Addis Ababa University

College of Education and Behavioral Studies School of Psychology department of social psychology

Determinants of Postpartum Depression in selected Health Facility in Addis Ababa Ethiopia

By: Addisalem Belachew(Bsc)

A Thesis submitted to Addis Ababa University College of Education and Behavioral Studies School of Psychology department of social psychology in partial fulfillment of the requirements for the degree of Masters in Social Psychology

May 2026

Addis Ababa Ethiopia

Addis Ababa University

College of Education and Behavioral Studies School of Psychology department of social psychology

Determinants of Postpartum Depression in selected Health Facility in Addis Ababa Ethiopia

Principal investigator: Addisalem Belachew(Bsc)

Address: Addis Ababa, Ethiopia

Email: addisbh7128@gmail.com Tel: +251957048383

ADVISOR: Dame Abera (PhD) Associate Professor of Applied Developmental Psychology

Address: Addis Ababa Ethiopia Email: dame288@gmail.com Tel: +251911843127

May 2026

Addis Ababa Ethiopia

Determinants of Postpartum Depression in selected Health Facility in Addis Ababa Ethiopia

By Addisalem Belachew

Approved by:

1.	_____	_____	_____
	Advisor	Signature	Date
2.	_____	_____	_____
	Internal Examiner	Signature	Date
3.	_____	_____	_____
	External Examiner	Signature	Date

DECLARATION

I, the under signed, declare that this thesis is my original work and has not been presented for a degree in any other University, and that all the sources of materials used for the thesis have been duly acknowledged.

Addisalem Belachew	_____	_____
Name	Signature	Date

ENDORSEMENT

This research project has been submitted to Addis Ababa University, College of Education and Behavioral Studies, School of Psychology for examination with my approval as University advisor.

_____	_____	_____
Name	Signature	Date

ACKNOWLEDGMENTS

I want to acknowledge Addis Ababa University College of Education and Behavioral Studies School of Psychology department of social psychology, for providing the academic environment and resources necessary for this research. I would like to express my sincere gratitude to my advisor, Associate Professor Dame Abera (PhD) for his invaluable guidance, encouragement, and constructive feedback throughout the development of proposal to final thesis completion. My appreciation also goes to Addis Ababa city administration health bureau sub cities and health centers for their guidance on ethical clearance support and encouragement. Last but not list I would like to extend my gratitude to the participant data collectors and supervisor. Finally I wish to thank my family and friends for their continuous support and motivation.

ABSTRACT

The purpose of this study was to investigate the determinants of postpartum depression in selected health facility in Addis Ababa in February 2026. A mixed methods design was used; combining quantitative screening of postpartum depressive symptoms cross sectional study with qualitative exploration of women's lived experiences thematic analysis. Data was collected from 268 postpartum new mothers within Twelve months following delivery, using validated tools and 6 in-depth interviews. The results were analyzed using inferential statistics and descriptive statistics. Qualitative data were analyzed using thematic analysis. Transcripts were coded, categories were developed, and themes were generated through an iterative process. Emerging themes were triangulated with quantitative findings to enhance validity. The result shows that 29.7% new mothers have postpartum depression; education, marital status, planned Pregnancy, visits from neighbors and family members, not experiencing domestic violence and not experience stigma from family members were significant predictors of postpartum depression among new mothers. Consistently qualitative result explores Participants described a range of emotional challenges including sadness, stress, sleep disturbance, and, in severe cases, self-harm ideation. These experiences were often linked to first-time motherhood, financial hardship, limited maternity leave, and lack of partner involvement. Postpartum depression should be integrated into maternal and child health services at public health centers, Incorporating digital platforms and social media-based support systems may also offer innovative ways to reach and support postpartum women.

Key Terms: Postpartum depression, Culture, coping mechanism, public health centers, Addis Ababa, Ethiopia

ABBREVIATIONS AND ACRONYMS

ANC - Antenatal Care

EPDS – Edinburgh Postpartum Depression Scale

EPI – Expanded Program of Immunization

EPIINFO - Epidemiological Information

LMIC – Low and Middle Income Countries

MDG - Millennium Development Goal

MNCH – Maternal Newborn and Child Health

MMR - Maternal Mortality Rate

OR - Odds Ratio

PNC – Postnatal Care

PPD– Post Partum Depression

QOC - Quality of Care

SDG – Sustainable Development Goal

SPSS - Statistical Package for Social Sciences

UNICEF - United Nations International Children's Emergency Fund

WHO - World Health Organization

Table of Contents

List of Tables

List of Figures

List of Annexes

1. INTRODUCTION

1.1 Background

A significant global public health issue that affects women after childbirth is postpartum depression (PPD). It is a mood disorder that manifests in the first 12 months following childbirth and is typified by persistent depression, loss of interest or pleasure, exhaustion, feelings of worthlessness or guilt, changes in appetite or sleep patterns, and feelings of inadequacy that interfere with mother functioning and infant care (Association, 2022).

Postpartum depression is part of the spectrum of perinatal mental health disorders that can affect women during pregnancy and after childbirth. Mental health issues, particularly depression, are common in the perinatal period, and globally about 10% of pregnant women and 13% of women who have recently gave birt h experience a mental disorder, with depression being the most prevalent condition. In low- and middle-income countries, these figures are even higher, with about 15.6% during pregnancy and 19.8 % after childbirth. PPD can be severe enough to impair a mother's ability to function and, in extreme cases, may lead to suicide, which is an important cause of maternal mortality in some regions(Layton et al., 2025).

worldwide one in five women may experience postpartum depression symptoms, significantly the substantial world burden of PPD and the need for culturally sensitive maternal mental health services in different diverse settings (Hahn-Holbrook et al., 2018). In other hand biological and psychological risk causes have critical research attention, there is significant increasing that postpartum depression is also deeply related by culture. Cultural values affects the expectations on new mothers, the meaning given to emotional distress, eager of help-seeking, and the strategies or coping mechanisms women use to cope(Dennis & Chung-Lee, 2006).Culture shapes postpartum depression by defining how symptoms are expressed, recognized, and managed, with social norms, traditional practices, and stigma either protecting against or increasing risk(Bina, 2008).Postpartum depression (PPD) is more identified as a significant mental health issue affecting new mothers due to diverse cultural settings. Research consistently shows that cultural

contexts shape both the experience and risk factors of PPD, influencing prevalence, symptom expression, coping, and help-seeking behavior(Hanlon et al., 2010).

In our country Ethiopia postpartum depression is a serious public health concern that affects mothers, infants, and families with higher prevalence compared to other countries; nearly 20.1% of women overall, with specific regional estimates such as 22.3% in Addis Ababa (Duko et al., 2020); rapid urbanization, evolving family arrangements, economic burden, and evolving gender roles are reshaping the experiences of new mothers. Traditional support systems may be weakening, while stigma surrounding mental illness remains strong(O'hara & McCabe, 2013).

In Ethiopia Postpartum depression (PPD) is heavily influenced by cultural factors such as poor social support, traditional gender roles, stigma toward mental illness, preference for male children, intimate partner violence, and cultural pressure related to childbirth and maternal responsibilities. These factors increase women's emotional stress, reduce help-seeking behavior, and contribute to the high burden of maternal mental health problems in the postpartum period. Studies in Ethiopia reported that cultural and social conditions, including limited autonomy and weak family support, significantly increase the risk of postpartum depression among mothers (Tolossa et al., 2020). Many women may therefore experience depressive symptoms without recognition or treatment.

Although the prevalence and associated factors of postpartum depression (PPD) have been widely studied, limited attention has been given to cultural determinants and coping mechanisms among postpartum mothers. Most existing studies focus mainly on the magnitude and clinical or socio-demographic risk factors of PPD, while evidence regarding how cultural beliefs, traditions, stigma, family dynamics, and maternal coping strategies influence postpartum depression remains scarce in Addis Ababa. Understanding the cultural determinants of postpartum depression and the coping strategies that women employ were necessary to design culturally appropriate maternal mental health services. This study seeks to fill gaps in the existing literature by examining these issues among new mothers in public health centers of Addis Ababa.

1.2 Statement of the Problem

Globally maternal mental health problems are considered as a major public health challenge;1 in 5 mothers after childbirth experience postpartum depression or **17.22 %** of women worldwide(Wang et al., 2021). Postpartum depression varies significantly across regions, with the highest pooled prevalence observed in Southern Africa 40 % to Denmark 6.5 %(Wang et al., 2021).

Overall, low- and middle-income countries (LMICs) bear a greater burden of PPD, with pooled prevalence estimates of around 20 %, compared with roughly 10–15 % **in** high-income countries, a difference attributed to socioeconomic stressors, limited mental health services, and under-screening(Organization, 2024).

Studies across Africa reports highly variable prevalence estimates between about **6.1**% in Uganda to 44% in Burkina Faso and 27% in Ethiopia reflecting difference in study settings, cultural contexts, and diagnostic tools used to measure postpartum depression(Atuhaire et al., 2020). In Ethiopia PPD affecting 20–30% of mothers within the first year after childbirth; which are 22 % in Addis Ababa health centers (Tolossa et al., 2020). The consequences extend beyond individual suffering to child development and family functioning which is influenced by hormonal changes after childbirth, a history of depression or anxiety, sleep deprivation, low social support, marital conflict, intimate partner violence, financial hardship, and social isolation, as well as society expectations of “perfect motherhood,” stigma around mental health, and not sufficient access to maternal healthcare, all of which can reduce help-seeking and increase vulnerability to depressive symptoms(Layton et al., 2025).

While postpartum depression is a worldwide concern, research rooted in Ethiopian Cultural context remains scarce. Available studies tend to emphasize prevalence and biomedical risk factors(Tolossa et al., 2020), while little attention has been paid to cultural beliefs, social expectations, and traditional practices that shape women's emotional experiences after childbirth.

Furthermore, many affected women do not seek professional help and instead rely on informal coping strategies, the nature of which is poorly documented. Lack of adequate

understanding of these determinants and coping mechanisms may lead to the development of interventions that are culturally inappropriate and ineffective. Therefore, there were a need to explore how culture influences both the development of postpartum depression and the responses of new mothers in Addis Ababa public health centers.

The purpose of this study was to explore the cultural determinants of postpartum depression and the coping mechanisms employed by postpartum mothers attending public health centers in Addis Ababa, Ethiopia. However, postpartum depression is recognized as a major public health concern globally and in Ethiopia, existing studies have largely focused on prevalence and biomedical or psychosocial risk factors, with limited attention given to the influence of cultural beliefs, traditional practices, and social expectations surrounding childbirth and motherhood.

Accordingly, This study seeks to develop an in-depth understanding of how cultural norms, gender roles, family structure, stigma related to mental illness, and community attitude shape women's emotional experiences during the postpartum period. Furthermore the study aims to investigate the informal coping strategies and help-seeking behaviors used by affected mothers in response to depressive symptoms. Through an analysis of this experience within the Ethiopian cultural context, the study aim to generate culturally grounded evidence that contribute to the development of appropriate, acceptable, and effective maternal mental health interventions and policies in Addis Ababa public health centers and similar settings.

1.3 Objectives of the Study

1.3.1 General Objective

To explore determinants of postpartum depression and coping mechanisms among new mothers visiting public health centers in Addis Ababa in February 2026.

1.3.2 Specific Objectives

To determine the prevalence of postpartum depression among new mothers visiting public health centers in Addis Ababa in February 2026.

To identify cultural beliefs and practices associated with postpartum depression among new mothers.

To examine coping mechanisms used by new mothers experiencing postpartum depressive symptoms.

To assess the role of family, social networks, religion, and health services in influencing coping strategies.

To explore perceived barriers to help seeking among depressed mothers.

1.3.3 Operational Definitions

Postpartum partum depression; The Edinburgh Postnatal Depression Scale (EPDS) assigns a score of 0, 1, 2, and 3 to Questions 1, 2, and 4, with a score of 0 for the first choice and 3 for the last. Questions 3, 5, and 10 are scored in reverse, with the final option receiving a score of 0 and the first choice receiving a score of 3. After totaling all of the results, it was determined that women with scores greater than 13 had postpartum depression. (Levis et al., 2020).

New mothers: a primiparous woman who has delivered her first baby.

1.4 Research Questions

• What cultural factors contribute to the onset and experience of postpartum depression among new mothers in Addis Ababa?

• How do cultural beliefs and expectations shape the perception and expression of postpartum depressive symptoms?

• What coping strategies do new mothers use to overcome postpartum depression and how are these strategies culturally influenced?

• What are the roles of family, community, and health institutions in supporting mothers with postpartum depression?

1.5 Scope of the Study

The study was focusing on new mothers within Twelve months after delivery who reside in Addis Ababa public health centers. It was examine cultural beliefs, practices, social expectations, and coping strategies related to postpartum depression. The studies were not clinically diagnosing depression but were relying on validated screening tools and subjective accounts of depressive symptoms. Geographically, it will be limited to selected health centers within Addis Ababa.

1.6 Significance of the Study

This study was contributed to an improved understanding of postpartum depression within the Ethiopian cultural context. The findings would help to health professionals, policy makers and program planners by support for evidence to guide culturally critical maternal mental health interventions. Health professionals may use evidence for to provide efficient clinical care and early detection of maternal mental health problems; program planners may use research data in designing targeted interventions and support programs; and policy makers may use as a standard or starting point in emerging evidence-based policies and resource allocation strategies for maternal mental health services. The study also conquering and represents the lived experiences of mothers, helping to minimize stigma and improve awareness. In the academic domain, the study would enrich literature on the cultural dimensions of mental health in low-income urban African settings and provide a basis for further research.

2. LITRATURE REVIEW

2.1 Theoretical Review

2.1.1 Social support theory

The Social Support Theory emphasizes the importance of interpersonal relationships in protecting individuals from psychological distress. The theory argues that emotional, informational, instrumental, and appraisal support from family, friends, and community members can improve mental health outcomes and reduce the impact of stressful life events.

The postpartum period often requires substantial emotional and practical support. Emotional support includes empathy, love, and encouragement. Instrumental support includes assistance with childcare, household responsibilities, and financial needs. The theory is highly relevant to the present study because variables the availability of support from husbands, family members, neighbors, religious institutions, and healthcare providers can reduce stress and facilitate adjustment to motherhood. Informational support involves guidance and advice regarding infant care and maternal health.
The theory suggests that mothers who receive strong social support are less likely to develop postpartum depression and are more likely to adopt positive coping mechanisms.

Within Ethiopian culture, support from husbands, mothers, mothers-in-law, neighbors, religious leaders, and extended family members plays an important role in maternal well-being. Women who receive adequate social support are more likely to cope effectively with postpartum challenges, while those lacking support may be at greater risk of depression. This theory is particularly relevant because one of the major findings of the current study was the protective role of visits from family members and neighbors against postpartum depression.

2.1.2 social Role theory

Social Role Theory was developed by Alice Eagly (1987) and explains how society assigns specific roles and expectations to individuals based on social and cultural norms. The theory argues that gender differences in behavior arise largely from societal expectations rather than biological factors alone.

In many cultures, motherhood is associated with expectations that women should be nurturing, emotionally strong, self-sacrificing, and primarily responsible for childcare. In Ethiopia, cultural norms often place substantial responsibility for infant care and household duties on mothers. These expectations may create psychological pressure,

especially when women face financial difficulties, inadequate support, or challenges adjusting to motherhood.

Social Role Theory helps explain how cultural expectations regarding motherhood, gender roles, and family responsibilities contribute to postpartum depression. The theory is particularly relevant in understanding how cultural beliefs about women's roles influence emotional experiences and coping strategies among postpartum mothers.

2.1.3 Stigma Theory

Stigma Theory, proposed by Erving Goffman (1963), explains how individuals possessing characteristics viewed negatively by society may experience discrimination, social exclusion, and psychological distress. Stigma can affect how people perceive themselves and influence their willingness to seek help.

Mental illness remains highly stigmatized in many societies, including Ethiopia. Women experiencing postpartum depression may fear being labeled as weak, irresponsible, or incapable mothers. Consequently, they may conceal their symptoms and avoid seeking professional support.

Within the context of this study, stigma from family members, communities, and society may contribute to postpartum depression by increasing emotional distress and limiting access to support and treatment. The theory therefore provides a useful framework for understanding barriers to help-seeking behavior among postpartum mothers.

2.1.4 Stress and Coping Theory

The Stress and Coping Theory developed by Richard Lazarus and Susan Folkman (1984) explains how individuals respond to stressful situations through cognitive appraisal and coping strategies. According to the theory, stress occurs when individuals perceive that environmental demands exceed their available resources.

The postpartum period presents numerous stressors, including childcare responsibilities, sleep deprivation, financial strain, relationship difficulties, and changing social roles.
Mothers use various coping strategies to manage these stressors. These coping mechanisms may include seeking social support, religious practices, problem-solving behaviors, healthcare utilization, and emotional regulation strategies.

The theory proposes that individuals first assess whether an event is threatening (primary appraisal) and then evaluate their ability to manage it (secondary appraisal). Based on these evaluations, they adopt coping strategies. Problem-focused coping aims to address the source of stress, whereas emotion-focused coping seeks to regulate emotional reactions.

In the context of postpartum depression, mothers may experience stress related to childcare responsibilities, family expectations, social isolation, economic challenges, and cultural pressures. Coping mechanisms such as seeking family support, religious practices, community involvement, healthcare utilization, and emotional expression may help reduce psychological distress. Therefore, this theory provides an important framework for understanding how postpartum mothers respond to cultural and social stressors.
This theory is particularly relevant because one of the objectives of the study is to examine coping mechanisms employed by postpartum mothers. It helps explain why some mothers successfully adapt to postpartum challenges while others experience depressive symptoms

2.1.5 Ecological Systems Theory

Developed by Urie Bronfenbrenner (1979), this theory explains that human behavior is influenced by different environmental system.

Postpartum depression can be understood as the result of interactions between mothers and these multiple social environments. This theory is particularly suitable because your study investigates family support, cultural beliefs, community influence, religion, and healthcare services.

The theory identifies five levels:
Microsystem (family, husband, child)
Mesosystem (interaction between family and healthcare services)
Exosystem (community support and workplace policies)
Macrosystem (culture, religion, social norms)
Chronosystem (life transitions such as childbirth)

2.2 Empirical Review

2.2.1 Risk Factors of Post-Partum Depression

According to recent research, hormonal fluctuations, unplanned pregnancy, a personal or family history of mental disorders, a lack of social and partner support, cultural stigma, and stressful life events are consistently found to be significant contributors to the onset and severity of postpartum depression (Khamidullina et al., 2025).

Due to financial stress, diminished autonomy, and a lack of social support, sociodemographic characteristics such as poor socioeconomic position, low educational attainment, young maternal age, unemployment, or being a housewife are linked to an increased risk of postpartum depression (Cooke et al., 2025). Postpartum depression was consistently associated with a history of depression or other mental illness, antenatal depressive symptoms, exposure to stressful life events or chronic stress, poor postpartum sleep quality, and traumatic or bad birth experiences (Engidaw et al., 2020; Zhao & Zhang, 2020).

Despite biological psychological and economic factors it's also influenced by social and cultural factors including cultural beliefs, rituals, and social support that shape prevalence and symptom expression across diverse societies, with region-specific stressors such as family dynamics, gender expectations, and limited help-seeking behaviors documented in studies from Asia, Africa, and the Middle East(Modukuru, 2024).

According to systematic reviews and met analyses of observational studies, postpartum depression in Ethiopia is substantially linked to low socioeconomic status, intimate partner violence, unintended pregnancy, prior history of depression, marital dissatisfaction, and obstetric-related factors like low birth weight infants or a history of miscarriage or stillbirth (Desta et al., 2021). Additional research conducted in Ethiopia

reveals that the main causes of postpartum depression are low family income, substance abuse, a lack of social support, unintended pregnancies, and sleep issues in infants (Kitil et al., 2024). Despite this prevalence and contributing factors cultural influence of postpartum depression not well studied in Addis Ababa.

2.2.2 Cultural Determinants of Postpartum Depression

Culture is defined as "The values, beliefs, customs, and lifestyle practices of a specific group that are taught, shared, and passed down and that influence their thought processes, choices, and behaviors in predictable ways (Leininger, 2001). Postpartum depression (PPD) affects women across cultures, with prevalence estimated between 10% and 40% worldwide, depending on socio cultural, economic, and health system factors (Bina, 2008). Culture shapes postpartum depression (PPD) globally through social norms around gender roles and support, cultural practices influencing maternal care and rest, varying beliefs and stigma that affect help-seeking behaviors**,** and differential expression and recognition of depressive symptoms, all of which contribute to its prevalence, experience, and treatment access across diverse settings (e.g., gender preference and family expectations elevate risk in some Asian contexts)(Tang et al., 2016); discrepancies in social support and family dynamics rooted in cultural roles can increase stress and the likelihood of PPD (e.g., in Chinese family systems)(Subba et al., 2024). widespread stigma and limited mental health literacy in many cultures discourage women from seeking professional help for PPD symptoms(Tolossa et al., 2020); and cultural postpartum practices and beliefs about health and illness can both protect against or exacerbate PPD depending on their nature and the level of social support they provide (Mesfin et al., 2025).

Postpartum depression (PPD) in Ethiopia is influenced by a combination of cultural, psychosocial, and structural determinants that shape women's emotional experiences and help-seeking behaviors following childbirth. Recent studies in Ethiopia show a persistently high prevalence of PPD, with common determinants including poor social support, unplanned pregnancy; intimate partner violence, household food insecurity, and low educational status are factors that intersect with cultural expectations of motherhood and family roles (Anato et al., 2022; Azale et al., 2018; Mekuria et al., 2023). A study shows that women reporting low support from family or community networks are at

significantly greater risk of PPD, reflecting the cultural benefit of extended social support following childbirth ((Anato et al., 2022; Fantahun et al., 2018).

Similarly pregnancy and psychological related causes such as unintended pregnancies and intimate partner violence, which are socially contextualized within gender norms and relational dynamics, are also strongly related with PPD risk (Anato et al., 2022; Azale et al., 2018). Moreover, socioeconomic stressors such as undernourishment and educational deficit compound mothers' psychological exposed by undermining their ability to meet culturally establishing a moral idea maternal and household roles(Mekuria et al., 2023). These factors indicate the benefit of culturally adapted screening strategies, social support and mainstreaming of mental health services into maternal care to address PPD within the Ethiopian context.

2.2.3 Copying Mechanism of Postpartum Depression

Postpartum depression (PPD) is worldwide maternal mental health issue that reveals and coping strategies are more influenced by cultural setting. A study shows that cultural norms shape how PPD is worked, experienced, and control, affecting both symptom manifest and help-seeking behavior to cope up with the PPD (Kassam, 2019; Rai et al., 2015).

Along with, support from family and community is consistently associated with minimization of depressive symptoms, particularly in Ethiopia cultures where extended family involvement is considered as norm, as it can redistribute childcare responsibilities and provide emotional validation.

Consistently, traditional postpartum practice such as parturition practices, dietary medication, and maternity rest periods may give efficient support and contribute to recovery, although their protective effects differentiate depending on the cultural setting and the mother's coping mechanisms within the practice (Bathula et al., 2024; Xin et al., 2024).

Other study suggests that Religious and spiritual coping is also commonly used and reported as, providing meaning, believe, and a sense of acceptance that aligns with cultural beliefs(Azale et al., 2018). Nevertheless, cultural discrimination like stigma surrounding mental illness and unbending of motherhood can conceal and access to professional care, emphasize the need for culturally adapted interventions.

compared with generic models it is more preferable that Contemporarily culturally tailored therapeutic programs, including group-based interventions for specific ethnic communities, improve acceptability and effectiveness to specified(Arifin et al., 2018). Thus, combining or integrating cultural values and practices of coping mechanisms into screening and treatment support frameworks may enhance engagement and outcomes for diverse populations of postpartum women. Nevertheless, cultural determinants of postpartum depression and its coping mechanisms among new mothers in Addis Ababa were not studied.

2.3 Summary of Reviewed Literature

According to the literature examined for this study, women in the first year following postpartum depression (PPD) is a prevalent and complex mental health issue that affects childbirth and is linked to detrimental outcomes for mothers, babies, families, and communities. worldwide, PPD prevalence varies greatly in every nation, with low- and middle-income nations studies shows greater rates. Based on the research, postpartum depression is still a major public health issue in Ethiopia, with prevalence ranging from roughly 19% to 37% in various areas, including Addis Ababa.

This assessment of the research also revealed that a mix of psychological, socioeconomic, biological, and cultural factors affect postpartum depression. Common factors that shape and identified across studies included low educational status, unplanned pregnancy, poor social support, domestic violence, financial hardship, previous history of mental illness, stressful life events, and cultural stigma related to mental health. Cultural beliefs, family expectations, gender norms, and traditional postpartum practices were also found to shape women’s emotional experiences, symptom expression, coping behaviors, and help-seeking practices during the postpartum period.

Similarly, the literature highlighted that social support from partners, families, and communities plays a major protective role against postpartum depression, in other hand religious and cultural coping practices may help women manage emotional distress. However, early detection and treatment of postpartum depression are still hampered by stigma, low mental health knowledge, and restricted access to culturally competent mental health care. Although a number of studies have looked at the prevalence and contributing factors of postpartum depression in Ethiopia, little is known about the cultural determinants of postpartum depression and coping strategies among new mothers in Addis Ababa, suggesting that more research is needed in this area

2.5 Conceptual Frameworks

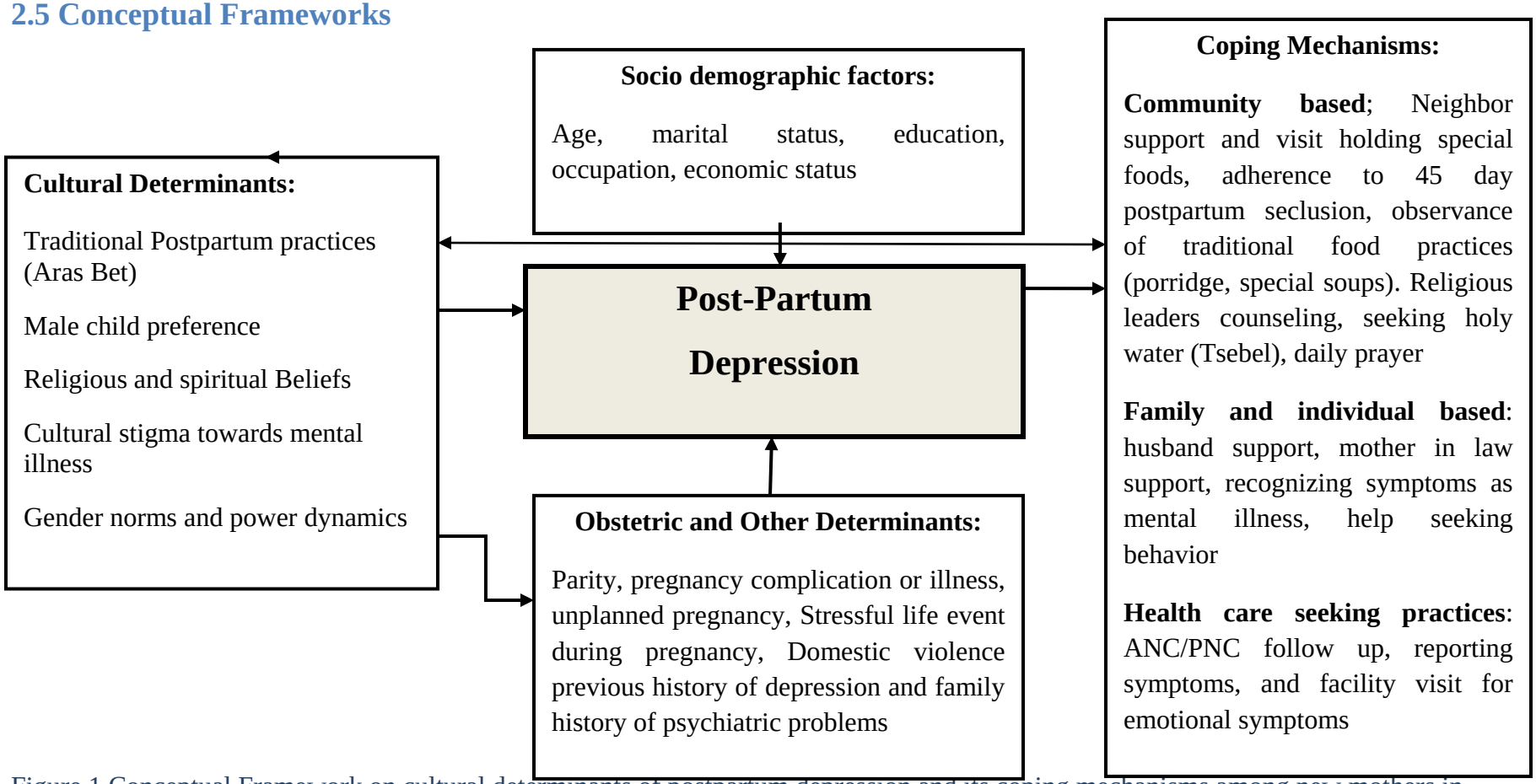


Figure 1.Conceptual Framework on cultural determinants of postpartum depression and its coping mechanisms among new mothers in Addis Ababa Public Health Centers (Bina, 2008; Dennis & Chung-Lee, 2006; Hahn-Holbrook et al., 2018; Hanlon et al., 2010; Wake et al., 2022).

3. Research Methodology

3.1 Study Design

Mixed-methods study designs were used, combining qualitative techniques like thematic analysis with quantitative cross-sectional research. The quantitative component would assess the magnitude of depressive symptoms and associated cultural factors, while the qualitative component would provide in-depth understanding of women's experiences and coping mechanisms.

3.2 Description of the Study Site

The study was conducted from February 2026 to March 2026 in selected public health centers of Addis Ababa Ethiopia. Addis Ababa is the capital city of Ethiopia and the seat of the African Union. There are 3,048,631 people living in the city, with 1,452,663 men and 1,595,968 women (58). There are eleven sub cities, six government-owned hospitals, and ninety-six health facilities in Addis Ababa. Every sub-city has one health center. Health facilities are readily available to the community. They are expected to offer a package that includes both preventative public health and necessary curative services.

3.3 Source of Data/Target Population/

The target populations were consist of new mothers aged 15 years and above, within twelve months postpartum, attending maternal and child health services in selected public health centers of Addis Ababa.

3.4 Samples and Sampling Techniques

For quantitative data the sample size would be determined using single population proportion formula with the following assumptions:

N = the number of participants to be interviewed;

$(Z\ \alpha/2)^2$ = standardized normal distribution value for the 95% CI, =1.96

P = Proportion of prevalence of postpartum depression P= 19.7% in Addis Ababa public health institution(Wake et al., 2022).

d = margin of error taken as 5%,

The sample size calculated using the above formula is N = (Z α/2)$_2$ p (1-p) d$_2$ N = (1.96)$_2$ *X* (0.197 (1-0.197)) (0.05)$_2$N = 243 Participants By considering 10% of non-response, the final sample size was 268.

Table 1. Sample size calculation for inferential objectives

S. No	Relevant Factors	P1	P2	CI (%)	Power (%)	Non-respondent rate (%)	Total calculated sample size (n_ total)	Reference
1	Low economic status	0.70	0.48	95	80	10	191	(18)
2	Unplanned pregnancy	0.69	0.42	95	80	10	132	
3	Poor socio cultural support	0.92	0.79	95	80	10	240	

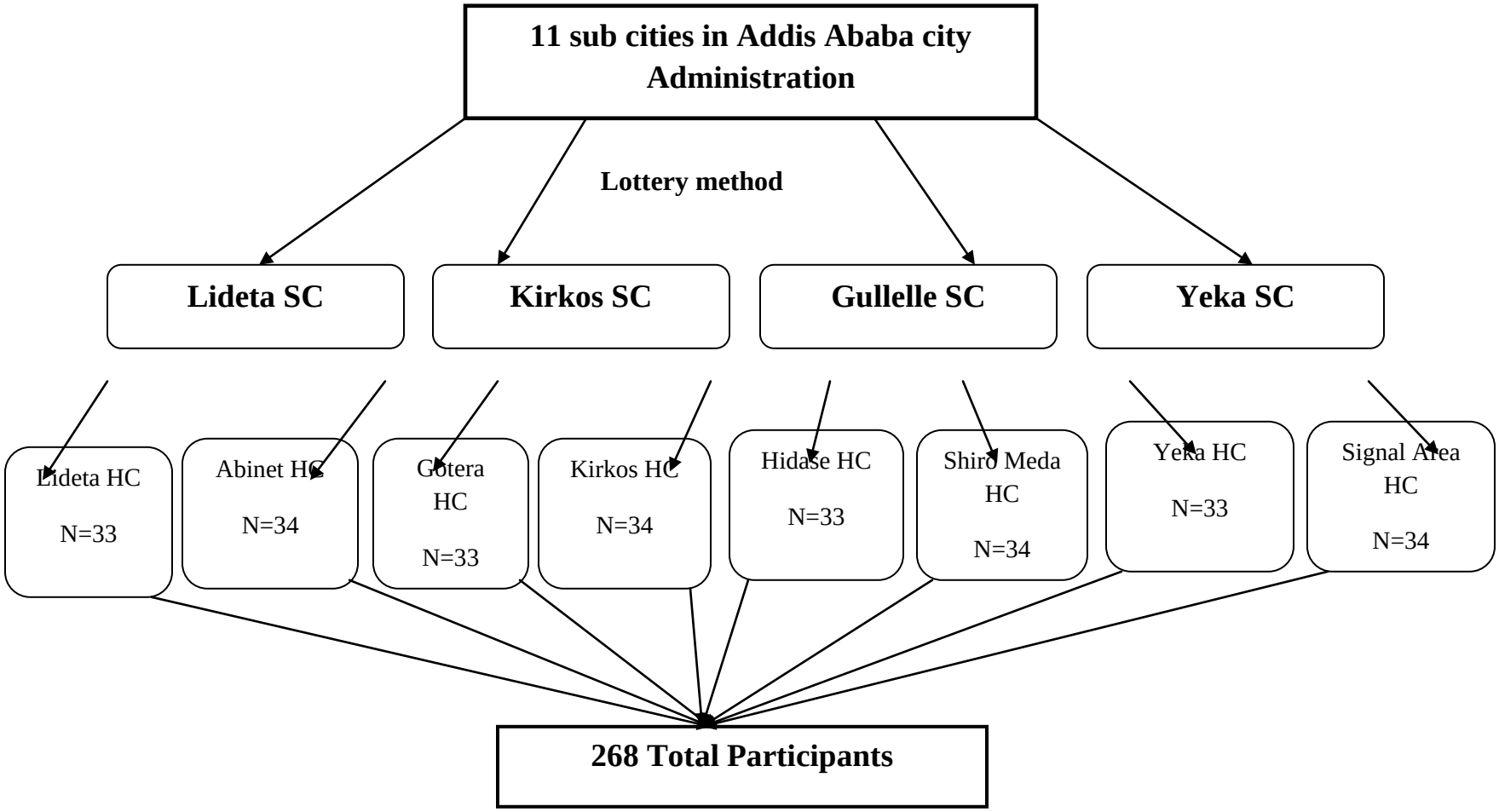
Thus the largest sample size was selected which was 268

Finally 268 participants were selected for quantitative data.

For qualitative data 6 participants were selected purposively from positive for depressive symptoms and who are willing to narrate their experiences.

In Addis Ababa there were 11 sub cities, from them four sub cities were selected by lottery method then two health centers were selected from each sub cities for the quantitative component, systematic samplings were applied to select postpartum new mothers from selected health centers. For the qualitative component, purposive sampling were used to identify six participants who screen positive for depressive symptoms and who are willing to narrate their experiences.

Fig 2: Schematic Presentation of Sampling Procedure



3.5 Instruments of Data Collection

Data were collected by using a structured interviewer-administered questionnaire for 268 participants and a semi-structured in-depth interview guide for 6 participants. The instruments were developed after reviewing relevant literature related to postpartum depression, cultural determinants, and coping mechanisms among postpartum mothers. Training was given to 8 data collectors and 1 supervisor by a researcher.

The structured questionnaire was designed to obtain quantitative data from postpartum mothers attending public health centers in Addis Ababa. The questionnaire consisted of five sections. The first section assessed socio-demographic characteristics of the respondents, including age, marital status, educational status, occupation, religion, and monthly income. The second section included obstetric and maternal health-related factors such as parity, pregnancy intention, history of abortion, mode of delivery, pregnancy and delivery complications, history of mental illness, and stigma from family. The third section assessed social and cultural determinants associated with postpartum depression and coping mechanisms. Questions focused on domestic violence, partners support, family, community and social support, traditional postpartum practices, newborn gender preference, and cultural beliefs regarding mental illness, influence of family and community expectations, seeking social support, religious/spiritual, emotional coping, problem-solving behaviors, Most items were measured using close-ended yes/no questions.

The Edinburgh Postnatal Depression Scale was used in the fourth section to measure postpartum depression (EPDS). A common screening tool for postpartum depression symptoms in postpartum mothers is the EPDS, a standardized 10-item questionnaire. A four-point Likert scale, ranging from 0 to 3, was used to rate each item, with the final score falling between 0 and 30. mothers who scored 13 or above were considered to have postpartum depression.

In-Depth Interview Guide

Qualitative data was gathered. from six selected participants using a semi-structured in-depth interview guide. The interview guide explored cultural beliefs and practices related to childbirth and the postpartum period, mothers' experiences of emotional distress following delivery, perceived causes of postpartum depression, family and community influences, coping strategies, health-seeking behaviors, and barriers to utilization of mental health services.

The interviews were conducted in Amharic by trained data collectors. With participants' consent, interviews were audio-recorded and supplemented by field notes to capture non-verbal expressions and contextual information.

Translation of the Instruments

The majority of the data gathering tools were created in English and translated into Amharic, the participants' native tongue. The Amharic version was then back-translated into English by independent language experts to ensure consistency and accuracy of the translation.

Pretest of the Instruments

A pretest was conducted on 10% of the total sample size in a health facility outside the selected study area before the actual data collection period. The purpose of the pretest was to evaluate the clarity, consistency, and applicability of the instruments. Necessary modifications were made based on the findings of the pretest.

Validity and Reliability

Cronbach's alpha coefficient was used to evaluate the Edinburgh Postnatal Depression Scale's (EPDS) reliability. To ensure uniformity throughout data collection, supervisors and data collectors received the proper training.

A pretest was conducted on 26 participants at feres Meda Health Center to assess clarity and consistency of the tool. Based on the pretest data, the internal consistency of the questionnaire was evaluated using Cronbach's alpha, which showed acceptable reliability ($\alpha = 0.98$, N=26). Necessary modifications were made before the actual data collection. Data collection was carried out by trained data collectors under close supervision to ensure data quality and completeness.

For the quantitative component, data were gathered from postpartum women using a structured questionnaire that included the Edinburgh Postnatal Depression Scale to assess postpartum depression and additional items on socio-demographic and cultural factors. For the qualitative component, data were collected through in-depth interviews using a semi-structured interview guide to explore cultural beliefs and coping mechanisms related to postpartum depression. Interviews were conducted face-to-face, audio-recorded with participants' consent, and later transcribed verbatim.

3.6 Procedures of Data Analysis

Quantitative data were coded, entered, cleaned, and analyzed using the IBM SPSS Statistics statistical software program. Descriptive statistical analyses, including frequencies, percentages, means, and tables, were used to summarize the findings. Bivariable logistic regression analysis was performed to assess the association between independent variables and postpartum depression (PPD). To identify independent predictors of PPD Variables that showed a statistically significant association in the bivariable analysis were included in the multivariable logistic regression model. Statistical significance was declared at a p-value of less than 0.05 and the strength of association was determined using adjusted odds ratios (AORs) with 95% confidence intervals (CIs).

Qualitative data were analyzed by using thematic analysis with the assistance of NVivo software. Audio-recorded interviews were transcribed verbatim, coded systematically, and organized into categories. Themes and subthemes were then developed through an iterative analytical process. Finally, the qualitative findings were triangulated with the quantitative results to improve the credibility and validity of the study findings.

3.7 Ethical Consideration

The Addis Ababa University Department of Social Psychology Research and Ethics Committee granted ethical clearance prior to the study's implementation (REC). The Addis Ababa City Administration Health Bureau Research Center subcities and Public Health centers granted permission to carry out the study. Each study participant gave their verbal consent after being briefly informed about the study's goals, the advantages of participating, the confidentiality of the information they provided, the fact that participation would be entirely voluntary, and the fact that refusing to participate would have no bearing on the subject or any family members.

4. Result and Discussion

4.1 Result

4.1.1 Socio Demographic characteristics of the Respondents

A total of 268 with in twelve months of postpartum women attending different services in Addis Ababa public health centers were participated on the study of which 266(99%) responds all questions and 2 discarded due to incomplete data. The mean age of the study participants were 23.81 with SD = 3.876. The median age of the respondents was 24 with the range of 16 – 33. Majority of the respondents were married 166(62.4%), Orthodox Christian 169(63.5%) and completing degree and above 119(44.7%). Among the respondents 94(35.3%) were civil servant 69(25.9%) merchant 63(23.7%) house wife and 40(15%) were daily laborer. From the total respondents 67(25.2%) of their monthly income covers their monthly expenditure while 91(34.2%) of them their monthly income were not covering their monthly expenditure (see table 5.1).

Table 2. Socio Demographic characteristics of the Respondents of postpartum women attending different services in Addis Ababa public health centers (N=266).

Characteristics	Frequency	Percent
Age in Years		
16 – 21	75	28.2%
22 – 27	152	57.1%
28 – 33	39	14.7%
Marital Status		
Unmarried	60	22.6%
Married	166	62.4%
Divorced/Widowed	40	15%
Religion		
Orthodox Christian	169	63.5%
Muslim	37	13.9%
Protestant	60	22.9%

Educational Status		
Illiterate	56	21.1%
8 complete	37	13.9%
10 – Level 4	54	20.3%
Degree and Above	119	44.7%
Occupation		
House wife	63	23.7%
Civil servant	94	35.3%
Merchant	69	25.9%
Daily laborer	40	15%
Monthly Income		
Covers monthly Expenditure	67	25.2%
Sometimes covers monthly Expenditure	108	40.6%
Not cover monthly Expenditure	91	34.2%

4.1.2 Obstetric and Mental Health Characteristics

Most 186(69.9%) of the respondents reported that it was their first pregnancy 85(32%) declared that it was unplanned and 77(28.9%) has previous abortion. Among the respondents 83(31.2%) of them has illness during their recent pregnancy and 41(15.4%) their child was ever admitted to ho hospital. 80(30.1%) of the respondents has bad feeling during pregnancy, 25(9.4%) has previous mental illness history and 12(4.5%) of them has a mental illness from family members (see Table 5.2).

Table 3. Obstetric and mental health characteristics of the Respondents of postpartum women attending different services in Addis Ababa public health centers (N=266).

Characteristics	Frequency	Percent
Gravidity		
1	186	69.9%
2	74	27.8%
3	6	2.3%
Parity		
1	1	100%
Planned Pregnancy		
Yes	181	68%
No	85	32%
Illness During Pregnancy		
Yes	88	33.1%
No	178	66.9%
Previous Abortion		
Yes	77	28.9%
No	189	71.1%
A child admitted due to illness		
Yes	41	15.4%
No	225	84.6%
Bad feelings in recent pregnancy		
Yes	92	34.6%
No	174	65.4%
Stigma from family member		
Yes	59	22.2%
No	207	77.8%
Mode of Delivery		
SVD	157	59%
CS	109	41%
Age of Newborns in month		

<=6 months	207	77.8%
>=7 months	59	22.2%
Previous Mental Illness		
Yes	30	11.3%
No	236	88.7%
Mental Illness from family member		
Yes	18	6.8%
No	248	93.2%

4.1.3 Social and Cultural characteristics of respondents

Nearly one third of the respondents 80(31.2%) were facing domestic violence among this 25(31.3%) emotional violence 22(27.5%) physical violence and 18(18.8%) were sexual violence. Majority 181(68%) of the respondents have visited by neighbors and families during their postpartum period and 161(60.5%) were visited by their holyprist shah or pastor. Majority 182(68.4%) of the respondents have good food and drinks during their postpartum period and nearly half 122(45.9%) of them has optimal care from husband (see table 5.3).

Table 4. Social and Cultural characteristics of respondents of postpartum women attending different services in Addis Ababa public health centers (N=266).

Characteristics	**Frequency**	**Percent**
Domestic Violence		
Yes	80	31.2%
No	186	68.8%
Type of Violence		
Physical	22	27.5%
Sexual	15	18.8%
Emotional	25	31.3%
Mixed	18	22.5%

Care from husband		
Yes	122	45.9%
No	144	54.1%
Visit from neighbor/family		
Yes	181	68%
No	85	32%
Visit from Prist/Sheck/Pastour		
Yes	161	60.5%
No	105	39.5%
Food and drinks during postpartum/genfo atmit		
Yes	182	68.4%
No	84	31.6%
Requesting Help		
Yes	184	69.2%
No	82	30.8%
Discussion with Health care provider		
Yes	243	91.4%
No	23	8.6%

4.1.4 Prevalence of post-partum Depression

The overall prevalence of postpartum depression among new mothers attending in public health centers of Addis Ababa was 79(29.7%) and 187(70.3%) have no depression based on Edinburgh Postpartum depression Scale Assessment tool(see fig 1).

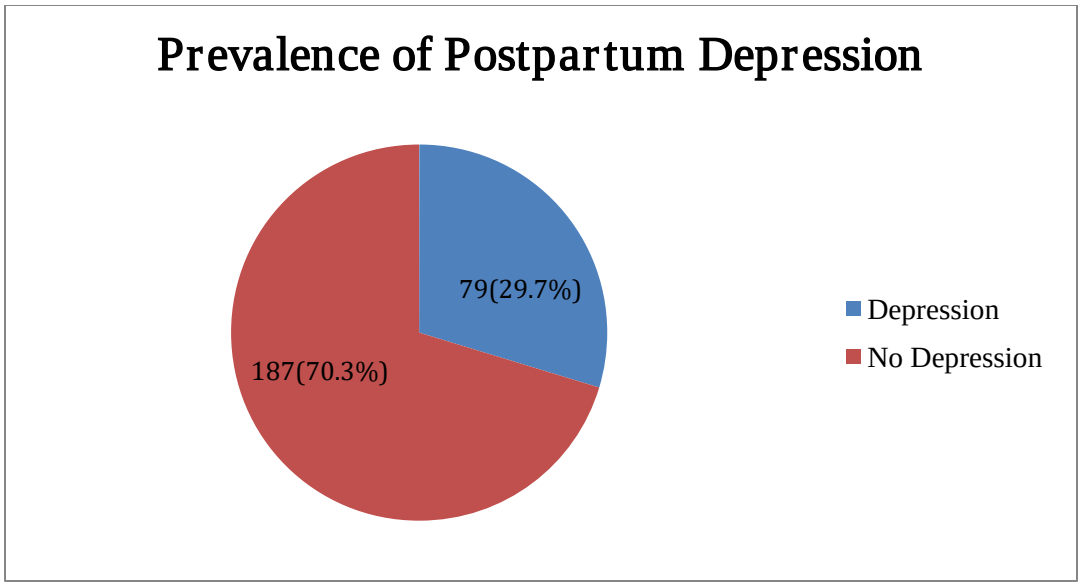


Fig 3. Prevalence of postpartum depression among new mothers attending public health centers of Addis Ababa N= 266

4.1.5 Bivariate and Multivariate logistic regression analysis of postpartum depression and its associated variables

The relationship between each independent variable and postpartum depression among postpartum women visiting public health institutions in Addis Ababa was examined using binary logistic regression analysis. Variables with a p-value less than .05 in the bivariable analysis at a 95% confidence interval (CI) were entered into the multivariable logistic regression model. The model included 17 independent variables: age, marital status, occupation, educational status, religion, monthly income, history of abortion, child admission to hospital, planned pregnancy, mode of delivery, bad feelings during pregnancy, stigma from family members during pregnancy, history of mental illness in self or family members, domestic violence, husband support, visits from neighbors or family members, visits from religious leaders, and availability of food and drinks during the postpartum period.

The multivariable logistic regression analysis showed that educational status, planned pregnancy, bad feelings during pregnancy, visits from neighbors or family members,

marital status, domestic violence, and stigma from family members were significantly associated with postpartum depression.

Regarding socio-demographic characteristics, women with higher educational status were significantly less likely to develop postpartum depression compared with women with lower educational status (AOR = 0.18, 95% CI [0.05, 0.71], p = .014). Likewise, being married was associated with significantly lower odds of postpartum depression compared with unmarried women (single, divorced, or widowed) (AOR = 0.04, 95% CI [0.01, 0.12], p < .001).

With respect to pregnancy-related factors, women with planned pregnancies were less likely to experience postpartum depression compared with women with unplanned pregnancies (AOR = 0.19, 95% CI [0.05, 0.79], p = .022). In addition, women who did not report bad feelings during pregnancy had significantly lower odds of postpartum depression compared with those who reported bad feelings during pregnancy (AOR = 0.01, 95% CI [0.003, 0.10], p < .001).

Social support was identified as an important protective factor. Women who received visits from neighbors or family members during the postpartum period were significantly less likely to experience postpartum depression compared with those who did not receive such support (AOR = 0.03, 95% CI [0.005, 0.15], p < .001).

Furthermore, participants who did not experience domestic violence had significantly lower odds of postpartum depression compared with those who experienced domestic violence (AOR = 0.03, 95% CI [0.009, 0.09], p < .001). Likewise, women who did not experience stigma from family members were significantly less likely to develop postpartum depression compared with those who experienced stigma (AOR = 0.07, 95% CI [0.02, 0.31], p < .001).

Overall, higher educational status, planned pregnancy, social support from neighbors and family members, being married, absence of domestic violence, and absence of stigma from family members were significant protective factors against postpartum depression

4.1.6 Qualitative Results

The study were exploring postpartum emotional experiences, coping mechanisms, and support systems among mothers in public health centers of Addis Ababa. Data were analyzed using Nvivo software nodes, thematic analysis, and key themes were generated from participants' narratives. The findings are organized into major themes and subthemes, supported by verbatim quotations from participants (P1–P6).

The study included six participants aged between 19 and 33 years. Participants varied in marital status, religion (Orthodox, Protestant and Muslim), education level, and employment status. All participants had infants aged between 2 and 6 months.

Seven ideas were determining following coding and thematic analysis, each containing subthemes as outlined below.

Theme 1 - Emotional Experiences Following Childbirth

In this qualitative study of these themes there was a lot of emotional challenge indicates by participant that include (sadness, stress, loneliness, and depressive symptoms). Many participants described persistent sadness and crying. For example, P1 explained: ***"I felt very sad after getting birth. I cried often and overwrought about my baby."*** Similarly, P5 shared*:* ***"I cried often and overwrought about my baby."*** Sleep disorder and stress were also common. P3 noted: ***"I was stressed and could not sleep for the first day."*** More severe emotional distress was reported by some participants. P4 described: ***"I feel self-harm sometimes without any reason."*** Correspondingly feelings of loneliness and isolation were particularly evident among participants with limited social support. P6 stated: ***"I felt depressed and isolated."***

Theme 2 - Causes of Emotional Distress

In the themes of causes of emotional distress postpartum emotional distress contributed by several factors such as sub themes (lack of child care experience or knowledge, financial challenge, lack of life partner support, work and maternity leave pressure).

First-time mothers expressed anxiety due to lack of experience. P1 explained: ***"As a first mother I have no idea how to care and handle my baby."*** financial stability challenges was also a major stressor. P2 reported: ***"I have no anything to feed my child."*** minimum maternity leave resulted to anxiety about back to work. P6 stated: ***"My maternity leave was almost ended and I fear to leave my baby."*** Many participants indicated that lack of emotional support from their husbands. P5 noted: ***"My husband was not emotionally supportive."*** Single motherhood further intensified distress, as seen in P2: ***"My baby's father was not with me and not supporting me."***

Theme 3 - Social Support Systems

In the themes of social support systems there was four Subthemes (Family support, community and neighbor support, health professional support and Social media discussion) significantly played a crucial role in emotional wellbeing of the participants. In this study Mothers and mothers-in-law were major sources of support. P1 stated: ***"My mother takes care of me and my child and I start to rest."*** Traditional postpartum support practices were also understood. P3 shared***: "My neighbor and family visit me holding genfo, atmit, doro wot… which relieves my stress."*** assist from healthcare providers during the postpartum period was also have major benefits. P4 reported: "***Those midwives in my postpartum period were supportive."*** Modern support systems emerged as well. P2 explained***: "I discussed with social media like 'Yenatoch Wog' Facebook group… they counsel and strengthen me."*** Those participants experienced least or no support has emotional distress. P6 stated: ***"No one support me even my husband was not supportive."***

Theme 4 - Cultural and Religious Beliefs

In this study religious and cultural beliefs profound emotional impacts on participants' understanding of postpartum distress. Some participants align emotional difficulties to supernatural causes. P1 explained: ***"Bad feelings during postpartum was devine due to evil eye or exposed to Satan."*** Similarly, P5 noted: ***"You are exposed to Satan due to aloneness."*** Cultural norms also shaped gender roles. P4 stated: ***"In our culture it***

believed that taking care of a child was mother's obligation." However Religious practices were widely used for healing and comfort. P1 shared: ***"Our confessor prays and gives holy water… I went to church to feel better."***

Theme 5 - Coping Mechanisms

One of the core objectives of this study was to explore the coping mechanisms a women uses to prevent postpartum depression. The subthemes in this portion includes Health service utilization, seeking social support, social media engagement and religious coping was among participants used coping strategies to manage their emotional challenges. Some participants sought professional help or health service utilization when symptoms worsened. P1 stated: ***"If it is exacerbated, I visit to health center for treatment."*** Prayer, church attendance, and spiritual guidance were among religious coping. P3 explained: ***"I call to my confessor and he prayed and visits me."*** Talking to family members was also an important coping strategy. P1 noted: ***"When I felt stressed and sad I told to my mother."*** Similarly, online virtual, digital and e-communities provided emotional support. P4 reported: ***"Social media discussion… was very supportive and calm emotional pain."***

Theme 6 - Barriers to Seeking Care

In this subject the major findings and includes describe the several key obstacles preventing women from accessing maternal care services. From the study participants the main challenges to seeking care and accessing mental health services were unawareness, structural barriers, stigma and fear. Some participants did not acknowledge postpartum distress as a health issue. P6 stated: ***"I did not go to hospital because I thought it is not illness."*** Limited maternity leave and absence of childcare services also restricted care access. Fear of discussing emotional problems was evident. P6 explained: ***"I was afraid to share for others."***

Theme 7 - Recommendations from Participants

generally, this theme recording the data suggestions provided by participants to enhance maternal health services and address identified challenges. In this study Participants suggested different strategies to improve postpartum wellbeing significance that stronger partner involvement is essential, particularly in providing both emotional and practical support during the early months after giving birth. As one participant mentioned, "***Partner support is a vital coping mechanism" (P2)***, while another noted that her ***husband's the absence of emotional support contributed to her distress (P5).*** Participants also show stressed the need for extended maternity leave, recommending that mothers should have to get sufficient time to remain at home until their baby begin additional feeding; for instance, one participant noted that mothers ***"should not start work until their child start additional feeding" (P3)***. In addition, the establishment of accessible community-based childcare services was identified as critical point, with P6 emphasizing that ***"community day care in our compound is very important."*** Finally, participants underscored the importance of enhancing awareness and promoting a shift in social norms toward shared parental responsibility, as reflected in the view ***that "caring a child is a responsibility of both parents" (P4).***

4.2 Discussion

The aim of this study was to investigate the cultural determinants of postpartum depression and the coping mechanisms employed by new mothers in Addis Ababa. The findings of the present study demonstrated that the prevalence of postpartum depression (PPD) among new mothers attending different services at public health centers in Addis Ababa was 29.7% (95% CI [24.2%, 35.2%]). This mixed-methods study combined quantitative data (n = 266) with 6 in-depth interviews, providing both contextual understanding and statistical evidence. The use of the Edinburgh Postnatal Depression Scale (EPDS) ensured solid analysis, at the same time qualitative data added depth and cultural perspective moreover; triangulation strengthened the validity of findings. However, the small qualitative sample (6 interviews) because of resource constraints limits depth and heterogeneity of opinion, Potential selection and response biases may affect representativeness the EPDS postnatal depression scale is also not diagnostic.

The quantitative analysis revealed that socio-demographic factors, such as educational level and marital status, were notable describes a joint with postpartum depression. Women with higher educational levels were less likely to experience postpartum depression compared with women who had lower educational levels (AOR = 0.18, 95% CI [0.05, 0.71], p =0.014). Similarly, married women had significantly lower odds of postpartum depression compared with unmarried women, including single, divorced, and widowed mothers (AOR = 0.04, 95% CI [0.01, 0.12], p <0.001). this findings aligned with previous studies in Addis Ababa, which reported that low educational attainment, younger maternal age, unemployment, and being a housewife were associated with increased risk of postpartum depression due to financial stress, limited autonomy, and inadequate social support (Cooke et al., 2025). The similarity of findings may be related to similarities in study setting and target population.

Pregnancy-related and psychosocial factors were also significantly associated with postpartum depression. Women with planned pregnancies were significantly less likely to develop postpartum depression compared with those with unplanned pregnancies (AOR = 0.19, 95% CI [0.05, 0.79], p =0.022). Social support emerged as a strong protective factor, as mothers who received visits from neighbors and family members had significantly lower odds of postpartum depression compared with those who did not receive such support (AOR = 0.03, 95% CI [0.005, 0.15], p <0.001). Similarly, women who did not experience domestic violence had substantially lower odds of postpartum depression compared with those who experienced domestic violence (AOR = 0.03, 95% CI [0.009, 0.09], p <0.001). Participants who did not experience stigma from family members were also significantly less likely to develop postpartum depression (AOR = 0.07, 95% CI [0.02, 0.31], p <0.001) These findings are consistent with recent Ethiopian studies indicating that poor social support, unplanned pregnancy, intimate partner violence, and household food insecurity are major determinants of postpartum depression and are closely linked with cultural expectations surrounding motherhood and family role (Anato et al., 2022; Azale et al., 2018; Mekuria et al., 2023). Previous study finding refers that women lacking sufficient family and community support are more exposed to postpartum depression, by clearly stated that the importance of extended social networks after childbirth (Anato et al., 2022; Fantahun et al., 2018). In addition, social support from family and community members has been consistently related with reduced depressive symptoms in cultures where extended family involvement is common, as such support helps redistribute childcare responsibilities and provides emotional reassurance (Ekpenyong & Munshitha, 2023; Kassam, 2019). Common findings were reported in a study conducted in China, which found that family dynamics rooted and inadequate social support problematic in cultural expectations increased stress and the likelihood of postpartum depression (Subba et al., 2024).

The qualitative findings more describe the quantitative results by explaining the lived experiences of postpartum mothers. The current study disclose that participants described experiencing sadness, stress, sleep disorder, and in severe cases, thoughts of self-harm. These emotional challenges were frequently associated with first-time motherhood,

financial difficulties, limited maternity leave, and inadequate partner involvement. Consistent with the quantitative findings, insufficient social and emotional support, particularly from partners, was identified as a major contributor to emotional distress. Similar findings have been reported in studies conducted in Asia, Africa, and the Middle East (Modukuru, 2024).

Cultural and religious beliefs also have a significant role how mothers thought and managed postpartum emotional challenges. Some of participants imputed their symptoms to supernatural or spiritual causes, while others align on religious and spiritual practices as base of comfort and healing. In terms of coping strategies, participants reported seeking emotional and practical support from family members, healthcare professionals, and online communities, in addition to beliefs in religious practices.

Despite the use of these coping mechanisms, several barriers to mental healthcare utilization were identified. These barriers included lack of knowledge postpartum depression as a medical condition, stigma related to mental illness, fear of reveal emotional problems, limited maternity leave, and inadequate childcare services. Such barriers may contribute to delayed help-seeking behaviors or failure to seek professional care. Previous studies have similarly reported that stigma and low mental health literacy in many cultural settings discourage women from seeking professional support for postpartum depression symptoms (Tolossa et al., 2020); generally, the findings of the present study highlight the multifactorial nature of postpartum depression among new mothers in Addis Ababa. The condition is shaped by socio-demographic, cultural, economic, psychological, and interpersonal factors. Therefore, interventions aimed at strengthening partner involvement, enhancing community and healthcare support systems, increasing awareness about postpartum depression, and addressing structural barriers such as limited maternity leave and childcare services are essential to improve maternal mental health outcomes.

5. Summary, Conclusion and Recommendation

5.1 Summary

The purpose of this study was assessing the cultural determinants of postpartum depression and the coping mechanisms employed by new mothers in Addis Ababa. The study aimed to answer the following research questions: How do cultural beliefs and expectations shape the perception and expression of postpartum depressive symptoms? What coping strategies do new mothers use to overcome postpartum depression and how are these strategies culturally influenced? What are the roles of family, community, and health institutions in supporting mothers with postpartum depression?

Both quantitative and qualitative methodologies were used in a mixed-methods study design. 266 postpartum moms who attended various services in Addis Ababa's public health centers participated in the quantitative component, which employed a cross-sectional study design. Data were collected using structured questionnaires and the Edinburgh Postnatal Depression Scale (EPDS). To find variables linked to postpartum depression, binary and multivariate logistic regression analyses were carried out. The qualitative component involved in-depth interviews with six postpartum mothers. The qualitative data were analyzed using thematic analysis with NVivo software to identify key themes and subthemes related to postpartum emotional experiences and coping strategies.

The Quantitative findings of the study revealed that the prevalence of postpartum depression among postpartum mothers was 29.7%, indicating that postpartum depression is a significant maternal mental health problem in the study area. The current study revealed showed that higher educational status, being married, planned pregnancy, and receiving social support from neighbors and family members were protective factors

against postpartum depression. In other hand, domestic violence, stigma from family members, and adverse emotional experiences during pregnancy significantly higher the likelihood of postpartum depression.

The qualitative findings further explained the lived experiences of postpartum mothers. Participants described emotional difficulties such as sadness, loneliness, stress, crying, sleep disorder, and emotional exhaustion after childbirth. Financial hardship, lack of childcare experience, limited partner support, work-related stress, and insufficient maternity leave were identified as major contributors to emotional distress. The study also found that family support, community support, healthcare providers, online social networks, and religious practices played important roles in helping mothers cope with postpartum emotional challenges. However, barriers such as lack of awareness about postpartum depression, stigma, fear of revealing, and limited access to childcare and mental health services negatively affected care-seeking behaviors.

The study results have crucial implications for healthcare practice, policy, and future research. The high prevalence of postpartum depression draws heed to the need for routine screening and early detection of maternal mental health problems during antenatal and postnatal care services. Healthcare providers should strengthen psychosocial counseling and support services for mothers at risk of postpartum depression. The study also emphasizes the importance of improving partner support, enhancing community and family support systems, preventing domestic violence, reducing stigma, and increasing awareness about postpartum depression. Furthermore, policymakers should consider expanding maternity leave, improving access to childcare services, and integrating maternal mental health services into routine maternal and child healthcare programs to improve maternal wellbeing and child health outcomes.

5.2 Conclusion

Based on the summary of the findings indicated above, the researcher draws the following conclusions, and their corresponding implications: The results of the present study showed that prevalence of postpartum depression was 29.7% nearly one in four new mothers experience depressive symptoms during the postpartum period. It indicates that postpartum depression is a major public health concern affecting maternal mental

health and wellbeing which can adversely affect mothers, newborns and families by impairing maternal mental and physical health, reducing mother–infant bonding and quality childcare, and increasing the risk of poor infant growth and developmental problems. It can also create emotional, social, and economic burdens on families through reduced productivity, family conflict, and increased healthcare costs.

The result also revealed that Education, planned pregnancy, social support, marital status, absence of domestic violence, and absence of stigma from family members were significant predictors of depression among new mothers in Addis Ababa. This finding implies that improving women's education, strengthening social and family support, promoting planned pregnancy, and preventing domestic violence and stigma may help reduce postpartum depression.

The qualitative results also depicted that Participants faces a wide range of emotional challenges, including persistent sadness, frequent crying, stress, sleep disturbances, loneliness, and, in severe cases, thoughts of self-harm. These emotional challenges more caused by lack of childcare awareness among first-time mothers, financial unstability, lack of partner involvement, and pressure related to minimum maternity leave and work responsibilities. This finding underlines the need for enhance psychosocial support, maternal education, partner support, and supportive workplace policies to minimize emotional distress and promote maternal mental wellbeing among new mothers.

The qualitative finding emphasizes social support systems as a vital protective factor. Support from family members, particularly mothers and mothers-in-law, neighbors, healthcare providers, and even online communities played an essential role in alleviating emotional distress. Coping mechanisms included seeking healthcare services, relying on family and community support, engaging in social media discussions, and practicing religious activities. Generally strengthening family, community, healthcare, and psychosocial support systems, as well as promoting positive coping strategies, may help reduce emotional distress and improve maternal mental health among postpartum mothers.

5.3 Recommendation

Public health centers and the Addis Ababa city administration Health Bureau should integrate routine screening for postpartum depression into antenatal and postnatal care services using the Edinburgh Postnatal Depression Scale (EPDS) through regular maternal health follow-up visits and referral systems for mothers with psychological symptoms.

Health professionals and Family Health teams should provide continuous health education for mothers, partners, and families on postpartum mental health, stigma reduction, and the importance of early help-seeking through community awareness sessions and counseling during maternal healthcare visits.

Families, community leaders, and healthcare providers should strengthen social and emotional support for postpartum mothers by encouraging partner involvement, family support, and community-based mother support groups.

The Ministry of Health Ethiopia and policymakers should strengthen maternal support policies by improving maternity leave conditions and promoting workplace environments that support maternal wellbeing, particularly for vulnerable and working mothers.

Healthcare providers and community stakeholders should implement culturally sensitive maternal mental health interventions by collaborating with religious leaders and integrating positive cultural and religious support practices into maternal healthcare services.

Public health institutions should improve access to mental health services by strengthening counseling services, reducing stigma within healthcare settings, and utilizing accessible communication platforms such as social media and mobile health education to support postpartum mothers.

6. REFERENCE

Anato, A., Baye, K., & Stoecker, B. (2022). Determinants of depressive symptoms among postpartum mothers: a cross-sectional study in Ethiopia. *BMJ open*, *12*(9), e058633.

Arifin, S. R. M., Cheyne, H., & Maxwell, M. (2018). Review of the prevalence of postnatal depression across cultures. *AIMS public health*, *5*(3), 260.

Association, A. P. (2022). Diagnostic and statistical manual of mental disorders [Internett]. In: Text Revision. Washington, DC: American Psychiatric Association.

Atuhaire, C., Brennaman, L., Cumber, S. N., Rukundo, G. Z., & Nambozi, G. (2020). The magnitude of postpartum depression among mothers in Africa: a literature review. *Pan African medical journal*, *37*(1).

Azale, T., Fekadu, A., Medhin, G., & Hanlon, C. (2018). Coping strategies of women with postpartum depression symptoms in rural Ethiopia: a cross-sectional community study. *Bmc Psychiatry*, *18*(1), 41.

Bathula, S. S., Helena, K., & Avvaru, K. (2024). Nutritional experiences of postpartum mothers-A qualitative study. *Journal of Family Medicine and Primary Care*, *13*(4), 1243-1248.

Bina, R. (2008). The impact of cultural factors upon postpartum depression: a literature review. *Health care for women international*, *29*(6), 568-592.

Cooke, A., Nasiri, N., Jayakumar, S. A., & Rangrej, S. B. (2025). A Systematic Review of the Effect of Socioeconomic Status on the Prevalence of Postpartum Depression (PPD). *International Journal of Psychology*, *60*(4), e70063.

Dennis, C. L., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth*, *33*(4), 323-331.

Desta, M., Memiah, P., Kassie, B., Ketema, D. B., Amha, H., Getaneh, T., & Sintayehu, M. (2021). Postpartum depression and its association with intimate partner violence and inadequate social support in Ethiopia: a systematic review and meta-analysis. *Journal of affective disorders*, *279*, 737-748.

Duko, B., Wolde, D., & Alemayehu, Y. (2020). The epidemiology of postnatal depression in Ethiopia: a systematic review and meta-analysis. *Reproductive health*, *17*(1), 180.

Ekpenyong, M. S., & Munshitha, M. (2023). The impact of social support on postpartum depression in Asia: A systematic literature review. *Mental health & prevention*, *30*, 200262.

Engidaw, N. A., Wubetu, A. D., & Basha, E. A. (2020). Prevalence of depression and its associated factors among patients with diabetes mellitus at Tirunesh-Beijing general hospital, Addis Ababa, Ethiopia. *BMC Public Health*, *20*(1), 266.

Fantahun, A., Cherie, A., & Deribe, L. (2018). Prevalence and factors associated with postpartum depression among mothers attending public health centers of Addis Ababa, Ethiopia, 2016. *Clinical practice and epidemiology in mental health: CP & EMH*, *14*, 196.

Hahn-Holbrook, J., Cornwell-Hinrichs, T., & Anaya, I. (2018). Economic and health predictors of national postpartum depression prevalence: a systematic review, meta-analysis, and meta-regression of 291 studies from 56 countries. *Frontiers in psychiatry*, *8*, 248.

Hanlon, C., Medhin, G., Alem, A., Araya, M., Abdulahi, A., Tomlinson, M., Hughes, M., Patel, V., Dewey, M., & Prince, M. (2010). Sociocultural practices in Ethiopia: association with onset and persistence of postnatal common mental disorders. *The British journal of psychiatry*, *197*(6), 468-475.

Kassam, S. (2019). Understanding experiences of social support as coping resources among immigrant and refugee women with postpartum depression: an integrative literature review. *Issues in Mental Health Nursing*.

Khamidullina, Z., Marat, A., Muratbekova, S., Mustapayeva, N. M., Chingayeva, G. N., Shepetov, A. M., Ibatova, S. S., Terzic, M., & Aimagambetova, G. (2025). Postpartum Depression Epidemiology, Risk Factors, Diagnosis, and Management: An Appraisal of the Current Knowledge and Future Perspectives. *Journal of Clinical Medicine*, *14*(7), 2418.

Kitil, G. W., Hussen, M. A., Chibsa, S. E., & Chereka, A. A. (2024). Exploring paternal postpartum depression and contributing factors in Ethiopia: a systematic review and meta-analysis. *Bmc Psychiatry*, *24*(1), 754.

Layton, E., Roddy Mitchell, A., Kennedy, E., Moran, A. C., Palestra, F., Chowdhary, N., McNab, S., & Homer, C. S. (2025). Maternal mental health matters: Indicators for perinatal mental health—A scoping review. *PloS one*, *20*(1), e0317998.

Leininger, M. (2001). Transcultural nursing care in the community. *Community Health Nursing: Caring for the Public's Health*, 218.

Levis, B., Negeri, Z., Sun, Y., Benedetti, A., & Thombs, B. D. (2020). Accuracy of the Edinburgh Postnatal Depression Scale (EPDS) for screening to detect major depression among pregnant and postpartum women: systematic review and meta-analysis of individual participant data. *bmj*, *371*.

Mekuria, K., Beyene, T., Lajore, B. A., Melkamu, T., & Ejajo, T. (2023). Disparities in postpartum depression among urban and rural mothers in hadiya zone shashogo District southern Ethiopia community-based comparative cross-sectional study. *Health Services Research and Managerial Epidemiology*, *10*, 23333928231217843.

Mesfin, A. A., Yimer, A., Begashaw, A., Nigusu, A., Zewude, A., Assefa, A., Tiruneh, A. G., & Girma, S. M. (2025). Prevalence and determinants of depressive symptoms among postpartum mothers visiting rural health centre in Ethiopia: A cross-sectional study. *Journal of Public Health in Africa*, *16*(4), 1576.

Modukuru, U. (2024). Association Between Cultural Factors and Postpartum Depression.

O'hara, M. W., & McCabe, J. E. (2013). Postpartum depression: current status and future directions. *Annual review of clinical psychology*, *9*(1), 379-407.

Organization, W. H. (2023). *Report of the sixth meeting of the WHO Strategic and Technical Advisory Group of Experts for Maternal, Newborn, Child and Adolescent Health and Nutrition, 15–17 November 2022*. World Health Organization.

Organization, W. H. (2024). Integrated operational framework for mental health, brain health and substance use.

Rai, S., Pathak, A., & Sharma, I. (2015). Postpartum psychiatric disorders: Early diagnosis and management. *Indian journal of psychiatry*, *57*(Suppl 2), S216-S221.

Subba, P., Petersen Williams, P., Luitel, N. P., Jordans, M. J., & Breuer, E. (2024). A qualitative study on the adaptation of community programmes for the promotion of early detection and health-seeking of perinatal depression in Nepal. *BMC women's health*, *24*(1), 273.

Tang, L., Zhu, R., & Zhang, X. (2016). Postpartum depression and social support in China: a cultural perspective. *Journal of health communication*, *21*(9), 1055-1061.

Tesfaye, W., Ashine, B., Tezera, H., & Asefa, T. (2023). Postpartum depression and associated factor among mothers attending public health centers of Yeka sub city, addis ababa Ethiopia. *Heliyon*, *9*(11).

Tolossa, T., Fetensa, G., Yilma, M. T., Abadiga, M., Wakuma, B., Besho, M., Fekadu, G., & Etafa, W. (2020). Postpartum depression and associated factors among postpartum women in Ethiopia: a systematic review and meta-analysis, 2020. *Public health reviews*, *41*(1), 21.

Wake, G. E., Fitie, G. W., Ashenafi, B., Tadese, M., & Tessema, S. D. (2022). Magnitude and determinant factors of postpartum depression among mothers attending their postnatal and vaccination services at public health institutions of Addis Ababa, Ethiopia. *Frontiers in Public Health*, *10*, 882205.

Wang, Z., Liu, J., Shuai, H., Cai, Z., Fu, X., Liu, Y., Xiao, X., Zhang, W., Krabbendam, E., & Liu, S. (2021). Mapping global prevalence of depression among postpartum women. *Translational psychiatry*, *11*(1), 543.

Xin, J. K. Y., Shian, G. Y., Han, T. T., & San, W. T. W. (2024). Experiences of postpartum Chinese women undergoing confinement practices: A qualitative synthesis. *International Journal of Nursing Practice*, *30*(6), e13251.

Zhao, X.-H., & Zhang, Z.-H. (2020). Risk factors for postpartum depression: An evidence-based systematic review of systematic reviews and meta-analyses. *Asian journal of psychiatry*, *53*, 102353.

7. APPENDIX

Appendix 7.1 Structured questionnaire; English version

Name of the Facility _____ Questionnaire identification no _____ Address of the client: _____

Introduction: How are you? My name is _____. I am a data collector for the thesis conducted by a student at Addis Ababa University the Degree of Masters of Arts in Social Psychology. This study aims to explore Cultural Determinants of Postpartum Depression and Its Coping Mechanisms: The Case of New Mothers visiting public health centers in Addis Ababa, Ethiopia. I would like to inform you that you are chosen to be interviewed. Before we go to the interview, I will request you to listen carefully to what I am going to read to you about the purpose and general condition of the study and tell me whether you agree or disagree to participate in this study.

Consent Form

The purpose of this study is to explore Cultural Determinants of Postpartum Depression and Its Coping Mechanisms: The Case of New Mothers visiting public health centers in Addis Ababa, Ethiopia. The study will be conducted through interviews. The interview will only take about 15-20 minutes of your time. At the end, it is hoped that the information you give us could help to explore cultural determinants of postpartum depression and its coping mechanisms among new mothers in Addis Ababa. The interview involves private life questions. I would like to assure you that this privacy should strictly be kept confidential. A code number will identify every participant and no name will be used. The interview is voluntary and there will not be any incentives. You have the right to respond or not respond to the all or some questions. You can also stop the interview in between if you are not interested. Your participation or non-participation, or refusal to respond to the questions will have no effect now or in the future on services that you or any member of your family may receive from service providers.

If you have any question you may contact: Addisalem Belachew (BA)

Address: Addis Ababa, Ethiopia Email: addisbh7128@gmail.com Tel: +251957048383

Are you willing to participate in this study?

1. Yes 2. No Thank you!!

If the study subject agrees to participate in the study, start the interview.

Interviewer signature certifying that informed consent has been given verbally by the respondent.

Name of the interviewer_____ Signature _____Date_____

Name of supervisor _____Signature_____ Date_____

Instruction: Ask the following questions then circle their answer on the options column if it is a choice question or write their answer on the blank space if it is an open ended question.

Part one: Socio Demographic Characteristics			
S.No	**Questions**	**Coding category**	
1	Age		
2	Marital status	Single 1 Married 2 Widowed/Divorced 3	
4	Religion	Orthodox 1 Muslim 2 Protestant 3 Catholic 4 Other------- 5	
5	Education	Primary 1 Secondary 2 Degree and above 3 No 4	
6	Occupation	House wife 1 Civil servant 2	

		Merchant 3 Daily laborer 4	
7	Does your/husband income covered monthly basic needs?	Never 1 Rarely 2 Sometimes 3 Always 4	
Part 2: obstetric and health related factors			
1	Number of pregnancy		
2	Number of alive children		
3	History of abortion	Yes 1 No 2	
4	Number of abortion		
5	Did any of your children are hospitalized?	Yes 1 No 2	
6	Have you ever experienced death of your baby?	Yes 1 No 2	
7	The mode of delivery for your last pregnancy?	Spontaneous Vaginal 1 Instrumental 2 C/S 3	
8	Was your last pregnancy planned?	Yes 1 No 2	
9	Age of your newborn in month		
10	Any illness/complication during your last pregnancy?	Yes 1 No 2	
11	Was there any negative life event during your last pregnancy?	Yes 1 No 2	
12	Stigma from family member		
13	Previous history of depression?	Yes 1 No 2	
14	Any of your relative suffered from mental illness?	Yes 1	

		No 2	
Part 3: Social and Cultural Factors			
1	Have you ever experienced any abuse in your home?	Yes 1 No 2	
2	What kind of abuse do you ever experienced?	Physical 1 Sexual 2 Emotional 3 Mixed 4	
3	Does a Father of your child is supporting both of you enough?	Never 1 Rarely 2 Sometimes 3 Always 4	
4	Did any of your relatives and neighbors present during your last child birth post-partum?	Yes 1 No 2	
5	Are you satisfied by the relationship you have with your mother-in-law?	Yes 1 No 2	
6	Does your religious leader visit you during your postpartum period?	Yes 1 No 2	
7	Does your last baby born a sex you desired?	Yes 1 No 2	
8	Does your last baby born a sex your husband/family desired?	Yes 1 No 2	
9	Does special soups and porridge prepared for your postpartum period?	Yes 1 No 2	
10	Does you seek help for your bad feelings	Yes 1 No 2	
11	Have you discussed about your feelings with health professionals during your postnatal visit?	Yes 1 No 2	

Appendix 7.2 Edinburgh Postnatal Depression Scale (EPDS)

Please circle the answer which comes closest to how you have felt in the PAST 7 DAYS, not just how you feel today(Levis et al., 2020).

In the past7days:

1.**Ihavebeenabletolaughandseethefunny side of things:**		6.**Thingshavebeengettingontopofme:**	
AsmuchasIalwayscould		Yes,mostofthetimeIhaven'tbeenabletocopeatall	3
Not quite so much now	0	Yes, sometimes I haven't been coping as well as usual	2
Definitelynotsomuchnow	1	No,mostofthetimeIhavecopedquitewell	1
Not at all	2	No, I have been coping as well as ever	0
	3		
2.**Ihavelookedforwardwithenjoymentto things:**		7.**IhavebeensounhappythatIhavehaddifficulty sleeping:**	
As much as I ever did		Yes,mostofthetime	3
Rather less than I used to	0	Yes, sometimes	
DefinitelylessthanIusedto	1	Notveryoften	2
Hardlyatall	2	No, not at all	1
	3		0
3.**Ihaveblamedmyselfunnecessarilywhen things went wrong:**		8.**Ihavefeltsador miserable:**	
		Yes,mostoftime	3
Yes, most of the time	3	Yes, quite often	2
Yes,someofthetime	2	Not very often	1
Not very often	1	No, not at all	0

No, never	0		
4.**Ihavebeenanxiousorworriedfornogood reason:**		9.**IhavebeensounhappythatIhavebeencrying:**	
No, not at all		Yes,mostofthetime	3
Hardly ever	0	Yes, quite often	2
Yes, sometimes	1	Onlyoccasionally	1
Yes, very often	2	No, never	0
	3		
5.**Ihavefeltscaredorpanickyfornoverygood reason:**		10.**Thethoughtofharmingmyselfhasoccurredtome:**	
Yes, quite a lot		Yes,quiteoften	3
Yes, sometimes	3	Sometimes	2
No, not much	2	Hardly ever	1
No, notatall	1	Never	0
	0		
TotalScore(addquestions1-10)_____			

Annex 7.3 Questions for Qualitative part

Key informant Interview Questioner

Section 1: Thank you for agreeing to participate in this study. We are interested in understanding mothers' experiences after childbirth, especially emotional wellbeing, cultural beliefs, and coping strategies. There is no right or wrong answers. Your responses will remain confidential. You may stop the interview at any time.

Section 2: Socio demographic: Age:_____ Marital status:_____ Education level:_____Occupation:_____ Number of children:_____ Baby's age:_____ Religion:_____

MAIN INTERVIEW QUESTIONS

1. Experience after Childbirth

Can you describe how you felt emotionally after giving birth?

What changes did you notice in your mood, sleep, or daily activities?

Probes: Feeling sad, overwhelmed, worried? Loss of interest? Irritability?

2. Cultural Beliefs about Postpartum Period

In your community, how is the period after childbirth viewed?

How does your culture explain emotional distress after childbirth?

Probes: Spiritual causes? Evil eye? Weak faith?"Normal motherhood stress"?

3. Family and Social Expectations

What expectations are placed on new mothers in your community?

How important is having family support after delivery?

How did your husband/partner support you?

Probes: Extended family pressure ? Financial stress ?Gender roles?

4. Coping Mechanisms

When you feel stressed or sad, what do you usually do?

Do you seek support from someone? Who?

What role does religion or prayer play?

Have you ever visited a health professional for emotional concerns?

Probes:Church/mosque attendance?Talking to mother/sister?Isolation?Traditional healers?

6. Help-Seeking Behavior

Where do women usually go for help if they feel emotionally unwell after childbirth?

What factors influence the decision to seek or not seek medical care?

What would make it easier for mothers to get help?

7. Recommendations

What support do you think new mothers need in Addis Ababa?

What changes should health facilities make?

How can community leaders help?

Closing: Thank you for sharing your experience. If you feel distressed or would like support, we can provide referral information to appropriate services.

Appendix 7.4 Structured questionnaire; Amharic version

በአዲስ አበባ ዩኒቨርሲቲ ሳይኮሎጂ ትምህርት ክፍል በማስተርስ ፕሮግራም የማህበራዊ ሳይኮሎጂ የመመረቂያ ጥናት

<u>መጠይቅ</u>

የጤና ተቋሙ ስም_____ የመጠይቅ መለያ ቁጥር_____

ማስተዋወቂያ

ጤና ይስጥልኝ_____እባላለሁ፡፡በአዲስ አበባ ዩኒቨርሲቲ ሳይኮሎጂ ትምህርት ክፍል በማስተርስ ፕሮግራም የማህበራዊ ሳይኮሎጂ ተማሪ ስሆን በአዲስ አበባ ከተማ አስተዳደር ስር በሚገኙ በተመረጡ ጤና ጣቢያዎች ለድህረወሊድ አገልግሎት ለክትባትና ለእናቶችና ህፀናት ህክምና እንዲሁም ለእድገት ክትትል ለሚመጡ እናቶች ከድህረ ወሊድ በኋላ የሚመጣ ድብርትና ተያያዥ ችግሮች ላይ በሚደረግ ጥናት መረጃሰብሳቢ ነኝ፡፡እርሶምየቃለመጠይቅተሳታፊሲሆኑወደቃለመጠይቁከመሄዳችንበፊትከዚህቀጥሎስለጥናቱአላማእናጠቅለልያሉመረጃዎችንየማነብሎትስለሆነበጥሞናካዳመጡበኋላጥናቱላይለመሳተፍፈቃደኛመሆንአለመሆንዎንይገልፁልኛል፡፡

ፈቃደኛነትንመጠየቂያቅፅ

የዚህጥናትአላማበአዲስ አበባ ከተማ አስተዳደር ስር በሚገኙ የመንግስት ጤና ጣቢያዎች ከድህረ ወሊድ በኋላ የሚመጣ ድብርትና ተያያዥ ችግሮችን መለየትና ያሉ መፍትሄዎችን መፈተሽ ነዉ፡፡ጥናቱየሚሰበሰበውበቃለመጠይቅይሆናል፡፡ቃለመጠይቁየሚወስደውጊዜከ15 እስከ 20 ደቂቃይሆናል፡፡እርስዎየሚሰጡትመረጃቃለመጠይቁየግልህይወትጥያቄዎችንያካትታል፡፡ይህየሚሰጡት መረጃበሚስጥርእንደሚጠበቅላረጋግጥልዎትእወዳለሁ፡፡እያንዳንዱተሳታፊበሚስጥርቁጥርይለያልስም አይጠቀስም፡፡ቃለመጠይቁበፈቃደኝነትላይየተመሰረተሲሆንምንምአይነትድጎማየለውምጥያቄዎቹንሙሉበሙሉምሆነበከፊልየመመለስመብትአሎትእንዲሁምካልተመቾዎትበመሀልቃለመጠይቁንማቆምይችላሉ፡፡የእርስዎመሳተፍወይም አለመሳተፍአሁንምሆነወደፊትእርሶምሆነቤተሰብዎበሚያገኙትአገልግሎትላይየሚያመጣውጉዳትአይኖርም፡፡

በጥናቱ ዙሪያ ማንኛውም ጥያቄ ካለዎት ከዚህ በታች የተጠቀሱትን ሰዎች በሚፈልጉት ጊዜ ማነጋገር ይችላሉ፡፡

አዲሳልም በላቸዉ ኢሜል፤addisbh7128@gmail.comስልክ: +251957048383

በጥናቱላይለመሳተፍፈቃደኛነዎት?

ሀ) አዎለ) አይደለሁምአመሰግናለሁ

ተሳታፊውየቃለፈቃደኝነቱንመስጠቱንየሚረጋግጥየጠያቂውፊርማ

የጠያቂዉ ስም _____ፊርማ _____ቀን ----/-----/--------

የሱፐርቫይዘሩ ስም _____ _____ፊርማ _____ ቀን ----/-----/--------

መመሪያ፡የሚከተሉትንጥያቄዎችከጠየቁበኋላምርጫለቀረበላቸውጥያቄዎችመልሳቸውንያክብቡምር ጫላልቀረበላቸውጥያቄዎችበተሰጠውክፍትቦታላይመልሱንይፃፉ።

ክፍል አንድ: ማህበራዊና የኋላ ታሪክ የሚዳስሱ ጥያቄዎች			
ተ.ቁ	**ጥያቄ**	**አማራጭ**	
1	እድሜ		
2	የጋብቻ ሁኔታ	ያላገባች----------0 ያገባች----------1 ባሏየሞተባት/አግብታ የፈታች----------2	
4	ሐይማኖት	ኦርቶዶክስ----------0 እስልምና----------1 ፕሮቴስታንት----------2 ሌላ----------3	
5	የትምህርት ሁኔታ	ምንም ያልተማረች----------0 እስከ 8 የተማረች----------1 እስከ 10/12 የተማረች----------2 ዲግሪና ከዛ በላይ ያላት----------3	
6	ስራ	የቤት እመቤት----------0 የመንግስት ሰራተኛ----------1 ነጋዴ----------2	

		የጉልበት ሰራተኛ----------3	
7	የአንቺ ወይም የባለቤትሽ ገቢ ወርሃዊ ወጫችሁን ይሸፍናል	በፍፁም----------0 ትንሽትንሽ----------1 አልፎ አልፎ----------2 ሁሌም----------3	
ክፍል ሁለት: ከእርግዝናና የስነአዕምሮ ጤና ጋር የተያያዙ ጥያቄዎች			
1	ምንያህል እርግዝና ነበረሽ		
2	በህይወት የተወለዱ ልጆች		
3	ዉርጃ አጋጥሞሽ ያዉቃል	አዎ0 የለም 1	
4	ስንት		
5	በህመም ምክንያት ሆሰፒታል ተኝቶ ሚያዉቅ ልጅ አለሽ	አዎ 0 የለም 1	
6	ልጅ ሞቶብሽ ያዉቃል	አዎ 0 የለም 1	
7	የመጨረሻ እርግዝናሽ የታቀደ ነበር	አዎ 0 የለም 1	
8	በመጨረሻ እርግዝናሽ ያጋጠመሽ ህመም ነበር	አዎ 0 የለም 1	
9	በመጨረሻ እርግዝናሽ ያጋጠመሽ መጥፎ ትዉስታ ነበር	አዎ 0 የለም 1	
10	የመጨረሻ ልጅሽ እንዴት ወለድሽ	በምጥ 0 በመሳሪያ በመታገዝ 1 በቀዶ ጥገና 2	
11	የመጨረሻ ልጅሽ ስንት ወሩ ነዉ		
12	በቤተሰብሽ/በባለቤትሽ የመጠላት የመገለል ስሜት ተሰምቶሽ ያዉቃል	አዎ 0 የለም 1	
13	ከዚህ በፊት ድብርት ወይም የአዕምሮ ጤና እክል ነበረሽ	አዎ 0 የለም 1	
14	የአዕምሮ ጤና እክል ያለበት ቤተሰብ አለ	አዎ 0	

		የለም 1	
ክፍል ሶስት: ማህበራዊና ባህላዊ ሁኔታዎችን የሚዳስስ ጥያቄ			
1	በቤት ዉስጥ ጥቃት አጋጥሞሽ ያዉቃል	አዎ 0 የለም 1	
2	የትኛዉ አይነት ጥቃት ደረሰብሽ	የአካል 0 ፆታዊ 1 የስነልቦና 2 ሁሉንም 3	
3	የልጅሽ አባት ሁለታችሁንም በበቂ ሁኔታ ይንከባከባችኋል	በፍፁም 0 ትንሽትንሽ 1 አልፎ አልፎ 2 ሁሌም 3	
4	ጎረቤት ቤተሰብ አራስ ጠይቀዉሻል	አዎ 0 የለም 1	
5	ከባለቤትሽ እናት ጋር ባለሽ ግንኙነት ደስተኛ ነሽ	አዎ 0 የለም 1	
6	የንስሃ አባትሽ/ ሽሁ ጠይቀዉሻል	አዎ 0 የለም 1	
7	የወለድሽዉ ልጅ የምትፈልጊዉ ፆታ ነዉ	አዎ 0 የለም 1	
8	የወለድሽዉ ልጅ ባለቤትሽ/ሌላዉ ቤተሰብ የሚፈልጉት ፆታ ነዉ	አዎ 0 የለም 1	
9	በአራስነትሽ ገንፎ አጥሚት በአግባቡ ታገኝ ነበር	አዎ 0 የለም 1	
10	መጥፎ ስሜት ሲሰማሽ እርዳታ ትጠይቂያለሽ	አዎ 0 የለም 1	
11	በድህረ ወሊድ ክትትልሽ ከባለሙያዎቹ ጋር ስለጤና ሁኔታሽ በግልፅ ትወያይ ነበር	አዎ 0 የለም 1	
ክፍል አራት፡ የአማርኛ ትርጉም ለ EPDS			
ተ.ቁ	ጥያቄ	መለያ ቁጥር	

1	ባለፉት ሰባት ቀናቶች ዉስጥ መሳቅና የነገሮችን አስደሳች ጎን ማዬት ችለዋል	ሀ. ሁሌ የምችለውን ያህል----0 ለ. አሁን በጣም ብዙም አይደለም-----1 ሐ. በእርግጥ አሁን ብዙም አይደለም--2 መ. በጭራሽ አይደለም----------3	
2	ባለፉት ሰባት ቀናቶች ዉስጥ ነገሮችን ወደፊት በደስታ ያዩ ነበር	ሀ. አዎ ሁሌም እንደማደርገው--0 ለ. በፊት ከመደርገዉ ያነሰ----1 ሐ. በእርግጥ በፊት ከማደርገው ያነሰ--2 መ. በአጠቃላይ ከባድ ነው----------3	
3	ባለፉት ሰባት ቀናቶች ዉስጥ ነገሮች ወደ አላስፈላጊ ሁኔታ ሲያመሩ ያለምክንያት ራስዎን ወቅሰዋል	ሀ. አዎ ብዙውን ጊዜ----------0 ለ. አዎ አንዳንዴ----------1 ሐ. ብዙ ጊዜ አይደለም----------2 መ. አይደለም መቼም ሆኖ አያውቅም----------3	
4	ባለፉት ሰባት ቀናቶች ዉስጥ ያለምንም በቂ ምክንያት ተሸብረዉ ተጨንቀዉ ያዉቃሉ	ሀ. አይደለም መቼም ሆኖ አያውቅም----------0 ለ. እምብዛም----------1 ሐ. አዎ አንዳንዴ----------2 መ. አዎ በጣም ብዙ ጊዜ----------3	
5	ባለፉት ሰባት ቀናቶች ዉስጥ ያለምንም በቂ ምክንያት የፍርሃትና የድንጋጤ ስሜት ተሰምቶዎት ያዉቃል	ሀ. አዎ በጣም ብዙ ጊዜ----------0 ለ. አዎ አንዳንዴ----------1 ሐ. አይደለም ብዙ ጊዜ አይሰማኝም----------2 መ. አይደለም በጭራሽ አይሰማኝም----------3	
6	ባለፉት ሰባት ቀናቶች ዉስጥ ነገሮች ከቁጥጥርዎ ዉጭ ሆኖብዎት ያዉቃል	ሀ. አዎ ብዙ ጊዜ ነገሮችን በአጠቃላይ መቋቋም አልችልም----------0 ለ. አዎ ልክ እንደ ብዙ ጊዜ አንዳንድ ነገሮችን መቋቋም አልችልም----------1 ሐ. አይደለም ብዙ ጊዜ በጥሩ ሆኔታ ነገሮችን እቋቋማለሁ----------2 መ. አይደለም ልክ እንደበፊቱ በጥሩ ሁኔታ ነገሮችን እቋቋማለሁ----------3	
7	ባለፉት ሰባት ቀናቶች ዉስጥ በጣም ደስተኛ ባለመሆንዎ እንቅልፍ እምቢ ብሎዎታል	ሀ. አዎ አብዛኛውን ጊዜ----------0 ለ. አዎ ብዙ ጊዜ----------1	

		ሐ. አልፎ አልፎ ብቻ----------2 መ. መቼም አይደለም----------3	
8	ባለፉት ሰባት ቀናቶች ዉስጥ የሃዘንና የብስጭት ስሜት ተሰምቶዎታል	ሀ. አዎ አብዛኛውን ጊዜ----------0 ለ. አዎ ብዙ ጊዜ----------1 ሐ. አልፎ አልፎ ብቻ----------2 መ. መቼም አይደለም----------3	
9	ባለፉት ሰባት ቀናቶች ዉስጥ በጣም ከማዘንዎ የተነሳ አልቅሰዉ ያዉቃሉ	ሀ. አዎ አብዛኛውን ጊዜ----------0 ለ. አዎ ብዙ ጊዜ----------1 ሐ. አልፎ አልፎ ብቻ----------2 መ. መቼም አይደለም----------3	
10	ባለፉት ሰባት ቀናቶች ዉስጥ እራስዎን ለመጉዳት አስበዉ ያዉቃሉ	ሀ. በጣም ብዙ ጊዜ----------0 ለ. አንዳንዴ----------1 ሐ.እምብዛም----------2 መ. በጭራሽ መቼም----------3	

የቁልፍ መረጃ ሰጪ ጥናትቃለ-መጠይቅመመሪያ

ርዕስ: በአዲስ አበባ ከሚኖሩ አዲስ እናቶች መካከል የወሊድ በኋላ ድብርት(Postpartum Depression) የባህላዊ ውሳኔ ምክንያቶች እና የመቋቋሚያ መንገዶች

ክፍል 1: ይህ ጥናትከወሊድ በኋላ የእናቶችን የስሜት ሁኔታ፣የባህል እምነቶች እና የመቋቋሚያ መንገዶች ለመረዳት ይደረጋል።ትክክል ወይም የተሳሳተ መልስ የለም።መረጃዎት ሚስጥራዊ ይሆናል፣በፈለጉት ጊዜም መቋረጥ ይችላሉ።

ክፍል 2: አጭር የግል መረጃ

እድሜ፡------የጋብቻ ሁኔታ፡------የትምህርት ደረጃ፡-----ሙያ፡-------የልጆችብዛት፡---------

የህፃኑ እድሜ፡------ሃይማኖት፡-------

ዋና የቃለ-መጠይቅ ጥያቄዎች

1. ከወሊድ በኋላ ያጋጠመዎት ልምድ

ከወለዱ በኋላ በስሜት እንዴት ተሰማዎት?

በስሜትዎ፣በእንቅልፍዎ ወይምበዕለታዊ እንቅስቃሴዎ ምን ለውጦች አሉ?

መነሻጥያቄዎች (Probes): ሀዘን?፣ጭንቀት?፣ድካም?፣ ንቁነትመቀነስ?

2. ስለ ወሊድ በኋላ ጊዜ የሚኖሩ የባህል እምነቶች

በማህበረሰብዎ ውስጥ የወሊድ በኋላ ጊዜ እንዴት ይታያል?

እናቶች ሊከተሉ የሚገባቸው ባህላዊ ልማዶችአሉ?

እነዚህን ባህሎች ካልተከተሉ ምን ይባላል?

ከወሊድ በኋላ የሚኖር የስሜት ችግር በባህል እንዴት ይተረጎማል?

መነሻ ጥያቄዎች: መንፈሳዊ ምክንያት?፣ ክፉዓይን?፣ የእምነት ድካም?፣ “መደበኛ የእናትነት ጭንቀት”?

3. የቤተሰብ እና ማህበራዊ ግፊት

አዲስ እናት ላይ የሚጣሉ ግዴታዎች ምንድናቸው?

ከወሊድ በኋላ የቤተሰብ ድጋፍ ምን ያህል አስፈላጊ ነው?

ባልዎ/ጓደኛዎእንዴትደገፉዎት?

5. የመቋቋሚያመንገዶች

ሲጭንቁወይምሲያዝኑምንታደርጋላችሁ?

ከማንድጋፍትፈልጋላችሁ?

ሃይማኖትወይምጸሎትምንሚናያለውነው?

ለስሜታዊችግርወደጤናባለሙያየመሄድ ልምድ አላችሁ?

መነሻጥያቄዎች: ቤተ-ክርስቲያን/መስጊድመሄድ፣ ከእናት/እህትጋርመነጋገር፣ ብቻመቀመጥ፣ ባህላዊሕክምና

6. የእርዳታመፈለጊያመንገድ

እናቶችስሜታዊችግርሲኖራቸውወዴትይሄዳሉ?

ወደጤናተቋምለመሄድየሚያነሱወይምየሚከለክሉምክንያቶችምንድናቸው?

እናቶችእርዳታእንዲያገኙምንመቀየርአለበት?

7. ምክር

በአዲስአበባአዲስእናቶችምንዓይነትድጋፍያስፈልጋቸዋል?

የጤናተቋማትምንመሻሻልአለባቸው?

ማህበረሰብእናመንፈሳዊመሪዎችእንዴትሊረዱይችላሉ?

መዝጊያ፡- እናመሰግናለን።ከዚህቃለ-መጠይቅበኋላማንኛውምድጋፍቢፈልጉወደተገቢየጤናአገልግሎትማመራትእንችላለን።

The undersigned agrees to accept responsibility for the scientific ethical and technical conduct of the research project and for provision of required progress reports as per terms and conditions of the Department of Social psychology in effect at the time of grant is forwarded as the result of this application.

Signature …… Date ……

Principal investigator:

Addisalem Belachew(Bsc)

Address: Addis Ababa, Ethiopia Email: addisbh7128@gmail.com Tel: +251957048383

APPROVAL OF THE FIRST ADVISOR

Supervisors: This thesis has been submitted for review with our approval as university Supervisors

1. Signature.…… Date …….

ADVISOR: Dame Abera (PhD) Associate Professor of Applied Developmental Psychology

Address: Addis Ababa Ethiopia Email: dame288@gmail.com Tel: +251911843127