 97.9\%$), so the pooled result should be interpreted as a summary of dissimilar studies rather than as a precise underlying prevalence. Differences in recruitment setting, timing, screening instrument, threshold, interviewer involvement, and the distinction between screening positivity and clinical diagnosis plausibly explain the variation. The evidence is therefore best represented as a set of context-specific estimates rather than one regional number.

Economic and Employment Factors

Economic hardship emerged as a recurring correlate of paternal postnatal mental-health difficulties. In Nigeria, unemployment was associated with depression at baseline, although the association was not maintained during follow-up (Ayinde & Lasebikan, 2019). Ethiopian studies reported associations between lower household income, perceived financial strain, poor wealth status, and depressive symptoms (Assefa et al., 2026; Worku, 2019; Wedajo et al., 2023).

Although findings were broadly consistent across settings, most evidence was derived from cross-sectional studies. Consequently, causal relationships cannot be established, and the direction of association remains uncertain.

Economic insecurity was a recurring correlate. In the Nigerian study, depression at baseline was more common among unemployed fathers than employed fathers, although the subgroup was small and unemployment was not a significant correlate at six weeks. This temporal difference cautions against treating unemployment as a uniform predictor across the postpartum period. Evidence from Ethiopia more consistently linked financial conditions to

paternal distress. The Wolaita study reported significant associations with family income, and the Mattu study identified poor wealth and perceived family-income stress as associated factors (Worku, 2019; Wedajo et al., 2023). The Ethiopian meta-analysis reported an association between low family income and paternal postpartum depression (OR 3.04, 95% CI 1.46–6.32) (Kitil et al., 2024). These findings align with a pathway in which economic pressure intensifies provider-role expectations, limits access to care and increases relational strain. Because the underlying studies were predominantly cross-sectional, they do not establish that low income independently causes depression.

Social Support and Interpersonal Relationships

Several studies identified social support and relationship factors as important correlates of paternal postnatal mental-health outcomes. Poor social support was associated with depressive symptoms in multiple Ethiopian studies (Assefa et al., 2026; Worku, 2019; Wedajo et al., 2023). Similarly, Tuji et al. (2023) reported higher odds of psychological distress among fathers reporting inadequate social support. Relationship difficulties, loneliness, and family conflict also emerged as recurring correlates. Collectively, these findings suggest that paternal mental health is influenced by broader family and social environments rather than solely by individual psychological factors.

Poor social support was consistently associated with paternal distress. The Ethiopian meta-analysis reported an association between poor social support and paternal postpartum depression (OR 4.28, 95% CI 2.53–7.23) (Kitil et al., 2024). Individual Ethiopian studies also identified poor family support, loneliness, and marital or relationship variables (Worku, 2019; Wedajo et al., 2023). In Addis Ababa, fathers with poor social support had higher odds of psychological distress (Tuji et al., 2023).

These findings place paternal mental health within a family and social system rather than treating it as an isolated individual outcome. Broader systematic-review evidence also identifies relationship and prior mental-health factors among potential influences on paternal postpartum depression (Wang et al., 2021). Nevertheless, the Nigerian prospective study did not find a significant maternal–paternal depression association at six weeks, indicating that couple-level co-occurrence may vary by population, timing, and measurement (Ayinde & Lasebikan, 2019).

Pregnancy, Infant, And Family-Related Factors

Unintended pregnancy was consistently associated with paternal depressive symptoms across several Ethiopian studies (Assefa et al., 2026; Dabala et al., 2024; Worku, 2019).

Infant-related factors also appeared important. Infant sleep difficulties were associated with depressive symptoms in several studies, while poor infant health was associated with paternal psychological distress (Dabala et al., 2024; Tuji et al., 2023). Additional associations were reported for adverse pregnancy outcomes and delivery-related complications (Wedajo et al., 2023). Although these findings identify recurring correlates, the observational evidence does not support causal conclusions.

Unintended pregnancy was associated with paternal postpartum depression in several Ethiopian studies. The Ethiopian meta-analysis estimated an odds ratio of 3.42 (95% CI 2.24–5.24), while individual studies reported adjusted associations of approximately 3.5 and 4.7 (Dabala et al., 2024; Kitil et al., 2024; Worku, 2019). An unintended pregnancy may

represent several overlapping pathways, including reduced preparation for fatherhood, financial pressure, relationship conflict, or ambivalence about the pregnancy. The observational evidence cannot distinguish among these explanations.

Infant-related circumstances were also relevant. The Ethiopian meta-analysis reported an association between infant sleep problems and paternal postpartum depression (OR 4.78, 95% CI 2.35–9.73) (Kitil et al., 2024). The Addis Ababa study found higher odds of paternal psychological distress when infant health was poor (Tuji et al., 2023). The Mattu study reported an association with adverse pregnancy outcomes (Wedajo et al., 2023). These findings support family-centred assessment that asks about infant health, sleep, and pregnancy outcomes, but they do not show that infant characteristics alone cause paternal depression.

Previous Mental Health Problems and Substance Use

A history of previous depression was associated with paternal depressive symptoms in Seka Town, Ethiopia (Dabala et al., 2024). Alcohol use and broader substance-use behaviours were also associated with depressive symptoms across several studies (Assefa et al., 2026; Dabala et al., 2024). The available evidence does not determine whether substance use functions primarily as a risk factor, a coping strategy, or both.

Substance use was associated with paternal postpartum depression in the Ethiopian meta-analysis (OR 2.96, 95% CI 1.63–5.37), and alcohol use was associated with depression in the Seka study (Dabala et al., 2024; Kitil et al., 2024). Cross-sectional data cannot determine whether substance use contributes to depression, represents coping with pre-existing distress, or reflects shared social and economic stressors. Previous depression was associated with paternal postnatal depression in Seka Town, where the reported adjusted odds ratio was 4.4 (Dabala et al., 2024). This finding supports taking a mental-health history during pregnancy or early postpartum care rather than treating paternal screening as an issue that begins only after delivery.

Recognition, Screening, and Service Delivery

Studies varied considerably in their measurement approaches. Most studies relied on self-report screening instruments, particularly the EPDS, whereas Tuji et al. (2023) used the K10 to assess psychological distress. Differences in instruments and cut-off scores reduced comparability across studies and complicated interpretation of prevalence estimates. The Tanzanian qualitative studies highlighted service-delivery challenges rather than prevalence. Midwives described paternal postnatal depression as a genuine but overlooked clinical issue. Participants reported barriers including stigma, inadequate training, limited resources, and the absence of father-inclusive services (Shidende et al., 2025a). Midwives also proposed several strategies to improve care, including enhanced professional education, greater father involvement in postnatal services, public awareness initiatives, and stronger referral pathways (Shidende et al., 2025b). However, none of these approaches has yet been evaluated as a clinical intervention, and they should therefore be regarded as proposed service responses rather than evidence-based models of care.

Regional studies have relied heavily on self-report instruments. The Wolaita study used the EPDS with a cut-off of at least 10, whereas the Addis Ababa study used the K10 to assess psychological distress (Tuji et al., 2023; Worku, 2019). A challenge with these instruments is that a positive screen is not a diagnosis, and comparisons between studies are difficult when instruments measure different constructs or use different thresholds.

The EPDS is widely used internationally, but its application to fathers remains methodologically unsettled. The 2024 meta-review identified substantial variation in cut-offs and sensitivity and noted that male-specific symptoms may be missed (Schöch et al., 2024). A qualitative meta-synthesis similarly found that studies often use general depression or anxiety measures rather than instruments designed specifically for paternal depression; it also identified masculinity norms and help-seeking barriers as relevant challenges (Kido et al., 2022). In sub-Saharan African settings, translation, literacy, local idioms of distress, privacy, and the social meaning of fatherhood may further influence responses.

The Tanzanian provider studies illustrate the gap between recognition and routine care. Midwives in Dar es Salaam described paternal postnatal depression as significant and frequently encountered but overlooked. They identified emotional, physical, and behavioural symptoms and reported insufficient resources, systemic obstacles, stigma, and inadequate training (Shidende et al., 2025a and Shidende et al., 2025b). These findings are valuable for implementation, but provider reports do not establish prevalence or fully represent fathers' experiences.

Health-System Responses and Intervention Implications

The regional evidence supports including fathers in perinatal mental-health pathways, but it does not establish the effectiveness of a specific intervention in sub-Saharan Africa. Tanzanian midwives reported using counselling, education, and interprofessional collaboration, while emphasising the need for improved training and resources (Shidende et al., 2025a). They recommended comprehensive midwifery education, public and community awareness, full involvement of fathers in postnatal care, and supportive facilities with dedicated spaces for fathers (Shidende et al., 2025b).

A feasible service model would invite fathers explicitly, offer private assessment, ask about prior depression and substance use, and assess social support, relationship strain, infant sleep, infant health, and financial stress. A positive screen should lead to clinical assessment and appropriate referral, not a diagnosis based on the questionnaire alone. This approach is consistent with the Nigerian study's recommendation that postpartum mental-health services extend to fathers, particularly unemployed men (Ayinde & Lasebikan, 2019).

Implementation should not simply copy maternal screening pathways. Fathers may attend services irregularly, work during clinic hours, or avoid disclosure in front of partners or family members. Evidence on screening and intervention challenges indicates that fathers are more likely to engage when services recognise them as patients and caregivers, and when professionals are trained to address paternal mental health (Kido et al., 2022; Schöch et al., 2024). Tanzanian findings further indicate that stigma, limited resources, and system-level barriers must be addressed alongside clinical identification (Shidende et al., 2025a).

DISCUSSION

This review identified evidence that paternal postnatal depression and related psychological difficulties occur across several sub-Saharan African settings. However, interpretation of prevalence remains complicated by substantial methodological variability. Studies differed in postpartum assessment periods, sampling approaches, outcome definitions, and measurement instruments. Consequently, variation in reported prevalence likely reflects methodological differences more than genuine differences between populations.

A key finding of the review is the importance of distinguishing among clinically diagnosed depression, screen-positive depressive symptoms, and broader psychological distress. For example, the Nigerian study measured depression using structured assessment and reported lower prevalence estimates than most Ethiopian studies, which relied on screening instruments. Similarly, the Addis Ababa study assessed psychological distress using the K10 and therefore should not be interpreted as measuring paternal postnatal depression directly (Tuji et al., 2023). Failure to distinguish between these constructs may contribute to considerable variation across the international literature.

Despite methodological differences, a few recurring correlates emerged across studies. Economic hardship, inadequate social support, unintended pregnancy, infant-health difficulties, sleep disruption, previous depression, and substance use were repeatedly associated with adverse paternal mental-health outcomes. Similar patterns have been reported in international systematic reviews and meta-analyses, suggesting that interconnected economic, relational, caregiving, and psychological factors influence paternal mental health (Dhanpal & Shil, 2024; Wang et al., 2021).

The review also identified important limitations in current screening approaches. Most studies relied on instruments originally developed for maternal populations, particularly the EPDS. Evidence from international methodological reviews suggests considerable variation in recommended cut-off scores and raises concerns regarding the sensitivity of existing instruments to male-specific presentations of distress (Schöch et al., 2024). Cultural adaptation poses an additional challenge in sub-Saharan African contexts, where local understandings of fatherhood, mental health, and help-seeking behaviour may shape symptom expression and reporting.

The Tanzanian studies provide valuable insights into implementation challenges. Midwives recognised paternal postnatal depression as an important but neglected issue and identified barriers relating to stigma, workforce preparation, and resource constraints (Shidende et al., 2025a). The recommendations emerging from Tanzanian providers offer a potentially useful framework for service development. Nevertheless, no included study evaluated the effectiveness of these approaches. Future implementation studies are therefore required before such models can be recommended as evidence-based interventions.

Several limitations of the evidence base should be acknowledged. The available literature is heavily concentrated in Ethiopia, with comparatively little evidence from other parts of sub-Saharan Africa. Most studies employed cross-sectional designs, limiting causal inference. Sample characteristics, postpartum assessment windows, and screening thresholds varied considerably. Furthermore, few studies incorporated diagnostic interviews, making it difficult to distinguish depressive disorder from elevated depressive symptoms identified through screening instruments.

Collectively, the evidence supports recognition of fathers as an important component of perinatal mental-health care. Nevertheless, current knowledge remains insufficient to support a single regional prevalence estimate or a definitive service model. Future research should prioritise longitudinal designs, culturally validated assessment methods, broader geographic coverage, direct qualitative investigation of fathers' experiences, and rigorous evaluation of father-inclusive interventions.

The service implication is not that every father should be diagnosed through a single questionnaire. Rather, fathers should be made visible in routine perinatal care, offered

confidential case finding, and connected to clinical assessment when symptoms or risk factors are identified. This is especially important because provider-focused Tanzanian evidence suggests that paternal depression may be recognised but overlooked amid stigma, limited training, and resource constraints (Shidende et al., 2025a). Screening must therefore be linked to referral capacity, culturally acceptable psychosocial support, and staff training. Without those elements, screening may increase identification without improving care.

A feasible service model would invite fathers explicitly, offer private assessment, ask about prior depression and substance use, and assess social support, relationship strain, infant sleep, infant health, and financial stress. A positive screen should lead to clinical assessment and appropriate referral, not a diagnosis based on the questionnaire alone. This approach is consistent with the Nigerian study's recommendation that postpartum mental-health services extend to fathers, particularly unemployed men (Ayinde & Lasebikan, 2019).

Research Gaps and Priorities

The evidence base needs geographic expansion. Detailed primary evidence is concentrated in Ethiopia, Nigeria, and Ghana, while Tanzanian evidence focuses on providers. Studies are needed across West, Central, Southern, and Francophone Africa, with deliberate inclusion of rural communities, fathers who do not attend maternal services, and men from diverse family structures.

- Paternal Postnatal Depression measurement tool validation. Future studies should compare translated screening instruments with structured diagnostic interviews, report the exact postpartum time point, and distinguish depressive disorder, depressive symptoms, and general psychological distress. The lack of consensus on EPDS cut-offs and the possibility of paternal presentations that are not captured by conventional tools make local validation essential.

- Longitudinal research will strengthen the evidence. Repeated assessment from pregnancy through at least the first postpartum year would clarify whether economic stress, maternal distress, infant health, sleep disruption, and relationship strain precede paternal depression, result from it, or reinforce one another. The Nigerian finding that baseline and six-week correlates differed demonstrates why a single postpartum assessment is insufficient.

- Evaluation of intervention effectiveness remains a priority. Future pragmatic and implementation studies should rigorously assess screening, referral, peer-support, couple-based, community-led, and culturally adapted interventions. Outcomes should encompass paternal mental health, maternal wellbeing, couple functioning, father-infant engagement, service utilisation, and potential adverse effects, including stigma and mislabelling.

- Evaluation of intervention effectiveness remains a priority. Future pragmatic and implementation studies should rigorously assess screening, referral, peer-support, couple-based, community-led, and culturally adapted interventions. Outcomes should encompass paternal mental health, maternal wellbeing, couple functioning, father-infant engagement, service utilisation, and potential adverse effects, including stigma and mislabelling.

CONCLUSION

Paternal postnatal depression is a significant yet under-recognised aspect of perinatal mental health in sub-Saharan Africa and warrants greater attention within maternal and child health systems. Although methodological limitations preclude robust regional prevalence estimates, the available evidence consistently indicates that fathers experience postnatal depressive symptoms associated with socioeconomic adversity, relationship difficulties, social constructs of masculinity, inadequate social support, and previous mental health problems. These findings support including fathers in perinatal mental health assessment and support pathways, while challenging the continued exclusion of paternal mental health from routine postnatal care.

Strengthening the recognition and management of paternal postnatal depression aligns directly with the UN Sustainable Development Goals (SDGs), particularly SDG Target 3.4, which seeks to promote mental health and well-being by addressing an overlooked population whose mental health influences maternal wellbeing, child development, and family functioning. It also contributes to SDG 5.4, which calls for recognising and valuing unpaid care and domestic responsibilities through shared family participation and support. Recognising and supporting fathers as active participants in perinatal care is therefore not only a mental health priority but also an essential component of advancing equitable family health and achieving sustainable development.

Compliance Statements

Informed consent statement: No human participants were directly involved in this narrative review; informed consent was therefore not applicable.

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