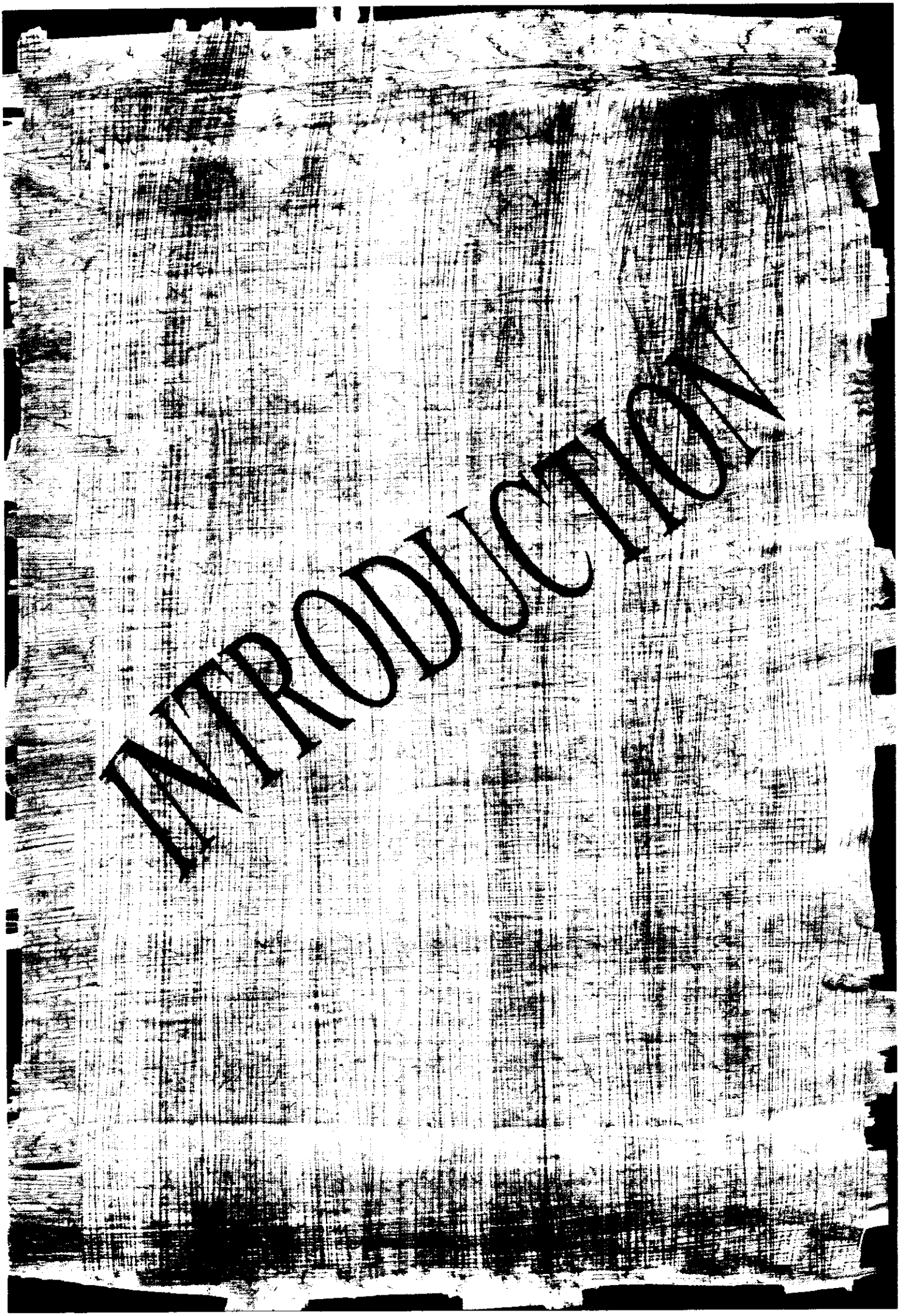
INTRODUCTION

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Depression is a major public health problem, which women present, as well as at other periods of their lives, at the puerperium. In the past 20 years, there has been increasing recognition that for some women, pregnancy may be burdened with mood problems particularly depression, that may impact both mother and child **(Zinga et al., 2005).**

The terminology and definition of mood disturbance during pregnancy and early postpartum period has yet to be clearly elucidated among clinical practitioners. Criteria for maternity blues have not been well established and it may be overlap with the beginning of postnatal depression **(Yamashita et al., 2000).**

Postpartum depression (PPD) is a disorder with broad public health implications and consequences that impact almost every aspect of child development **(Freeman et al., 2005).**

Rates for depression have been reported to be as high as 13% during pregnancy and 12 to 22% postpartum, with postpartum suicidal ideation at nearly 7% **(O'Boyle et al., 2005). Logsdon et al. (2006)** reported that about 13% of women experience depression in the first year after childbirth.

Most of the studies in this area try to find an association between stress factors and PPD and on the other hand some trials have been done to give a biological base for the illness **(Latorre-Latorre et al., 2006).**

Women who have suffered one episode of PPD comprise a high risk group for subsequent episode **(Wisner et al., 2001).**

Robertson et al. (2005) reported that the following factors were the strongest predictors of PPD: depression during pregnancy, anxiety during pregnancy, experiencing stressful life events during pregnancy or

the early puerperium, low levels of social support, and a previous history of depression.

Wewerinke et al. (2006) stated that the most important risk factor for PPD is a history of psychiatric disorders. Obstetric risk factors for depression are unplanned or unwanted pregnancy, pregnancy-related hypertension, emergency caesarean section (CS) and early discharge from the hospital. Other factors are low socioeconomic status, recent life event, negative self-image, little social support, immigration in the last 5 years, feelings of loss of control during pregnancy and feeding problems with the child.

Owoey et al. (2006) found the risk factors for PPD to be mainly psychosocial, including unwanted pregnancy, unemployment and marital conflict.

Gjerdingen and Chaloner (2006) found PPD to be independently predicted by younger age, by being primigravida, by not having the desired gender for their babies and by in-law relationship problems.

The antenatal and postnatal period provides an ideal opportunity to screen women for these risk factors. The women identified to be at risk can be identified, and preventive interventions can be implemented **(Mallikarjun and Oyebode, 2005).**