Abstract

Postnatal Depression (PND) is a major mood disorder associated with childbirth. In Nigeria, its prevalence ranges from 15% to 23%. Previous studies on PND in Nigeria have largely focused on its preponderance and the biomedical explanation regarding its occurrence. Little attention has been given to the socioeconomic and cultural factors linked to its occurrence. This study examined some of these factors and their implications for healthcare seeking among women experiencing PND in Ibadan, Nigeria. The Health Belief Model was adopted as framework. Ibadan was purposively selected due to the existence of well-established healthcare facilities that handle issues related to PND. Five major healthcare facilities were randomly selected. The study found that lack of awareness about PND, perceived ineffectiveness of medical treatment, ignorance about its symptoms, poverty and out-of-pocket mode of payment accounted for delay in or not seeking healthcare for PND. The study recommends appropriate sensitization for women, husbands, and the general public as well as waiving of medical expenses on PND treatment as necessary for reducing its incidence and prevalence in relevant Nigerian communities.

Keywords: Mood disorder, awareness about PND, incidence and prevalence of PND

Introduction

Childbearing is synonymous with excitement in Africa where a high premium is placed on children (Michael, Nwokocha and Ukwandu, 2021). Among some mothers, however, the birth of a child, including postnatal experiences is characterized by tension, anxiety and depression. As studies reveal, about 10-15 percent of mothers all over the world experience postnatal depression.
Factors Constituting Barriers to Healthcare

Postnatal depression is a mood disorder that affects a number of mothers of new babies (Frieder, Fersh, Hainline and Deligiannidis, 2019). It usually begins 15 days after childbirth (Gjerdingen, Crow, McGovern, Miner and Center, 2011; Alasoom and Koura, 2014). As has been reported, PND sometimes last throughout the whole year after delivery (Dadi, Akalu, Baraki and Wolde, 2020). Some of the symptoms associated with PND include withdrawal from relatives, weakening of the mother-infant attachment, eating disorder, a feeling of hopelessness, anger and suicidal ideation (Field, 2010; Drake et al., 2014; ACOG, 2016).

The prevalence of PND is reported to be high in many parts of the world (Wachs, Black and Engle, 2009; Kathree, Selohilwe, Bhana and Petersen, 2014). As high as 15 percent prevalence rate is reported in low and middle-income countries (Fisher, de Cabral-Mello, Patel, Rahman, Tran, Holton and Holmes, 2012). The prevalence rate for Nigeria ranges between 15% and 23%, which is relatively high and above the global average (Adewuya, Eegunranti and Lawal, 2005; Chinawa et al., 2016). To be sure, PND is sometimes confused with postnatal blues and postnatal psychosis. While postnatal blues is not as serious as PND, the latter is milder than postnatal psychosis. As has been reported, postnatal blues which affects about 80 percent of women who have given birth can be managed without medical treatment (March of Dimes, 2017). Some of the symptoms associated with postnatal blues include crying without provocation, mood swings, anxiety, sadness and lack of concentration; it often begins and ends within the first two weeks of child delivery (McCarty, 2016).

Postnatal psychosis, on the other hand, occurs in less than 1 percent of mothers (Seyfried and Marcus, 2003; Grissette, Spratling and Aycock, 2018). The symptoms associated with it include hallucination, delirium, paranoia and feeling of harming oneself or baby (Pearlstein, Howard, Salisbury and Zlotnick, 2009; Laursen, Munk-Olsen, Mortensen, Abel, Appleby, Webb, 2011). Postnatal psychosis requires immediate psychiatric and intensive medical treatment to recover (Postpartum Support International, 2018).

The consequences of PND are far-reaching especially considering that it also affects newborns (Almond, 2009; O’Hara and McCabe, 2013). Studies have linked malnourishment, poor cognitive and physical health of infants to PND (Perfetti, Clark and Fillmore, 2004; Govender, Naidoo and Taylor, 2020). One of the consequences of PND is behavioral disorders that could affect some infants later in life, as adults (Parsons, Young, Rochat, Kringelbach and Stein, 2012). Early diagnosis and treatment of PND is recommended; delay in seeking medical help may increase the chances of mothers and their babies further experiencing other forms mental and physical consequences (Righetti-Veltema, Bousquet and Manzano, 2003; Liberto, 2012).

There are many factors restricting women from seeking medical treatment for PND. Martínez, Vöhringer and Rojas (2016), for instance, identified low anhedonia, lack of panic and none history of depression as barriers to early
treatment of the condition. Other barriers include wrong perceptions about PND, the fear of being misunderstood by others, and the nonchalant attitude of partners towards their spouses’ feelings (Edhborg, Friberg, Lundh and Widström, 2005; Montgomery, Bailey, Purdon, Snelling and Kauppi, 2009; Barbosa and Angelo, 2016).

Beliefs and attitudes are equally important factors that account for delay in the treatment of PND, especially in sub-Saharan Africa where access to healthcare services is quite limited. Previous studies on PND in Nigeria had focused mainly on biomedical factors (Dewuya, Eegunrant and Lawal, 2005; Agbaje, Anyanwu, Umoke, Iwuagwu, Iweama, Ozoemena and Nnaji, 2019). Little attention has been paid to socioeconomic and cultural factors including the beliefs and attitudes that inherently account for delay in diagnosis and treatment of PND among mothers. More so, the opinions of husbands on PND has rarely been documented despite the fact that the latter play crucial roles in deciding whether and when their wives could access medical treatment in line with patriarchal ethos governing household relations (Michael and Ekpenyong, 2018). This study, therefore, examined a collection of factors that undermine early diagnosis and treatment of the condition among women in Ibadan, Nigeria.

Theoretical framework
The study is anchored on the Health Belief Model which was developed by a group of social psychologists that included Rosenstock, Hochbaum, Kegeles and Leventhal in the 1950s. It focuses on the attitudes and beliefs of people about seeking medical help (Rosenstock, 1974; Rosenstock, Strecher and Becker, 1988). The model explains that the decision to seek medical attention is shaped by perceived susceptibility, severity, benefits, barriers, cues to action and self-efficacy. As such, women with postnatal depression are more likely to seek medical care when they perceive that they are susceptible to or are at risk of a health condition. An association between perceived severity and susceptible increases the chances for health actions to be undertaken with the aim of reaping the perceived benefit of such an action.

It is worthy of note that the Health Belief Model reinforces the leaning of the Rational Choice Theory, which is premised on costs and benefits analysis (Ritzer 2008, Nwokocha and Michael, 2015). This demonstrates that there are barriers in taking actions to prevent or promote health outcomes, and the decision to undertake such actions against health challenges are often weighed against perceived threat/barriers. Where perceived benefits for seeking medical treatment outweigh perceived barriers, the former propels individuals to take appropriate actions related to health seeking. The common barriers associated with getting treatment for PND among women include perceived cost of health care, stigmatization, inconveniences, pain and danger. Similarly, in carrying out appropriate actions, self-efficacy is crucial because it focuses on the individual’s perceived capacity to successfully execute the actions needed to ensure good health. Mothers with PND are likely to seek medical care and
adhere to medical recommendations when they believe that they can carry out such actions. In doing so, cues to actions play essential role and could explain the reason women need adequate supports from husbands, family members, friends and health care providers to effectively access information that could assist in critical healthcare-seeking decisions.

Methods
The study adopted the exploratory survey design and utilised a multi-stage sampling technique for quantitative data collection. Ibadan was selected purposely due to the availability of well-established healthcare facilities that handle cases of postnatal depression. While five major healthcare facilities were randomly selected, 380 postnatal mothers were systematically sampled from Ojoo Primary Health Centre, Molete Primary Health Centre, Victory Medical Centre, Adeoyo Maternity Hospital, and College of Medicine, University College Hospital. Using the Edinburgh Postnatal Depression Scale (EPDS), under the guide of clinical psychologists, respondents were screened for PND.

The EPDS scale recommended 12 points and above to regard a person as having PND (Adewuya, Eegunranti and Lawal, 2005). This implies that women who scored at least 12 out of the 30 points (≥ 12 ≤ 30) were classified as experiencing PND and were selected for the study. Nineteen In-depth Interviews (IDIs) were conducted among mothers with PND. Additionally, IDIs were conducted with men as husbands, in-laws and biological parents who provided care for women experiencing PND. Quantitative data were analysed using descriptive statistics, while qualitative data were content-analysed. The sample size was determined using Krejcie and Morgan (1970) formula.

A total of 422 copies of a questionnaire were proportionally administered on respondents across the five healthcare centers selected for this study. However, 380 copies of the questionnaire were returned and found valid for analysis. The Social Sciences and Humanities Research Ethics Committee of the University of Ibadan granted approval for the research to take place. All the respondents selected for the research freely agreed to participate in the exercise after being briefed on the purpose of the study.

Results
Table 1 presents the socio-demographic characteristics of the respondents. A large majority of the respondents (90.9%) were aged 20-39 years. About 29 percent of the respondents were 25-29 years old.
### Table 1: Socio-demographic Characteristics of Respondents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (N=380)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤19</td>
<td>3</td>
<td>0.8</td>
</tr>
<tr>
<td>20-24</td>
<td>72</td>
<td>18.9</td>
</tr>
<tr>
<td>25-29</td>
<td>112</td>
<td>29.4</td>
</tr>
<tr>
<td>30-34</td>
<td>104</td>
<td>27.4</td>
</tr>
<tr>
<td>35-39</td>
<td>58</td>
<td>15.2</td>
</tr>
<tr>
<td>40+</td>
<td>32</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married (living together)</td>
<td>316</td>
<td>83.2</td>
</tr>
<tr>
<td>Married (not living together)</td>
<td>52</td>
<td>13.7</td>
</tr>
<tr>
<td>Single mother</td>
<td>4</td>
<td>1.0</td>
</tr>
<tr>
<td>Cohabitation</td>
<td>8</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Type of Marriage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monogamy</td>
<td>353</td>
<td>92.9</td>
</tr>
<tr>
<td>Polygyny</td>
<td>27</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Ethnic Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yoruba</td>
<td>333</td>
<td>87.7</td>
</tr>
<tr>
<td>Igbo</td>
<td>27</td>
<td>7.0</td>
</tr>
<tr>
<td>Hausa</td>
<td>3</td>
<td>0.8</td>
</tr>
<tr>
<td>Others</td>
<td>17</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>35</td>
<td>9.3</td>
</tr>
<tr>
<td>Employed (paid employment)</td>
<td>146</td>
<td>38.5</td>
</tr>
<tr>
<td>Employed (self-employment)</td>
<td>198</td>
<td>52.2</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>27</td>
<td>7.1</td>
</tr>
<tr>
<td>Secondary</td>
<td>177</td>
<td>46.6</td>
</tr>
<tr>
<td>Tertiary</td>
<td>176</td>
<td>46.3</td>
</tr>
<tr>
<td><strong>Place of Antenatal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital/Clinic</td>
<td>362</td>
<td>95.2</td>
</tr>
<tr>
<td>Alternative Medicine</td>
<td>18</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>146</td>
<td>38.3</td>
</tr>
<tr>
<td>Two or more</td>
<td>234</td>
<td>61.7</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
<td>206</td>
<td>54.1</td>
</tr>
<tr>
<td>Islam</td>
<td>173</td>
<td>45.6</td>
</tr>
<tr>
<td>Traditional</td>
<td>1</td>
<td>0.3</td>
</tr>
</tbody>
</table>
Most of the respondents (96.9%) were married, although only 83.2 percent were currently living with their husbands. About 93 percent of the respondents were in monogamous unions, and the majority of them (87.7%) were Yoruba. A few of them (9.3%) were unemployed while 38.5 percent of the respondents had employers; 52.2 percent were self-employed. Slightly over 92 percent had secondary or tertiary education. The majority of the respondents (95.2%) accessed antenatal care from hospitals/clinics while more than half of the respondents (61.7%) had two or more children.

**Barriers to healthcare seeking for postnatal depression**

One of the barriers to seeking medical treatment by women with PND was the lack of the awareness of the occurrence of postnatal depression among the respondents. This manifested as a lack of appropriate information about the symptoms, causes, prevention and treatment/care of PND which prevented mothers from seeking prompt medical attention. One of the mothers experiencing PND noted during one of the interviews:

> I did not consult a doctor on time because I didn’t perceive postnatal depression as something that needed medical attention. Although, I considered postnatal depression as something unhealthy, it never came to my mind that consulting a health expert was necessary. I just thought that it was one of those post pregnancy symptoms that could go away by itself after some period of time. (IDI/Mother with PND/Igbo/2016)

This statement shows that some women perceive PND as a mere inconvenience, like postnatal blues, which does not require medical attention for them to recover. This attitude is largely attributed to the cultural beliefs and values that hold sway in most African countries. The import of the above scenario is unmistakable and suggests that ignorance and misinformation about maternal and infant healthcare practices are still largely implicated in negative pregnancy outcomes. An interview conducted with one of the husbands revealed that men/husbands were equally ignorant of the symptoms and implications of PND. They associated abnormality with physical illness to the extent that any condition that does not manifest physically was considered normal. This view was hinged on the erroneous belief that it was normal for women to suffer from post-delivery illness, so medical attention was unnecessary. In his words:

> ...I didn’t observe any sign that was related to physical illness in my wife. Moreover, I never knew about postnatal depression before now. I didn’t know that a woman could suffer depression after delivery… I did believe that my wife was okay, and would fully recover after few days of delivery. (KII/Husband/Yoruba/2016)
It, therefore, means that since most men played crucial roles in health-related matters that affected their wives, their ignorance about the reality of PND and the attendant consequences could greatly expose depressed women to risks that could have been prevented with timely intervention. The study also found that another barrier to seeking medical treatment for PND is the perceived inefficacy of medical treatment. Most women that suffered from postnatal depression and believed that they needed care reported the difficulty experienced in identifying facilities that could provide them with the care they desired. Another dimension relates to the demystification of PND as common and to be expected among mothers. One of the respondents noted that:

A woman with PND is not ill, she is just worried over issues. Even if she is given medical healthcare, it cannot completely solve her problem because, the cause of the worry may not be related to medical issues. This means that drugs can only momentarily suppress worries which would reignite, unless the exact cause of her worry is attended to. (IDI/Mother experiencing PND/Yoruba/2016)

An in-depth interview conducted with a relative of a woman with PND not only corroborated the above statement but the respondent also opined that the condition is not a physical illness. This perhaps explains why some women rely on home remedies and recourse to spiritual assistance rather than seeking orthodox medical attention. The respondents expressed her dissatisfaction with the treatment offered to her relative whom she accompanied to the medical facility where she was receiving treatment for treatment of PND. Perhaps the respondent expected an immediate reversal of the condition failure for which she label the therapy as ineffective. She explained in frustration:

I remember the time I took my relative who had postnatal depression to the hospital. She was given some drugs, but I would say that the drugs did not really work for her, because she was still experiencing her negative thoughts, headache, and unwilling feelings. (KII/Significant Other/Yoruba/2016)

While the respondent may have exhibited some form of erroneous perceptions about the inefficacy of orthodox medical care in the treatment of the condition, there could be situations psycho-social support may prove more helpful for dealing with PND than the conventional treatments accessed in formal medical facilities. is some sense in her take that not all PND cases require drugs. Indeed, the role of counselling, love and care for patient recovery may not be overstated considering that financial, sociocultural and household pressures and lack of adequate support system have persistently been implicated as some of the drivers of PND. This assertion was further supported by quantitative findings, which revealed that more than half of the respondents (54.5%)
perceived PND as a condition that does not require medical treatment for patients to recover from.

**Figure 1**: Distribution of respondents by perceived Orthodox Healthcare Seeking for Treatment of Postnatal Depression

Poverty is another barrier to seeking medical treatment for PND. This is because poverty makes it difficult for postnatal depressive women to patronize health facilities, especially in a country like Nigeria where out-of-pocket payment is common. This perceived inability to afford hospital bill makes a significant number of mothers to suffer in silence, even when they are aware that their postnatal symptoms require medical attention. One of the mothers in the study revealed that she had experienced sleeplessness, loss of appetite, anxiety, difficulty in maintaining bond with her baby, among symptoms of PND. However, she couldn’t visit hospital or clinic for proper examination because of financial constraints:

I did not visit the hospital because there was nobody that could pay or cater for my hospital bills. I knew that sleeplessness, loss of appetite, anxiety, difficulty in maintaining bond with my baby are negative symptoms associated with child delivery and demanding medical attention, but I couldn’t afford hospital bills… *(IDI/Mother with PND/Yoruba/2016)*

In the same vein, another respondent, when asked whether she sought for medical care for PND noted that lack of money to settle hospital bills prevented her from seeking health care. This explains why some women with PND do not seek prompt medical treatment. These responses suggest that some
of the women that experienced depression knew that it was a medical condition that required some attention but were constrained by financial limitation. Thus, there is an inverse relationship between poverty and access to healthcare particularly with regard to postnatal depression. As one of the respondents corroborated:

… I did not seek medical attention; would they (hospital) give me money? Hospital would even collect money from me (referring to hospital bills). I didn’t consult any doctor because I don’t have money to pay them. (IDI/Mother with PND/Igbo/2016)

However, for some of the mothers, other factors apart from money were responsible for why they did not seek orthodox medical care for PND. Quantitative results show that respondents reported several reasons which included: the belief that PND was not a physical/medical illness (33.6%); perceived efficacy of the social support system (26.6%); perceived inefficacy of orthodox medicine for treating PND (21.1%) and the perceived causes of postnatal depression which was not believed to be linked to medical factor(s) (18.7%).

![Figure 2: Distribution of respondents by reasons medical attention was not perceived necessary for postnatal depression](image)

**Discussion**

The findings of this study revealed that the lack of awareness of postnatal depression among some mothers was a barrier to seeking medical treatment for PND. Ignorance related to the causes, symptoms, prevention and treatment/care for PND undermined early presentation for care. Delay in seeking prompt
Factors Constituting Barriers to Healthcare

55

medical attention or not seeking treatment all increases the likelihood of
unavoidable complications (Parsons, Young, Rochat, Kringelbach and Stein,
2012; Liberto, 2012). To be sure, when depression is not treated, it could lead
to negative lifestyle or behaviour modifications such as drug or alcohol abuse,
mood disorder, which impacts negatively on relationships and daily activities
of such individuals among others (Bruce, 2021).

Interestingly, several women that experienced PND in the study area
neither perceived it as abnormal nor did they understand the enormity of the
consequences when not properly treated. As the study revealed, women and
their Significant-Others described the symptoms of PND as quite normal
among new mothers and as merely inconveniences or pressures that come with
childbearing that should not require a woman seeking medical attention. The
perception of the normality of PND in certain cultural settings in Nigeria
serves as a disincentive for seeking medical care for the condition. Such
erroneous perception masks the reality and weight of the problem and
unwittingly reinforces the culture of silence that pervades the pregnancy-
postnatal corridor particularly in sub-Saharan African with the worst maternal
and infant health statistics globally (Adewusi and Nwokocha, 2018; Seun-
Addie and Nwokocha, 2018; Nwokocha, Chukwudeh and Ukwandu, 2020).
The view of PND as normal aligns with earlier studies which noted that the
fear of being misunderstood by partners and family members on reporting PND
experience discouraged from voicing their conditions (Edhborg, Friberg,
Lundh and Widström, 2005; Montgomery, Bailey, Purdon, Snelling and
Kauppi, 2009; Barbosa and Angelo, 2016).

The study also revealed that husbands were ignorant of the symptoms of
PND. As such, they associated postnatal abnormality with physical illness
only. To several men and husbands, incongruous behaviours which are not of
physically defined were considered as normal and would not require medical
examination. As studies indicate, the consequences of PND are not limited to
mothers; newborns, other children and husbands in some cases are also
indirectly affected (Almond 2009; O’Hara and McCabe (2013). This situation
calls for the urgent sensitization of married men in particular and the public in
general about the symptoms of PND and the need to seek prompt medical care
when such symptoms are observed. Involving husbands in advocacy and
sensitisation related to PND is critical to the success of campaigns considering
the influence of patriarchy and patrilineal in African household decision
making processes (Michael, Nwokocha and Ukwandu, 2021)

Another barrier to seeking healthcare for PND which this study revealed
was the perceived inefficacy of medical treatment. The danger in such falsity
cannot be overstated and indeed accounted for the main reason seeking for care
from the wrong place or not doing anything at all, and wishing that the
symptoms will fizzle out naturally (Parsons et al., 2012). For some women that
experienced PND, the study found that although they were convinced on the
need to seek for medical assistance, being able to identify adequate facilities
that could provide care was a challenge. As a result, they could not present
themselves for facility-based therapy but rather opted for self-medication, which has been linked with avoidable maternal risks (Govender et al., 2020). As studies have noted, women with PND need adequate support and care, regardless of their ages, ethnicity and socioeconomic differences (Michael and Ekpenyong, 2018; Azale, Fekadu and Hanlon, 2018).

In addition, the study revealed that poverty makes it difficult for women with PND to approach healthcare facilities for medical attention, especially in Nigeria, where payment is usually through out-of-pocket. The inability to afford hospital bills prevents a number of women from seeking health care. As such, they opted for silence and endurance as coping mechanisms, even when they are aware that they needed facility based medical care and support. A respondent, for an instance, reported that she had symptoms of PND like sleeplessness, loss of appetite, anxiety, difficulty in maintaining friendly attachment with new born, yet could not visit a hospital or clinic. Therefore, policy makers and other stakeholders in the healthcare sector should consider making postnatal health care available, accessible and affordable to all in order to limit to the barest minimum the incidence and prevalence of maternal morbidity and mortality caused resulting from PND in relevant Nigerian context (Agbaje et al., 2019).

**Conclusion and policy options**

This paper has shown that beliefs and attitudes largely influenced the disposition of women and their Significant-Others towards postnatal depression. Other factors included the lack of awareness about PND, perceived inefficacy of medical treatment, ignorance of the symptoms of PND, poverty and out-of-pocket expenses for healthcare services. These factors have been implicated in delays related to health seeking behaviour. Reinforcing the assumption that when certain actors involved in decision making perceive themselves or their Significant-Others as non-susceptible to complications associated with PND or consider medical treatment as ineffective for the treatment of PND, they are less likely to access formal medical therapy. Some would rather resort to self-medication, endurance and social support as alternatives, which might ultimately become harmful.

Therefore, the need for adequate sensitization of women, their husbands and the general public on issues related to PND in addition to waiving medical expenses for postnatal care is critical to improving the situation.

**References**


