

Postpartum Depression Screening in Primary Care Settings: Evidence, Implementation Challenges and Opportunities for Integrated Maternal Mental Health

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Abstract: Postpartum depression is a common and potentially disabling complication of childbirth that affects maternal functioning, relationships, infant care and child development. Primary care offers repeated opportunities for early identification because women interact with health services during postnatal visits, immunization sessions, family-planning consultations and infant-care encounters. Screening with validated instruments—principally the Edinburgh Postnatal Depression Scale and Patient Health Questionnaire-9—can improve recognition, but a positive score is not a diagnosis and must be followed by clinical assessment. Screening is beneficial only when accompanied by clear pathways for suicide-risk assessment, diagnostic confirmation, psychosocial support, treatment, referral and follow-up. International recommendations increasingly support repeated screening during pregnancy and the postpartum period within systems capable of providing appropriate care. Evidence suggests that integrated and collaborative-care models can improve engagement and depressive outcomes, whereas screening without treatment capacity may increase workload without improving health. In India, a systematic review estimated a pooled postpartum depression prevalence of approximately 22%, although estimates varied considerably by setting, timing and measurement method. Primary-care implementation is constrained by stigma, limited privacy, inadequate mental-health training, fragmented records and shortages of specialist services. Nevertheless, India's network of community health workers, postnatal contacts and Ayushman Arogya Mandirs provides a feasible platform for stepped care. Future programmes should prioritize culturally validated tools, repeated rather than one-time screening, task-sharing, family-sensitive support, digital follow-up and cascade-based monitoring from screening to remission.

Keywords: postpartum depression; maternal mental health; screening; primary health care; Edinburgh Postnatal Depression Scale; India.

INTRODUCTION

The postpartum period is marked by profound biological, psychological and social change. Sleep disruption, breastfeeding difficulties, physical recovery, altered family relationships and responsibility for a newborn can create distress even in women without a psychiatric history. For some, these pressures coincide with a depressive disorder characterized by persistent low mood, loss of interest, guilt, hopelessness, impaired concentration, disturbed sleep beyond that expected from infant care and, in severe cases, suicidal thoughts.[1]

Postpartum depression should be distinguished from the transient “postpartum blues,” which commonly involves tearfulness, irritability and emotional lability during the first days after childbirth and usually resolves without specific treatment. It must also be distinguished from postpartum psychosis, a

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psychiatric emergency characterized by severe mood disturbance, confusion, delusions, hallucinations or markedly disorganized behaviour.

WHO estimates that approximately 13% of women globally experience a mental disorder after childbirth, with higher estimates in low- and middle-income settings.[2] The burden is shaped by previous depression, antenatal anxiety, poverty, intimate-partner violence, low social support, obstetric complications, unintended pregnancy, infant illness and stressful life events.

Primary care is well positioned to identify postpartum depression because it is longitudinal, accessible and connected with maternal and infant health. The central question, however, is not whether a questionnaire can detect symptoms. It is whether screening can be converted into timely, safe and acceptable care.

Why Screening Matters

Postpartum depression frequently remains undiagnosed. Women may attribute symptoms to ordinary motherhood, fear being considered an inadequate parent or avoid disclosure because of stigma and concerns about family reactions. Clinical encounters often focus on bleeding, contraception, breastfeeding, infant weight and immunization, leaving little time for emotional wellbeing.

Untreated depression can impair self-care, adherence to medical advice, breastfeeding confidence, maternal-infant interaction and family functioning. Severe illness may involve self-harm, suicide risk or thoughts of harming the infant. Maternal depression is also associated with adverse child-development outcomes, although the relationship is influenced by poverty, nutrition, caregiving support and other social factors.

Screening creates a structured opportunity to ask about symptoms that might otherwise remain hidden. It can normalize discussion of mental health and reduce dependence on clinicians recognizing depression through observation alone. Yet screening is not intrinsically therapeutic. Its public health value depends on the effectiveness of the care that follows.

Screening Is Not Diagnosis

A screening instrument estimates the probability that clinically important depressive symptoms are present. It does not establish a psychiatric diagnosis. Positive screens can occur because of anxiety, grief, severe sleep deprivation, intimate-partner violence, bipolar disorder, thyroid disease, anaemia or other medical and social conditions.

Every positive result therefore requires clinical assessment covering:

- symptom duration, severity and functional impairment;
- previous depressive, manic or psychotic episodes;
- current suicidal thoughts, intent or plan;
- thoughts of harming the infant;
- substance use;
- intimate-partner violence and immediate safety;
- medical causes and medication effects;
- social support, caregiving demands and financial stress.

Before antidepressant treatment is initiated, clinicians should assess for past mania or hypomania because bipolar depression may first become apparent during the perinatal period. Postpartum psychosis requires urgent specialist and emergency assessment rather than routine outpatient follow-up.

Principal Screening Instruments

Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) is the most widely used postpartum-specific instrument. It contains 10 self-reported items and was designed to reduce emphasis on somatic symptoms such as fatigue and sleep disturbance, which commonly occur after childbirth.[3] Scores range from 0 to 30, with higher scores indicating greater symptom burden.

The EPDS includes an item addressing thoughts of self-harm. Any concerning response requires direct clinical enquiry regardless of the total score. The instrument has been translated into many languages, but optimal cut-offs vary by population, timing and purpose. A threshold suitable for maximizing sensitivity in community screening may generate more false positives than a higher threshold used in specialist settings.

The EPDS should therefore be locally validated rather than applied with an imported universal cut-off. Translation must consider meaning, literacy, idioms of distress and cultural reluctance to disclose emotional symptoms.

Patient Health Questionnaire-9

The Patient Health Questionnaire-9 (PHQ-9) assesses the nine diagnostic symptom domains of major depression. It is widely used in primary care and enables continuity of measurement beyond the postpartum period.

A systematic review found that the PHQ-9 had acceptable validity for detecting perinatal depression and showed substantial convergence with the EPDS.[4] Because several PHQ-9 items concern sleep, appetite and fatigue, interpretation may be complicated during pregnancy and early motherhood. Nevertheless, its familiarity, availability and compatibility with general depression care make it operationally attractive.

Two-stage screening

A brief two-item depression screen may be used initially, followed by the EPDS or PHQ-9 when positive. This reduces questionnaire burden but can create additional loss between stages. In settings where women have infrequent contact with services, direct administration of one validated full instrument may be preferable.

No tool should be selected solely because it is short. Choice should consider local validation, language, licensing, staff familiarity, scoring ease and integration with referral protocols.

When and Where Should Screening Occur?

Postpartum depression may begin during pregnancy, in the early weeks after childbirth or several months later. A single screen before discharge is therefore insufficient. Immediate postpartum assessment may also be confounded by pain, exhaustion and acute obstetric stress.

International guidance supports screening during pregnancy and again during postpartum care. ACOG recommends standardized screening for depression and anxiety at the initial prenatal visit, later in pregnancy and during postpartum visits, with systems for assessment, treatment and follow-up.[5]

WHO recommends multiple postnatal contacts, including within 48–72 hours, at 7–14 days and around six weeks, creating opportunities to assess emotional wellbeing alongside physical recovery and infant care.[6]

In primary care, screening can occur during:

- postnatal home visits;
- six-week maternal examinations;
- immunization and well-baby visits;
- breastfeeding or nutrition consultations;
- family-planning services;
- chronic-disease or general outpatient visits during the first postpartum year.

Infant-care visits are especially valuable because mothers often attend even when they do not seek care for themselves. Screening in paediatric or immunization settings must nevertheless include consent, privacy, maternal documentation and a defined clinical response.

Evidence for Screening Programmes

The effectiveness of screening depends on the surrounding care system. The USPSTF recommends adult depression screening, including during pregnancy and postpartum, but specifies that adequate systems must exist for diagnosis, effective treatment and follow-up.[7]

Screening studies frequently demonstrate increased detection, but evidence for improved maternal or child outcomes is less consistent when screening is implemented without collaborative treatment. Screening can fail at several points: women may not complete the tool, positive results may not be reviewed, referrals may not be attended, and treatment may not be available.

Collaborative care addresses these gaps through a care manager, structured symptom monitoring, specialist consultation, stepped treatment and communication with the primary-care clinician. Evidence from obstetric and primary-care settings suggests that such models can improve treatment engagement and depression outcomes, particularly among women facing socioeconomic disadvantage.

The relevant intervention is therefore not the questionnaire alone but a **screening-to-recovery pathway**.

Table 1. Operational framework for postpartum depression screening in primary care

Programme component	Recommended practice	Common implementation failure	Quality indicator
Eligible population	Screen during pregnancy and repeatedly during the first postpartum year	One-time screening before discharge	Proportion screened at defined antenatal and postpartum contacts
Screening tool	Use a validated local-language EPDS or PHQ-9	Unvalidated translation or arbitrary cut-off	Tool, language and cut-off documented
Privacy	Conduct screening in a confidential and supportive setting	Questionnaire completed in front of relatives	Proportion offered confidential screening
Positive result	Undertake clinical assessment and diagnostic confirmation	Screen score recorded as diagnosis	Positive screens receiving assessment within a defined period
Suicide and self-harm	Review concerning responses immediately and directly	Reliance on total score alone	Same-day documented safety assessment
Bipolar and psychosis assessment	Ask about mania, psychotic symptoms and severe behavioural change	Antidepressant prescribed without differential diagnosis	High-risk women receiving appropriate specialist assessment
Mild symptoms	Psychoeducation, active follow-up, social support and low-intensity psychological intervention	Reassurance without scheduled review	Follow-up completed within 2–4 weeks
Moderate-to-severe depression	Structured psychotherapy, medication when indicated and collaborative care	Referral without confirmation of attendance	Treatment initiation and retention rates
Social determinants	Assess violence, financial hardship, infant illness and family support	Symptoms treated without addressing ongoing adversity	Identified social risks linked to relevant support
Documentation	Maintain a maternal mental-health record linked across contacts	Scores remain in separate registers	Continuity of records across maternal and infant services
Programme outcome	Monitor symptom improvement, function and safety	Success defined only as number screened	Proportion improving or reaching remission

Stepped-Care Management After Screening

Women with mild symptoms and preserved functioning may benefit from psychoeducation, sleep and practical support, peer or family assistance, active monitoring and low-intensity psychological intervention. Persistent or moderate symptoms generally require structured psychotherapy, pharmacological treatment or both.

Psychological interventions with evidence in perinatal depression include cognitive behavioural therapy, interpersonal psychotherapy and behavioural activation. In low-resource settings, selected interventions can be delivered by trained non-specialists under supervision. The Thinking Healthy Programme demonstrated that community-based cognitive-behavioural strategies delivered by trained health workers could improve maternal depression in a low-resource South Asian setting.[8]

Medication decisions should consider depression severity, previous response, breastfeeding, maternal preference and the risks of untreated illness. Treatment should not be withheld automatically because a woman is breastfeeding. Clinical evaluation must weigh the evidence for individual medicines and involve shared decision-making.

Women with psychosis, mania, severe functional impairment, active suicidal intent or immediate risk to the infant require urgent specialist or emergency care. Primary-care protocols must specify whom to contact, where to refer and how transport and family safety will be managed.

Public Health Significance

Postpartum depression screening links maternal health, child health and primary mental healthcare. It can improve case detection among women who would otherwise have no contact with specialist services and can reduce stigma by making emotional assessment a routine part of postnatal care.

Its importance extends beyond individual treatment. Screening data can reveal geographical and social patterns of distress, guide workforce planning and identify service gaps. However, aggregate scores must not be used to obscure structural determinants such as violence, poverty, inadequate maternity leave and lack of childcare.

A programme that identifies depression but cannot address intimate-partner violence, severe financial hardship or infant malnutrition will have limited effectiveness. Maternal mental health requires coordination with social protection, nutrition, reproductive health and child-development services.

Indian Perspective

The 2017 systematic review of Indian studies estimated a pooled postpartum depression prevalence of 22%, with substantial heterogeneity across regions, instruments and timing.[1] The estimate demonstrates a major burden but should not be interpreted as a precise current national prevalence. Most studies were facility-based and cross-sectional, and several used screening scores without diagnostic interviews.

Commonly reported Indian risk factors include antenatal depression, low partner support, domestic violence, financial stress, adverse obstetric experiences and culturally mediated pressures such as preference for a male child. These are not uniformly distributed and require locally grounded assessment. India has several operational advantages. ASHAs and auxiliary nurse midwives undertake household and postnatal contacts; immunization sessions provide repeated opportunities; and Ayushman Arogya Mandirs are intended to integrate mental health with comprehensive primary care. The District Mental Health Programme can provide referral and supervision.

Yet routine postpartum depression screening is not consistently institutionalized. Barriers include high workload, limited privacy during home visits, inadequate training, fear of asking about suicide, poor availability of counsellors and weak feedback from referral facilities. Women may also hesitate to disclose distress when family members are present or when mental illness is associated with stigma or loss of maternal credibility.

A feasible Indian model would use a validated regional-language tool during antenatal care, the six-week postpartum visit and a later infant-immunization contact. ASHAs or ANMs could administer or facilitate screening, while community health officers or medical officers confirm assessment and initiate stepped care. District mental-health teams could provide consultation for complex cases.

Screening should never be converted into another numerical target without ensuring privacy, supervision and treatment capacity.

Recent Advances

Digital and telehealth-supported care

Telehealth can reduce travel, childcare and stigma-related barriers. A 2021 systematic review found that telehealth interventions reduced depressive and anxiety symptoms among women with postpartum depression, although studies were heterogeneous and larger rigorous trials were needed.[9]

Digital systems can administer questionnaires, generate reminders and support symptom monitoring. Their role should remain supplementary. Women with limited digital literacy, shared phones, controlling partners or poor connectivity may be excluded, and digital disclosure can create privacy risks.

Task-sharing

Task-sharing trains nurses, midwives, community workers or lay counsellors to deliver structured psychological support under supervision. It is particularly relevant where psychiatrists and psychologists

are scarce. Effectiveness depends on competency assessment, regular supervision and protected time; simply adding counselling duties to an overburdened worker is unlikely to succeed.

Measurement-based care

Repeated use of the same validated scale can monitor response and guide stepped treatment. Symptom scores should be combined with functioning, safety and patient-defined recovery because numerical improvement may not reflect resolution of violence, poverty or caregiving stress.

Emerging digital biomarkers

Research is exploring passive smartphone sensing, voice features and machine-learning models to identify depression risk. These remain experimental. Small samples, algorithmic bias, privacy concerns and uncertain clinical benefit preclude replacing validated questionnaires and human assessment.

Challenges and Limitations

There is no universally optimal screening interval or cut-off. Lower thresholds increase sensitivity but can overwhelm under-resourced systems with false-positive results. Higher thresholds reduce workload but miss women who may benefit from support.

Somatic symptoms overlap with normal postpartum experiences and medical conditions. Anaemia, thyroid dysfunction, chronic pain and sleep deprivation should be considered during assessment.

Language translation does not guarantee cultural validity. Some women express depression through bodily symptoms, interpersonal distress or culturally specific idioms rather than sadness. Interviewer-administered tools may improve access for women with low literacy but can increase social-desirability bias.

Screening may cause harm when confidentiality is weak or disclosure of domestic violence creates retaliation. Staff need protocols for safe enquiry and referral.

Finally, postpartum depression research often focuses on women who attend facilities. Migrants, women delivering at home, adolescents and those experiencing severe violence or poverty may be least likely to be represented.

Future Directions and Policy Priorities

India should incorporate a clearly defined maternal mental-health pathway into routine antenatal, postnatal and infant-care services. National guidance should specify tools, timing, cut-offs, safety assessment, referral criteria and follow-up responsibilities.

Programme monitoring should use a cascade: eligible women, screened, screen-positive, clinically assessed, treatment initiated, retained and improved. Reporting only screening coverage may conceal complete failure after detection.

Regional-language validation studies should use diagnostic interviews as reference standards. Research should compare one-time with repeated screening and evaluate implementation across rural, tribal, urban-slum and migrant populations.

Primary-care teams need training in supportive communication, suicide assessment, bipolar disorder, psychosis, medication counselling and family engagement. Specialist supervision can be delivered through district teams and teleconsultation.

Future studies should measure maternal functioning, infant care, breastfeeding, quality of life, treatment burden and cost-effectiveness—not only questionnaire scores.

CONCLUSION

Postpartum depression screening in primary care is justified by the condition's frequency, consequences and under-recognition. The EPDS and PHQ-9 offer practical methods for identifying women who require further assessment, but neither tool provides a diagnosis.

Screening is effective only when embedded in a responsive system. Positive results must lead to clinical assessment, suicide-risk evaluation, stepped treatment, referral when necessary and continued follow-up. Repeated screening is preferable to a single early postpartum assessment because depression may emerge at different points during the first year.

India has a substantial burden of postpartum depressive symptoms and a primary-care network capable of reaching mothers repeatedly. The principal challenge is no longer demonstrating that screening is possible; it is building a confidential, culturally appropriate and adequately resourced pathway from detection to recovery.

Maternal mental health should become a routine component of quality postnatal care, but screening must remain a means rather than an endpoint. The true measure of success is whether women feel safe enough to disclose distress and can obtain effective care without stigma, delay or abandonment after a positive score.

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