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Postpartum Depression and Maternal Wellbeing among Nursing Mothers in Ibadan North Local Government Area, Oyo State

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ABSTRACT
This research determines the factors that contribute to postpartum depression and maternal well-being among nursing mothers in Ibadan North Local Government Area, Oyo State, Nigeria. The study was a facility-based cross-sectional design study, aimed at nursing mothers visiting primary health centers in Ibadan North Local Government Area. Using a simple random sampling method, 300 consenting nursing mothers were sampled from 5 PHCs. Data were collected using the Edinburgh Postnatal Depression Scale (EPDS). The data were analyzed using the Chi-square approach to determine the association or relationship between postpartum depression and maternal well-being, and logistic regression was utilized to identify the significant components. The respondents' median age was 27.73±4.78 and their ages ranged from 20 to 44. Results include no significant correlation between mothers' well-being and postpartum (p value is 0.622); however, there is one between ethnic groupings and educational attainment (p value is 0.016), (p value 0.001). The risk factors for postpartum depression were experienced by more than half (83%) of the respondents. Since postpartum depression is frequently ignored and underdiagnosed, postnatal care should place equal emphasis on both physical and emotional health. Investments in successful prevention, diagnosis, and treatment initiatives are needed to identify nursing mothers who require assistance to protect the health of both mother and child.

Keywords: *Postpartum depression, maternal well-being, nursing mothers, health issues and mental health*

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INTRODUCTION

The term depression refers to a mood disorder. It might be characterized as sadness, grief, or rage that interferes with daily tasks. Depression is the most prevalent ailment impacting people among all common mental health illnesses. (Larson, Heidi, Clarissa Simas & Richard Horton, 2020). According to estimates from the World Health Organisation in 2004, 10% of the more than 150 million people who suffer from depressive disorders reside in Africa. Depressive disorders are the most prevalent among women of reproductive age. Maternal health has emerged as a crucial public health issue and a global challenge since females are more likely than males to experience depression. Postpartum depression, an overwhelming condition that affects a mother's behavior, is the most typical mental health difficulty following childbirth.

A mother who experiences Postpartum Depression (PPD) after giving birth often does so due to a combination of hormonal changes, psychological adjustment to motherhood, and exhaustion (Gila-Díaz Andrea et al, 2020). Other symptoms include social disengagement, trouble bonding with the infant, and feelings of guilt or worthlessness. From one continent to another, a survey of the literature found prevalence rates ranging from 0% to approximately 60%. PPD prevalence has been estimated to be around 20% in lower-middle-income nations based on literature evaluations (Webber, Elaine, & Jean Benedict, 2019). Abiodun 2017 estimated an 18.6% prevalence in a developing society in a similar population to studies done in Nigeria, where 10–30% of women seeking primary care have PPD. Positive associations have been shown between some factors, including psychological, biological, and social ones, and PPD. Postpartum depression has also been linked to psychosocial risk factors such as a history of depression, a strained marriage, a lack of social support, stressful times or events before childbirth, a low social standing, childcare stress, and problems during childbirth (Adeoye, Ikeola, Abiodun Sogbesan & Oluyomi Esan, 2022).

Postpartum or "baby" blues, postpartum depression or postpartum no psychotic depression, and postpartum psychosis are the three conditions that fall under the umbrella term "postpartum depression". To avoid or reduce its negative effects, postpartum depression must be treated as soon as possible. Postpartum depression expenses can be detrimental to the mother, the child, the family, and society when left untreated (Walters Christine Nicole, 2022). A high risk of infanticide or suicide exists among mothers who experience postpartum depression or psychosis because they frequently have thoughts of harming themselves or their child (Craft, Rowley & Perry-Jenkins, 2022). Thus, it is crucial for the health of the mother, child, and family that early screening, identification, and intervention take place. Recognizing the physical and mental health issues that may affect labor, delivery, and the postpartum period is one of the development goals specified by the U.S. Department of Health and Human Services in 2017 in the Healthy People 2010 objectives. The health

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and wellness of women and their families have been affected by postpartum depression in the past (Al Nasr et al, 2020).

The subject of postpartum depression has received a lot of research in recent years. Researchers have previously questioned whether postpartum depression is a condition that is specific to women from Westernized countries. The Edinburgh Postnatal Depression Scale, a widely used tool for identifying postpartum depressive symptoms, has been translated into a wide range of languages and is utilized in a large number of nations outside of the United States. Since then, attention has been drawn to longitudinal research examining depressive symptoms during pregnancy, postpartum depression, and depression in adoptive mothers (Anjum, Faiza, Madieha Akram, Raja Shaharyar, Muhammad Yaseen, Zahira Batoo & Asma Zafar, 2020).

Mothers who experience depressive symptoms are known to behave in ways that put their children at higher risk for health problems, which has a detrimental impact on how they parent. It has been well-documented that the adverse effects, which include the impact that a mother's depressed symptoms can have on her infant's early and later development. Evaluations of the effectiveness of numerous professional therapies, such as Cognitive Behavioral Therapy, group therapy techniques, and prescription medications, have all been conducted for the treatment of postpartum depression. Research on postpartum depression is extensive. Even though postpartum depression has been better understood and treated recently, research on the disorder's theoretical foundations is still needed. There is no universally accepted theoretical foundation for postpartum depression, according to researchers. It is challenging to make generalizations about the nature and progression of postpartum depression because different frameworks have been put forth in an effort to understand how symptoms emerge after birth. This is because these models frequently have different conceptualizations of the etiology of postpartum depression.

In addition, PPD is seen as a critical factor in achieving five of the eight MDGs and falls under the maternal mental health diagnosis category according to the WHO. Therefore, the WHO urges governments and international organisations to act right now to address maternal mental health as part of health services. Data on the availability of maternal mental health care throughout pregnancy and after delivery are, nevertheless, scarce for Nigeria. In Nigeria, access to mental health care throughout pregnancy and after delivery is limited to urban areas. This has led to reproductive-aged women in rural areas of the nation turning to non-medical settings to seek and receive services, mostly from traditional healers and untrained and unlicensed birth attendants (Abiama Emmanuel Ekpedoho & Stephanie Onyinyechi Ezeh, 2020).

The WHO chose 2015 as the deadline for member countries to complete all of the MDGs. The degree of progress made, significant obstacles encountered, supportive settings, priorities for development aid, and capability for monitoring progress were all taken into consideration when analyzing the MDGs in each nation. According to the WHO 2014, between 1990 and 2013, the global maternal mortality ratio decreased by 45%, from 380 to

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210 deaths per 100,000 live births. In 2013, about 300,000 women perished worldwide due to conditions associated with pregnancy and childbirth. The WHO 2013 reports that Nigeria has achieved very modest progress toward the 2015 MDG target to improve maternal health. In contrast, an evaluation of Nigeria's progress towards attaining the goals revealed mixed outcomes. Nigeria currently has a maternal mortality rate of 350 per 100,000 live births, which is higher than the goal rate of 250 per 100,000 live births. In contrast to the goal of 100%, experienced healthcare providers are now present at 53.6% of births, and prenatal coverage (at least one visit) is at 67.7%[16]. As a result, it is critical to concentrate on and do more studies on postpartum depression and maternal well-being in Nigeria.

Statement of the Problem

Based on the system of health care delivery and social support accessible to women, PPD prevalence differs from nation to nation. Prevalence levels in northern nations like Germany are estimated to be 3.6%, while in Canada they range from 8.46% to 8.69%. Prevalence rates are substantially greater in low- and middle-income nations in the global south. It can reach 39.4%, for instance, in Bangladesh. It is predicted to be 29% in Nepal. PPD, which is estimated to affect 25% of Ethiopian women, is a big worry for their reproductive health, according to research findings. Nigerian estimates were recorded at 22.4% and 22.9%. PPD ratings vary widely among emerging and sub-Saharan African nations, from 1.9% to 82.1%. PPD in women may be a significant global concern, but there are seldom any obvious deliberate or proactive interventions.

The high prevalence rates are a sign that the issue needs to be addressed to provide desirable regard to postpartum women's health around the world, so they can care for their newborns. However, there aren't many studies done in this area of the country; thus, more research is required in developing nations like Nigeria.

The mother's inability to have a child of the desired gender, marital strife, the husband's lack of support, a lack of a social support system, being a single mother, and other factors, such as the many and diverse factors associated with postnatal depression, such as illnesses in the baby and congenital abnormalities, the presence of physical illness in the new mother, the baby born from unwanted/unplanned pregnancy, etc., make this more so demonstrates that the study's importance, particularly in light of its impact on health, cannot be minimized.

Furthermore, several studies that looked into PPD were created in industrialized nations, and the majority of screening tools for postnatal depression were created and refined within the industrialized Western world[17]. In fact, even when the same screening tool is employed, there is global evidence suggesting the prevalence rates of postnatal depression vary by country. To assess postpartum depression and maternal well-being among nursing mothers in Ibadan North Local Government Area, Oyo State.

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Aim and Objectives of the Study

This study aims to investigate the effect of postpartum depression on maternal well-being among nursing mothers in Ibadan North Local Government Area, Oyo State, Nigeria. The specific objectives are to:

i. Determine the prevalence of postpartum depression and maternal well-being of nursing mothers in Ibadan North Local Government Area, Oyo State.
ii. Assess the relationship between postpartum depression and maternal well-being among nursing mothers in Ibadan North Local Government Area, Oyo State; and
iii. Identify the factors associated with postpartum depression among nursing mothers in Ibadan North Local Government Area, Oyo State.

Research Questions

The following research questions were answered in the study;

1. What is the prevalence of postpartum depression among nursing mothers in Ibadan North local government area, Oyo State, Nigeria?
2. What is the relationship between postpartum depression and maternal well-being among nursing mothers in Ibadan North Local Government Area, Oyo State, Nigeria?
3. What are the associated factors militating against the maternal well-being among nursing mothers in Ibadan North Local Government Area, Oyo State, Nigeria?

The study shall focus on postpartum depression and maternal well-being among nursing mothers within Ibadan North Local Government Area, Oyo State, Nigeria. This research shall be carried out among mothers who attend primary healthcare centers within the research location.

Literature Review

While many women may experience temporary mood dysphoria within approximately two weeks after giving birth, it is important to note that approximately 13% of new mothers actually face a genuine form of major depressive disorder (MDD) known as postpartum depression (PPD) (Slomian Justine, Germain Honvo, Patrick Emonts, Jean-Yves Reginster, & Olivier Bruyèr, 2019). PPD is indeed a serious mental health issue that requires attention and support. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines PPD as a specifier for MDD (American Psychiatric Association, 2023). This means that if a woman meets the criteria for MDD and the onset occurs within a certain timeframe after giving birth, it is categorized as PPD. Furthermore, PPD can also be defined symptomatically by surpassing a specific threshold on a screening measure, such as the Edinburgh Postnatal Depression Scale (EPDS) (Yang Kelly Guanhua, Caryn RR Rodgers, Esther Lee & Benjamin Lê Cook, 2020). The EPDS is commonly used to assess and identify symptoms of PPD, helping healthcare professionals in diagnosing and providing appropriate treatment. It is crucial to recognize the severity of PPD and utilize diagnostic tools to

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identify and address this condition to provide necessary support and treatment for affected individuals.

Generally, PPD typically arises within 4 to 6 weeks following childbirth and shares similar symptoms with MDD. These symptoms may include a persistent depressed mood, loss of interest or pleasure in previously enjoyable activities, disturbances in sleep patterns, changes in appetite, feelings of exhaustion or lack of energy, a sense of worthlessness or overwhelming guilt, difficulties concentrating, heightened irritability, increased anxiety, and recurring thoughts of suicide or self-harm (Slomian Justine, Germain Honvo, Patrick Emonts, Jean-Yves Reginster, & Olivier Bruyèr, 2019). PPD can vary significantly based on various factors, including the specific definition of the disorder, the country or region being studied, the diagnostic tools employed, the chosen threshold for screening measures, and the timeframe considered for determining prevalence (Alshikh et al., 2021).

Different studies and research utilize different criteria and methodologies to assess and diagnose PPD, leading to variations in reported prevalence rates. Additionally, cultural and societal factors and access to healthcare and mental health services can impact the identification and reporting of PPD cases. Moreover, the timeframe considered for determining prevalence can also influence the reported rates. Some studies may focus on the immediate postpartum period, while others may extend the assessment over a longer period. According to a pooled estimate, the prevalence of postpartum depression (PPD) among mothers in the Middle East was found to be significantly high, with a rate of 27%. The estimate was accompanied by a 95% confidence interval ranging from 0.19 to 0.35, indicating the range within which the true prevalence is likely to fall (Alshikh et al, 2021).

Studies have indicated varying and higher prevalence rates for postpartum depression (PPD) compared to the commonly reported figure of 1 in 10 women affected during the first year (Adelodun, Musibau & Arulogun 2021). When examining lower-middle-income countries, a literature review estimated the prevalence of PPD at approximately 20% (Obioha Ezinwanne Gloria, Mobolanle Rasheedat Balogun, Tope Olubodun, & Ifeoma Okafor, 2021). In Nigeria, studies have revealed rates of PPD ranging from 10% to 30% among women attending primary care. Additionally, developing societies reported a prevalence of 18.6% within a similar population. Untreated PPD can have negative consequences for both infants and mothers. Non-systematic reviews have indicated that when compared to mothers without PPD, untreated depressed mothers pose risks to their children, including poor cognitive functioning, behavioral inhibition, emotional maladjustment, violent behavior, externalizing disorders, as well as psychiatric and medical disorders during adolescence (Ahorsu Daniel Kwasi et al, 2020).

It is crucial to keep in mind that there is probably more than one cause when reading studies on the etiology of mental disease. Even if a person has a hereditary sensitivity or tendency to develop depression, there must be experience and environmental factors that interact to generate the illness. Genetic and biological investigations of mood disorders reveal that they are complicated ailments. As a result, some of these variables likely

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contribute to the emergence of postpartum depression (Zhao, Xiao-hu, & Zhi-hua Zhang, 2020).

Biological Factors

The risk of depression is influenced by the age of the mother during pregnancy. Studies have indicated that the highest levels of depression are reported among mothers aged 13 to 19 years, while the lowest rates are observed in women aged 31 to 35 years (Mustafa Nilofar, Qurutulain Mushtaq, Rehana Kanwal, Humaira Tabassum, Qudsia Nawaz, & Samina Rehan Khan, 2023). Additionally, research conducted on 1950 women between 2 to 12 weeks postpartum revealed that increasing maternal age and maternal self-efficacy are associated with a reduced risk of postpartum depression (Edinoff et al., 2021). Furthermore, glucose metabolism disorders during pregnancy have been identified as predisposing factors for postpartum depression. It has been observed that women with higher blood glucose levels (with a mean of 120 mg/dl versus 114 mg/dl) one hour after undergoing the glucose challenge test with 50 g of glucose are at a higher risk of developing postpartum depression compared to others (Mustafa et al., 2023). Serotonin and tryptophan levels in the bloodstream have been identified as significant factors influencing depression. A study has demonstrated a link between various alleles of the serotonin transporter gene and serotonin receptors with mood disorders and depression (Doulabi et al, 2019).

Serotonin, a monoamine neurotransmitter, is synthesized through an enzymatic pathway from the amino acid tryptophan. The amount of serotonin present in the body is directly influenced by an individual's diet. Consuming protein-rich foods can decrease the levels of tryptophan and serotonin in the brain, whereas consuming carbohydrates can have the opposite effect (Takayanagi & Tatsushi, 2022). In cases of nutritional deficiencies, a reduction of up to 15% in brain tryptophan (a precursor to serotonin) has been associated with an increased rate of depression, including postpartum depression (Takayanagi, Yuki, & Tatsushi Onaka, 2022).

Research has explored the role of corticotropin-releasing hormone (CRH) in the regulation of steroid hormones and its connection to depression. CRH is produced not only in the hypothalamus but also during pregnancy in the placenta, uterus, and ovaries. It plays a role in regulating the pituitary-hypothalamus-adrenal axis, which influences the production of steroid hormones. Following delivery and the expulsion of the placenta, there is a significant decrease in CRH levels, leading to reduced production of steroid hormones like estrogen. This hormonal shift increases the vulnerability to depression during the first 12 weeks after childbirth (Kang Dongyu et al., 2023). Additionally, there is some evidence suggesting an inverse association between levels of free thyroxine and total serum thyroxine concentrations with symptoms of postpartum depression. Although the exact relationship between thyroid dysfunction and postpartum depression remains uncertain, this condition may contribute to the development of postpartum depression in a subgroup of women (Tikka et al., 2022). According to a report, a positive thyroid peroxidase antibody test during

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pregnancy at 32 weeks may increase the risk of postpartum depression by 2-3 times. Further research is needed to better understand the connection between thyroid function and postpartum depression, but these findings highlight the potential influence of hormonal factors, such as CRH and thyroid hormones, on the development of postpartum depressive symptoms.

In addition to the association of certain endogenous hormones with postpartum depression, there is also evidence pointing to the involvement of the cytokine network and inflammatory responses in the pathophysiology of depression (Adelodun Aminat, Musibau Titiloye, & Arulogun Oyedunni Sola, 2021). The administration of cytokines such as interferon alpha and cytokine inducers like lipopolysaccharides and typhoid vaccines has been found to induce behavioral changes overlapping with symptoms of depression, such as mood disorders, anorexia, fatigue, sleep disorders, and mood swings (Doulabi Mahbobeh Ahmadi et al, 2019). In the context of postpartum depression, women experiencing depression may develop a psychoneuroimmunological disorder triggered by the inflammatory response disruption during labor and delivery (Fekadu et al., 2020).

Additionally, alterations in the regulators of T-cells have been observed in depressed women before delivery (Kang Dongyu et al., 2023). The exact mechanism explaining these T-cell changes in depression remains unknown. However, it has been observed that depressed patients' exhibit increased T-cell apoptosis, which may be linked to heightened immune system activity and tryptophan depletion. Tryptophan is crucial for T-cell proliferation, and in an environment lacking tryptophan, T-cells undergo an apoptosis process (Kim Sehee et al, 2022). The increased apoptosis of T-cells in depressed patients, coupled with reduced responsiveness to glucocorticoids, leads to a decrease in available T-cells and diminishes the brain's capacity to respond to immunological stimuli [28]. These findings suggest that alterations in the immune system, including T-cell dynamics and inflammatory responses, play a role in the development of depression and may contribute to the pathophysiology of postpartum depression (Fekadu et al., 2020).

In a recent study, researchers investigated the possibility that some women may be more sensitive to reproductive hormones than others and that in this subgroup, typical endocrine processes connected to birthing may cause an emotional episode. They constructed a scaled-down model to recreate some of the hormonal events of pregnancy and labor to test the idea. Eight women in each of the two groups, eight with a history of postpartum depression and eight without, were tested. Over the course of eight weeks, both groups of women received a gonadotropin-releasing hormone agonist to mimic the supraphysiological gonadal steroid levels of pregnancy. Then, the agonists were stopped to mimic childbirth (Moieni et al., 2020).

While none of the 8 women who did not have a history of postpartum depression showed any mood symptoms throughout the withdrawal phase, five of the eight women with a history of the condition experienced substantial affective symptoms. The data, according to the authors, supported the idea that estrogen and progesterone may play a role in a

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subgroup of women's development of postnatal depression (Kang Dongyu, Huixi Dong, Yidong Shen, Jianjun Ou, & Jingping Zhao, 2023).

2. Obstetric Factors

The relationship between the number of childbirths and postpartum depression has yielded conflicting findings in different studies. Some studies suggest that postpartum depression is more prevalent in women who have had multiple childbirths (multiparous women) compared to those who have not yet given birth (nulliparous women). However, other studies report a higher prevalence of postpartum depression in nulliparous women (Fekadu et al., 2020). Moreover, a study involving 86 participants within six weeks after delivery found that having two or more children was associated with a higher likelihood of experiencing depression, potentially due to the increased psychological burden (Rollè Luca, et al, 2020). These varying outcomes highlight that the number of childbirths alone is not an independent factor for the development of postpartum depression. Instead, it suggests that the occurrence of this condition is influenced by psychosocial conditions that arise from the experience of multiple childbirths. The complex interplay between psychological factors, social circumstances, and the challenges associated with having multiple children contributes to the manifestation of postpartum depression (Tikka et al., 2022).

An increased risk of postpartum depression is associated with a challenging pregnancy. Various factors contribute to this risk, including conditions that necessitate emergency cesarean section or hospitalization during pregnancy (Moya Ernest et al, 2023). Additionally, postpartum complications and labour-related complications such as meconium passage, umbilical cord prolapse, and obstetric hemorrhages significantly impact the incidence of postpartum depression (Lyubenova Anita et al., 2021). Mothers who give birth to infants with a weight below 1500 grams face a considerably higher risk of postpartum depression compared to others. The risk in this group can be 4 to 18 times greater than in women whose infants have a higher birth weight. These factors associated with a risky pregnancy contribute to the vulnerability of postpartum depression (Smorti Martina et al., 2019). The physiological and emotional challenges faced during pregnancy, as well as the medical complications encountered during labor and childbirth, can contribute to the development of postpartum depression (Soghier Lamia et al., 2020).

The occurrence of depression can be influenced by a discrepancy between a mother's expectations and the actual events during pregnancy. Specifically, women who strongly desire natural childbirth during the perinatal period but end up undergoing a cesarean section are more susceptible to postpartum depression compared to others (Lim Grace et al, 2019). Conversely, maintaining a natural state throughout pregnancy, free from complications and adequately preparing for delivery, appears to have a positive effect on preventing postpartum depression. Several factors have been identified that can reduce the risk of postpartum depression. These include the use of epidural anesthesia during childbirth, attending childbirth preparation classes during pregnancy, and continued breastfeeding after

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giving birth, as they have been associated with a decreased likelihood of developing postpartum depression (Emamian et al., 2019). However, it is important to note that insomnia during pregnancy can increase the risk of recurrent postpartum depression, particularly in women with a previous history of the condition (Fekadu et al., 2020).

3. Clinical Factors

Clinical considerations include elements like having previously had mental symptoms, having a family history of the condition, and assessments of affect during pregnancy. A prior history of depression was a moderate to significant predictor of subsequent postpartum depression, according to the findings of both meta-analyses. According to subsequent research, women who have experienced postpartum depression in the past are more likely to experience it again. Information was aggregated from six studies (about 900 women) to assess the relationship between postpartum depression in women and a family history of the disorder. The findings revealed no link between a family history of the condition and postpartum depression. However, 490 women with a family history of psychiatric disease were shown to have a higher risk of postpartum depression. Establishing a good family history of mental illness can be challenging since it requires the subject to be aware of and willing to disclose any relatives who have psychiatric issues. There is a link between family history and postpartum depression, but there are currently no techniques for getting precise information (Lyubenova et al., 2021). Postpartum depression is moderately to strongly predicted by low mood during pregnancy.

4. Psychological Factors

A higher risk of PPD is associated with a previous history of depression and anxiety, among other factors. Numerous studies have reported a significant relationship between PPD and a prior history of depression, which is considered a powerful factor in the development of PPD (Goweda & Tayseer, 2020). Additionally, the occurrence of mental health disorders, particularly depression, during pregnancy serves as a strong predictor for the onset of PPD. The presence of a pre-existing depressive condition or experiencing depression during pregnancy increases the vulnerability to PPD. These findings underscore the importance of considering a woman's mental health history and monitoring her well-being throughout pregnancy to identify those at higher risk for developing PPD. Evidence suggests that women with a prior history of depression are more vulnerable to hormonal changes, providing insight into these relationships. Also, it has been reported that the presence of a moderate to severe premenstrual syndrome (PMS) history is a factor influencing the onset of postpartum depression. In cases of severe PMS, alterations in the serotonin transport system have been observed, and specific variations in the serotonin transporter polymorphism are associated with major depression. Higher levels of serotonin polymorphism may contribute to tryptophan depletion and trigger the development of postpartum major depression.

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In addition to a previous history of depression, various other factors can contribute to the risk of postpartum depression. One such factor is having a negative attitude towards the recent pregnancy. Women who experience feelings of disappointment, ambivalence, or lack of attachment towards their pregnancy may be more prone to developing postpartum depression. The number of life events a woman has experienced can also play a role in increasing the risk of postpartum depression. Major life stressors such as financial difficulties, relationship problems, or the loss of a loved one can add to the emotional strain during the postpartum period, potentially triggering or exacerbating depressive symptoms. A history of sexual abuse in the past is another predisposing risk factor for postpartum depression. Women who have experienced such trauma may carry unresolved emotional issues, which can resurface during the vulnerable postpartum period and contribute to the development of depression. Furthermore, factors related to the mother's perception of her baby and self-esteem can impact the risk of postpartum depression (Goweda & Tayseer, 2020). Reluctance towards the baby's gender, such as a preference for a different gender or disappointment about the baby's sex, can create emotional distress and increase the likelihood of depressive symptoms. Low self-esteem, especially in relation to parenting abilities, can also contribute to feelings of inadequacy, stress, and ultimately, postpartum depression.

5. Social Factors

Social support encompasses various forms of assistance, including emotional, financial, intellectual, and empathetic support. It has been established that social support plays a crucial role in reducing the occurrence of postpartum depression (Mohammad Reza, Rashidi, & Reza Malki, 2020). In contrast, a lack of social support is recognized as a significant environmental factor contributing to the onset of depression and anxiety disorders. During the International Conference on Population and Development, empowering women with decision-making power within their households and increasing partner support were identified as key solutions to enhance women's reproductive health. Incidents of spousal sexual violence and other forms of domestic violence during pregnancy are also regarded as factors that contribute to the development of postpartum depression. Beyond the support from family members and the community, certain behaviors, such as smoking during the prenatal period, are social factors associated with an increased risk of postpartum depression, with a likelihood of 1.7 times higher (Asres et al, 2021).

The relationship between smoking and postpartum depression is influenced by both socioeconomic status and the link between socioeconomic status and depression. This interplay adds complexity to the association. Additionally, the physiological changes experienced during pregnancy can be perceived as stressful for certain mothers, potentially triggering depressive symptoms and initiating smoking behavior (Mobolaji et al., 2021). Conversely, lower education levels and low income are linked to an increased risk of

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postpartum depression. These socioeconomic factors play a role in shaping the likelihood of experiencing postpartum depression (Emamian et al., 2019).

Losing a job, getting divorced, moving, or losing a loved one are all known to be stressful experiences that can set off depressive episodes in people who have never had an affective disorder before. As stressful life experiences in and of themselves, pregnancy and childbirth are frequently thought to contribute to depression. The consequences of additional stressful life experiences that women go through throughout pregnancy and the puerperium, however, have been researched by certain researchers. These occurrences, which are assumed to represent added stress at a time when women are particularly vulnerable, could be a contributing factor in postpartum depression.

Several earlier studies have studied the effect of social support in reducing postpartum depression, and it is believed that receiving social support from friends and family during difficult times may be a protective factor against developing depression (Emamian et al., 2019).

Social assistance is a multifaceted idea. Spouses, relatives, friends, or coworkers are all potential sources of support. There are several forms of social support as well, including instrumental support, informational support, and emotional support. Instrumental support is tangible help in the form of material assistance or assistance with duties (expressions of caring and esteem). Researchers have also looked at the relationship between received support and perceived support (a person's overall opinion or idea that people in their social network would help them in a time of need) (where supportive exchanges may be directly observed or measured by asking people). Receiving support requires measuring both its amount and quality, which may be done by counting the number of network members and the regularity with which helpful acts are performed. Postpartum depression and emotional and practical assistance are negatively correlated, according to studies. Perceived social isolation (or a lack of social support) is a significant risk factor for postpartum depression symptoms. There could be discrepancies between the social assistance that is perceived and that is really given.

Depressed women feel their spouses fell short in both instrumental and emotional support after giving birth. In contrast to women who were not depressed, these women did not perceive their spouse as being less helpful throughout pregnancy. However, unlike during pregnancy, the sad women's friends and parents were also thought to be less encouraging during the puerperium. In a follow-up investigation, these findings were supported discovered that the degree of postpartum depressive symptoms was correlated with numerous variables of perceived social support measured during pregnancy. Surprisingly, rather than the level of closeness with the husband, the strongest predictor was the availability of companionship and a sense of belonging to a community of others who shared similar traits. Postpartum depression is more likely to occur in pregnant women who do not obtain adequate social support. This idea was supported by a more recent study that

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claimed that informational support from lots of people in your social network protected against postpartum depression.

It is important not to undervalue how having children affects a mother's psychological functioning on all fronts. In many circumstances, the family system must be rebuilt, and many spouses take on more traditional responsibilities. The majority of parenting responsibilities typically fall to the woman; therefore, the parents must determine how their new duties will affect their former work habits and make the appropriate adjustments. The connection between the partners frequently deteriorates as a result of the extra responsibility of childcare, and there is less time for socializing. The pressures of being a new mother can be lessened with the father's assistance. When assessing the role of factors in the emergence of postpartum depression, these stresses should be taken into consideration. Women who encounter marital issues during pregnancy are more likely to develop postpartum depression. Women with postpartum depression felt their husbands were less helpful than women who were not sad, although these differences were only noticeable after childbirth and not when a woman was pregnant.

Women's contentment with the relationship was gauged using a straightforward Likert scale, and more formal tests like the Dyadic Adjustment Scale (DYAS) were also used. A self-report design or an interview could be used for the evaluation. Potential reporting bias is eliminated by the use of prepartum data as the basis for the meta-analyses. It has previously been discovered that postpartum depressed women view their husbands as being less helpful, but it is unclear whether their depressive symptomatology has an impact on how they see their relationship. Because the measurements were taken before delivery, these results are free of such bias.

There has been a lot of focus on the role that socioeconomic status plays in the causes of depression and other mental health issues. Mental health illnesses have been linked to socioeconomic deprivation markers such as unemployment, low income, and low educational attainment. Depressive disorders are more prevalent in impoverished nations, according to recent studies from North America, Latin America, and Europe. The etiology of postpartum depression has also been researched in relation to socioeconomic disadvantage. Which socioeconomic status measures were used in this meta-analysis is not clear, though. Postpartum depression had a tiny but significant predictive link with factors like low income, the mother's profession, and lower social status. Other socio-demographic factors, such as marital status, pregnancy, employment position, and parity, did not, however, demonstrate a meaningful association with postpartum depression. Recent research that was excluded from the meta-analyses revealed that postpartum depression was substantially correlated with unemployment and financial stress. Financial stress was identified as a significant risk factor for postpartum depression in low-income populations.

Infant-related variables can only be measured postpartum by definition. As a result, their ability to forecast outcomes is biased, especially when compared to the impartiality of the mother's reports. Postpartum depression has already been linked to child-related

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variables; having a challenging baby or a baby with neonatal complications was associated with a diagnosis of postpartum depression, while higher levels of childcare-related stressors were associated with higher levels of depressive symptomatology. Postpartum depression symptomatology was only moderately predicted by childcare stress and having an infant with a challenging temperament. Researchers have discovered that mothers with postpartum depression describe their children less favorably than control mothers and report more behavioral issues with their newborns. Therefore, reporting of newborn traits may be biased as a result of the mothers' symptoms.

Several lifestyle factors, including dietary patterns, sleep quality, exercise, and physical activity, can impact postpartum depression. Adequate consumption of vegetables, fruits, legumes, seafood, milk and dairy products, olive oil, and a diverse range of nutritious foods has been observed to potentially reduce the risk of postpartum depression by up to 50%. Vitamin B6 plays a crucial role as a cofactor in the production of serotonin from tryptophan. Therefore, a deficiency in this vitamin may be involved in the development of postpartum depression. A study reported a positive relationship between vitamin B2 absorption levels during the 21st week of pregnancy and the occurrence of postpartum depression. Furthermore, an ecological study conducted across 23 countries found that increased consumption of seafood is associated with a reduced risk of postpartum depression.

DHA is a compound found in fish oil. In terms of micronutrients, a deficiency in zinc and selenium intake has been linked to an increased likelihood of experiencing postpartum depression. Research suggests that zinc plays a role in influencing serotonin reuptake, contributing to its antidepressant effects (Fatemeh et al, 2021). Additionally, selenium deficiency can potentially affect postpartum depression by disrupting thyroid function. Good dietary sources of zinc include red meat, grains, meat, and fish.

Postpartum Depression in Nigeria

A study aimed to ascertain the incidence of postpartum depression and evaluate risk variables among mothers in northeastern Nigeria. Four hundred eighty-three women who gave birth at a tertiary medical facility in northeastern Nigeria were given the Edinburgh Postnatal Depression Scale (EPDS) questionnaire as part of the study's materials and methods. Using a pro forma questionnaire created by the researchers, their socio-demographic and clinical data were also gathered. According to their study, 188 participants scored 13 or higher on the EPNDS, resulting in a 22.4% prevalence rate for postnatal depression. Employment (odds ratio (OR) = 0.49, 95% (CI) = 0.27-0.86, P value = 0.018), lack of support from the husband (OR = 0.34, 95% (CI) = 0.19-0.60, P value = 0.000), and prim parity (OR = 0.56, 95% (CI) = 0.35-0.88, P value = 0.013), among others, are associated with the development of postnatal depression. Other factors include an unplanned pregnancy. The study revealed a sizable percentage of new mothers suffer from postnatal

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depression. It could have a detrimental impact on their parenting abilities and potentially have bad consequences for the woman and the child.

In a cross-sectional study, 401 women who attended postpartum and immunization clinics at the University College Hospital, Ibadan, were used. The information was gathered using a self-administered survey that included a socio-demographic portion that was self-developed, the Edinburgh postnatal depression scale to evaluate postpartum depression, and the International Physical Activity Questionnaire (short type) to measure physical activity. To identify independent components, analysis was performed using Chi-square and a multivariate analysis. The cutoff for significance was 0.05. 37.8% of responders, or more than one-third, were found to have postpartum depression. Many people were moving around (72.1%). When compared to lower levels of physical activity, high levels showed a 1.25 higher risk of postpartum depression (95% CI = 0.797-0.97). Independently linked to postpartum depression were the child's age, gender, and relationship satisfaction. Postpartum depression is more common than had been previously thought in southwest Nigeria, and high levels of physical activity may make it more likely.

METHOD

The study adopted a facility-based, cross-sectional survey to investigate the effect of postpartum depression on maternal well-being among nursing mothers in Ibadan North Local Government Area, Oyo State, Nigeria. The study population was nursing women attending postpartum healthcare programs at community health clinics in the Ibadan North Local Government Area of Oyo State. The study sites were Idi Ogungun PHC Agodi, Ago Tapa PHC Mokola, Barika PHC Agbowo, Bodija PHC Adinloju and Agbowo PHC. A simple random sampling method was adopted in selecting the participants for this study. A total of 300 nursing women attending postpartum healthcare programs at community health clinics in the Ibadan North Local Government Area, Oyo State, were used for this study.

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RESULTS

Table 1: EDPS Test on Postpartum Depression among Nursing Mothers (Prevalence of Depression) N=300

Variables	Frequency	Percent
I have been able to laugh and see the funny side of things		
Yes	34	14.7
No	266	85.3
I have been looking forward to the enjoyment of things		
Yes	66	22.0
No	234	78.0
I have blamed myself unnecessarily when things go wrong		
Yes	261	87.0
No	39	13.0
I have been anxious or worried for no good reason		
Yes	235	78.3
No	65	21.7
I have felt scared or panicky for no good reason		
Yes	154	51.3
No	146	48.7
Things have been getting on top of me		
Yes	114	38.0
No	186	62.0
I have been so unhappy that I have had difficulty in sleeping		
Yes	198	66.0
No	102	34.0
I have felt sad or miserable		
Yes	232	77.3
No	68	22.7
I have been so unhappy that I have been crying		
Yes	217	72.3
No	83	27.7
The thought of harming myself has occurred to me		
Yes	27	273
No	9	91

Source: Field Survey, 2022

Table 4.2 indicates that I've been able to smile and see the amusing side of things, the women's reactions to the remark. The majority of responders, 266 (85.3%), chose NO, while 34 (14.7%) selected YES. When asked to comment on the second statement, "I have anticipated enjoying things," 234 (78.0%) of the respondents said NO. Only 66 (22.0%) of the replies from the women were "YES." These are the participants' responses to the statement, "I have unfairly placed the blame for things going wrong on myself." The majority of responders, 261 (87.0%), said "Yes," while only 39 (13.0%), did not. The following are the respondents' answers to the question, "I have been concerned or worried for no good reason." 65 (21.7%) responded NO, while 235 (78.3%) chose YES. Women's replies to the statement "I have felt anxious or terrified for no very good reason" Only 154

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(51.3%) of the respondents selected the option "YES," while 146 (48.7%) opted for NO. The replies offered by the women in response to the statement "Things have been getting on top of me" are as follows 184 (62%) women chose NO, compared to 114 (38%) who picked YES. These are the respondents' answers to the question, "Have you ever been so sad that you have trouble falling asleep?" A sizable 198 (66%) of the participants answered "YES," while 102 (34%) answered NO. When asked if they had ever felt depressed or unhappy, the majority of respondents, 232 (77.3%), indicated YES, while 68 (22.7%) of the women responded NO. 217 respondents (72.3%) agreed with the statement, "I have been so sad that I have been crying," whereas 83 respondents (27.7%) disagreed. The majority of responders, 273 (91%), disagreed with the statement "The notion of injuring myself has come to me," while 27 (9%), did.

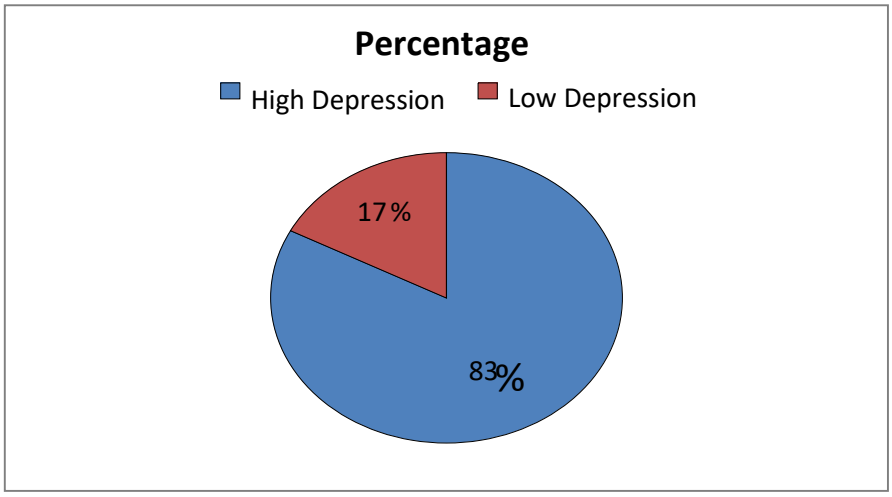

Figure 1: Prevalence Level of Postpartum Depression. Source: Fieldwork, 2022

Table 2: Maternal Well-Being Test of the Respondents

Variable	Frequency n=300	Percent
Your health		
Dissatisfied	177	59.0
Satisfied	123	41.0
The amount of pain that you have		
Dissatisfied	168	62.0
Satisfied	114	38.0
Amount of energy for everyday activities Dissatisfied	189	63.0
Satisfied	111	37.0
Amount of control you have over your life		
Dissatisfied	205	68.3
Satisfied	95	31.7
Your ability to take care of yourself without help		
Dissatisfied	208	69.3
Satisfied	92	30.7
Your physical appearance		

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Dissatisfied	188	62.7
Satisfied	112	37.3
The amount of sleep you are getting		
Dissatisfied	296	98.7
Satisfied	4	1.3
Your breasts		
Dissatisfied	280	93.3
Satisfied	20	6.7
your surgical incision		
Dissatisfied	265	88.3
Satisfied	35	11.7
Your sex life		
Dissatisfied	187	62.3
Satisfied	113	37.7
Your peace of mind		
Dissatisfied	151	50.3
Satisfied	149	49.7
Your personal faith in God		
Dissatisfied	113	37.7
Satisfied	187	62.3
Your happiness in general		
Dissatisfied	134	44.7
Satisfied	166	55.3
Your life in general		
Dissatisfied	138	46.0
Satisfied	162	54.0
Your amount of worries in your life		
Dissatisfied	129	43.0
Satisfied	171	57.0

Source: Field Survey, 2022

Table 3 shows less than half of the respondents, 123(41%), are content with their health situation, while 177(59%) of the respondents claimed they are not. While 114 (38%) of the respondents claimed they are content with the level of discomfort they are experiencing, the majority of respondents 168 (62%) are not. The majority of respondents, 189 (63%) said they are not happy with the energy they have for daily activities, while just 111 (37%), said they are happy with their energy for daily activities. 95 of the respondents, or 31.3% of the women, said they are content with the level of control they have over their lives, compared to 205 respondents, or 68.3%, who said they are unsatisfied with it. The majority of respondents, 208 (69.3%), said they were not satisfied with their capacity to care for themselves without assistance, while 92 (30.7%) said they were. Less than half of the women, 112, (37.3%), indicated they are content with their physical appearance, while the majority of respondents, 188 (62.7%), said they are not. Fewer than 4 (1.3% of the respondents) stated they were content with the quantity of sleep they are getting, while the majority of respondents, 296 (98.7%), said they are not. The majority of the 280 respondents (93.3%) reported being unsatisfied with their breasts, while only 20 respondents (6.7%) expressed the other opinion. Majority of the women, 265 (88.3%), were not happy with their surgical incision, compared to 35 (11.7%) of the responders. While 113 respondents (37.7%) indicated they were content with their sex life, the majority of respondents 187 (62.3%) said they were unsatisfied with it. The majority of respondents, 151 (50.3%), reported being unsatisfied with their level of peace of mind, compared to 149 (49.7%), who said they were.

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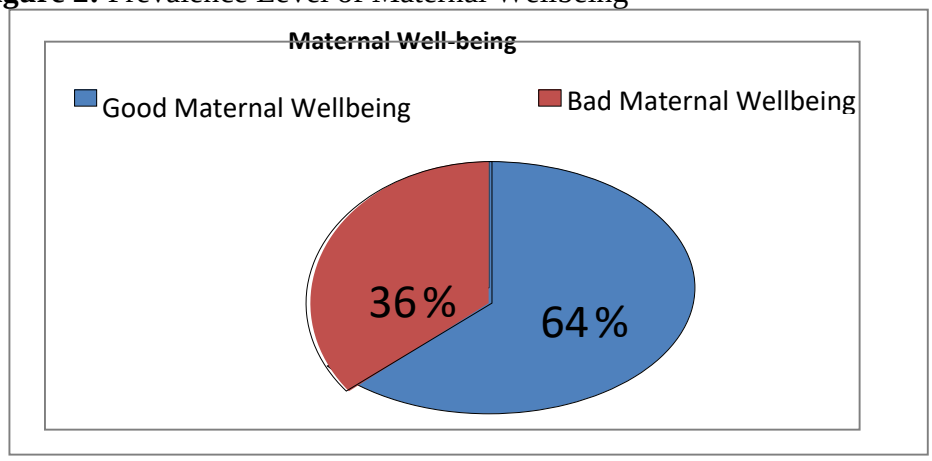
Less than half of the respondents, or 113 (37.7%), said they were unsatisfied with their individual confidence in God, while the remainder 187 (62.3%), said they were.

While 166 (55.3%) of the respondents were happy with their general level of fulfillment some of the women 134 (44.7%), were not. 162 (54%) of the respondents indicated they were content with their lives overall, 138 (46%) of the respondents expressed dissatisfaction with their lives overall. While 171 (57%) of the respondents said they were content with the level of stress in their lives, 129 (43%) of the respondents said they were dissatisfied.

Figure 2: Prevalence Level of Maternal Wellbeing



Source: Fieldwork, 2022

Table 3: Women to Risk Factors Assessment on Postpartum Depression (n=300)

Variables	Frequency	Percent
Do you have a good r/ship with parents?		
Yes	259	86.3
No	41	13.7
Do you have a good r/ship with your spouse?		
Yes	237	79.0
No	63	21.0
Does your husband help with house chores		
Yes	130	43.3
No	170	56.7
Is this pregnancy intended?		
Yes	208	69.3
No	92	30.7
Did you have difficulty getting pregnant?		
Yes	168	56.0
No	132	44.0

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Did you and your partner have a joint arrangement in this pregnancy?		
Yes	171	57.0
No	129	43.0
Does he encourage you to seek professional help when needed?		
Yes	177	59.0
No	123	41.0
Ever had previous experiences of miscarriage or stillbirth		
Yes	158	52.7
No	142	47.3
Ever had prolonged labor in the past		
Yes	114	38.0
No	186	62.0
Ever anxious about being able to cope with the expected baby		
Yes	176	58.7
No	124	41.3
Any health problems in this pregnancy		
Yes	118	39.3
No	182	60.7
Ever relied on drugs, alcohol or other substances to deal with things		
Yes	18	6.0
No	282	94.0

The table above shows, the majority of respondents, 259 (86.3%), report having healthy relations with their parents and other family members, while only 41 (13.7%) report having weak relationships with these relatives. While 63 (21%) respondents said they do not have a great relationship with their spouses, the majority of respondents 237 (79%) had a healthy relationship with them. 130 respondents (43.3%) reported receiving assistance from their spouses with housework and child care, compared to 170 respondents (56.7%) who said they did not receive any assistance from their partners in these areas. 208 respondents, or 69.3%, indicated that their pregnancy was planned. Only 92 (30.7%) of the women reported that they did not aim to get pregnant. The majority of respondents 168 (56%) said it was tough for them to get pregnant, while only 132 (44%) said it was not hard for them.

When asked if they had made clear decisions along with their partners regarding delivery, the majority of respondents 171 (57%) said they did. Less than half of the women 129 (41%) said they did not. The majority of respondents, 177 (59%) do receive motivation to seek professional help, when necessary, as opposed to the remaining respondents, 123 (41%), who do not. 158 (52.7%) of the respondents had lost a pregnancy or had a stillborn child, whereas 142 (47.3%) had never lost a pregnancy or had a stillborn child. The majority of the women, 186 (62%), had never before undergone lengthy labor; however, 114 (38%), had. The majority of respondents, 176 (58.7%), stated that they were concerned about their ability to handle the impending kid, while 124 (41.3%) of the respondents said they were not concerned. Less than half of the respondents (118, or 39.3%) reported having health issues while pregnant, while the majority of respondents (182, or 60.7%), did not. Only 18 (6.0%) of the women use drugs, alcohol, or other substances to cope with their problems, compared to 282 (94%) of the respondents who do not use any of these substances.

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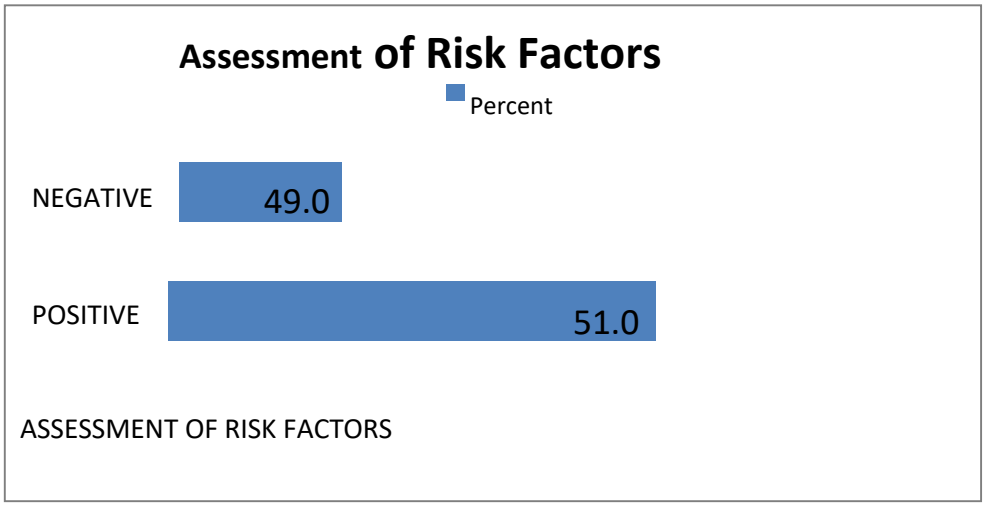

Figure 3: Assessment of Risk Factors for Postpartum Depression
Source: Fieldwork, 2022

Table 4: Association between Postpartum Depression, Socio Demographic Factors and Maternal Wellbeing

Variable	High depression	Low Depression	P value	Chi square
Age			0.733	2.785[a]
20-24 years	80.6%	19.4%		
25-29 years	85.1%	14.9%		
30-34 years	84.4%	15.6%		
35-39 years	78.8%	21.2%		
40-44 years	84.6%	15.4%		
Religion			0.711	0.681[a]
Christianity	82.5%	17.5%		
Islam	83.5%	16.5%		
Traditional	71.4%	28.6%		
Ethnic Group			0.016	10.330[a]
Yoruba	81.8%	18.2%		
Hausa	71.4%	28.6%		
Ibo	100.0%	0.0%		
Others	100.0%	0.0%		
Level of Education			0.001	13.298[a]
Primary	61.1%	38.9%		
Secondary	85.2%	14.8%		
Tertiary	86.1%	13.9%		

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Do you drink				
Yes	82.4%	17.6%	6.803	0.658
No	82.8%	17.2%		
Do you smoke			0.878	0.024
Yes	81.2%	18.8%		
No	82.7%			
Risk factors			0.168	1.902[a]
Positive	85.6%	14.4%		
Negative	79.6%	20.4%		
Maternal wellbeing			0.622	0.243[a]
Good	81.9%	18.1%		
Bad	84.1%	15.9%		

Source: Field Survey, 2022

As shown in the above table, respondents within the age category 25-29years of age had the largest number of depressions 80(85.1%) compared to women within the age range of 20-24 years 39(62.1%) then participants who are 35-39years had lowest frequency, 41(78.8%). The relationship between respondents' age and their experience of postpartum depression was not statistically significant, p-value = 0.733. A total of 139 respondents were Muslims, of whom more than half, 116, were depressed. Of the 154 Christians who responded, just 27 (17.5%) were not depressed and 127 (82.5%) were. Religion and depressive experiences had a significant connection (p-value = 0.711). Similarly, there is no statistically significant correlation between the risk factors, drinking and smoking, with p-values of 0.168, 0.803, and 0.878, respectively.

According to this research, there is no connection between postpartum depression and maternal well-being (p-value: 0.622). Participants with tertiary education were found to have the highest frequency and percentage of experience of depression. A total of 115 respondents had tertiary education as their highest level of education, of which 99(86.1%) were categorized as depressed. Additionally, out of 149 respondents with secondary education as their highest level of education, 14.8% were not depressed, and 127 (85.2%) were depressed. Out of 36 respondents with primary school as their highest level of education, 22 (61.1%) were depressed. As a result, it was shown that there was a substantial correlation between educational degree and depressive experience. The p-value is 0.001. The majority of respondents (231) were Yoruba, with 42 (18.2%) being classed as not depressed and 189 (81.8%) as depressed. A total of 35 respondents were Hausas and 25(71.4%) were depressed while 10(28.6%) were not depressed. There were 18 Ibo responders in all, and 18 (100%) of them reported having depression while 0% did not. Postpartum depression and respondents' ethnicity were significantly correlated. (p = 0.016).

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Table 5: Logistics Regression Coefficient of Selected Socio-Demographic Characteristics, Possible Risk Factors and Prevalence of Maternal Well Being Associated with the Prevalence of Post-Partum Depression

Variable	UOR	P Value	95%ci	AOR	P Value	95% ci
Maternal wellbeing						
Good	1.173	0.623	0.622	2.212		
Bad						
Religion						
Christianity	0.531	0.464	.098	2.885		
Islam	0.496	0.418	.091	2.713		
Traditional						
Level of Education						
Primary	3.937	0.002	1.678	9.242		
Secondary	1.072	0.845	.535	2.149		
Tertiary						
Marital Status						
Married	1.7	.621	.208	13.982		
Not married						
Joint delivery arrangement with partner						
Yes						
No	0.487	0.02	0.266	0.893		
Previous miscarriage or stillbirth	0.66	0.217	0.341	1.277		
Yes	0.96		0.906	0.530	1.755	
No	5					
Anxious to be able to cope with the baby						
Yes	0.244		0	0.128	0.465	0.258 0 0.136
No	0.527					

Source: Field Survey, 2022.

As shown in the table above, joint delivery arrangements have a strong correlation with postpartum depression prevalence at UOR, with a P value of 0.02 (0.266, 0.893%). Additionally, there is a significant relationship between postpartum depression prevalence and anxiety about being able to handle the infant at p value 0 (0.128, 0.465%). Nevertheless, there is no correlation between maternal well-being (0.622, 0.222%), religion (0.098, 0.885%), marital status (0.208, 13.9%), and past miscarriage (0.530, 1.755%)**.** According to UOR, respondents who identify as traditionalists are three times less likely to have postpartum depression than respondents who identify as Christians and two times less likely to experience it than those who identify as Muslims. When compared to respondents who are not married, married respondents at UOR are twice as likely to have postpartum depression. The findings also indicate that spouses who make joint plans are three times less likely than partners who do not suffer from postpartum depression. The study also demonstrates that postpartum depression is five times less likely to occur in people who are

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worried about adjusting to parenthood than in people who are not. In Conclusion, those with good maternal well-being are two times more likely to not experience postpartum depression than those experiencing bad or poor maternal well-being.

On the prevalence of Post- Partum Depression, in the Ibadan North Local Government, the study sought to identify the rates of depression among pregnant women who visited particular primary health institutions. It showed an 83% prevalence rate, which is fairly high and significant for public health. The high incidence supports a study who found that high prevalence rates are common in low and middle-income nations. The high prevalence rate of depression was caused by the risk variables' high frequencies, which were analyzed. Lack of support is a significant risk factor for postpartum depression, with more than half of all respondents reporting that their partners do not assist them with housework or child care. Few respondents receive the necessary incentive to seek professional help, less than half of respondents acknowledged the baby was not intended, and just a small percentage of respondents said they had miscarried. These are all significant depression risk factors that have led to the illness's high prevalence (Fekadu et al., 2020). A significant portion of respondents (85.3%) claimed they could not laugh as easily or see the amusing side of things as often as they formerly could, whereas 14.7% disagreed.

Additionally, only 22% of respondents said they look forward to the enjoyment of things significantly less than they used to, while 78% said they do so frequently. The World Health Organisation reports that for at least two weeks, many women experience low mood, a loss of interest and enjoyment, and impaired energy. Many people who experience depression also experience anxiety symptoms, irregular eating and sleeping patterns, guilt or feelings of low self-worth, impaired attention, and even symptoms that are medically unexplained (Goweda, Reda, & Tayseer Metwally, 2020). When things went wrong, more than half of the respondents (57%) blamed themselves needlessly (87%); the remaining 13% did not place any blame. Few respondents claimed they become anxious or worried extremely frequently, although more than half of those polled stated they occasionally do so. In this study, more than half of the respondents reported they had experienced fear or panic in the previous days for no apparent reason, while less than half said they did not experience fear or panic.

The majority of nursing mothers (62%) claimed that they have been able to cope most of the time, while just a small percentage of respondents reported that they occasionally haven't been coping well because things have been piling on top of them. Additionally, this survey found that while 22.7% of nursing mothers reported they did not feel depressed or gloomy in the previous week, 77.3% of them claimed to do so rather frequently. 3% of the respondents indicated they occasionally become so upset that they cried, while 27.7% claimed they had never experienced such an emotional breakdown. This may be connected to Camacho's results. Physical, physiological, psychological, and social changes that occur during pregnancy and the postpartum period (puerperium) can directly affect a woman's mental health (Asres, Gizew Dessie, 2018). Depression is distinct from

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common mood swings and fleeting emotional reactions to problems in daily life. Depression may develop into a significant medical illness, particularly if it lasts for a long time and is moderate to severe in intensity. The affected person may experience severe suffering and perform poorly at work, in school, and in the family. Suicide can result from depression at its worst. Every year, suicide is thought to be the cause of 1 million deaths. However, 91% of respondents indicated they had never considered harming themselves, whereas 9% of respondents said it had occasionally crossed their minds.

On Maternal Well- Being, this study shows that more than half of the respondents have poor maternal wellbeing Many of the respondents had higher rates of dissatisfaction in areas of amount of energy for everyday activities (63%), amount of control over their lives (68.3%), ability to take care of themselves (69.3%), their physical appearance (62.7%), amount of sleep gotten (98%), breasts (93%) and surgical incisions (88%); and mid rates in the amount of worries (43%), sex life (62%) and physical appearance (62%). Studies show that body dissatisfaction before and during pregnancy leads to higher levels of PPD in the postpartum period. Women gain weight with pregnancy, and after childbirth they are most concerned about losing this excess weight. It has been reported that being overweight is a reason for greater dissatisfaction with body image and more PPD (Faleschini, Sabrina, Lynne Millar, Sheryl Rifas-Shiman, Helen Skouteris, Marie-France Hivert, & Emily Oken, 2019).

On the assessment of risk factors associated with Postpartum Depression, the study found that almost half of respondents claimed the baby was not planned, more than half of respondents do not receive assistance from their spouses with household tasks and child care, and more than half of respondents had high exposure to risk factors for postnatal depression. However, more than half of the respondents had had miscarriages or stillbirths, and only a small number had previously gone through extended labor. Poor postnatal care, poor nutrition, a lack of social support, unwanted pregnancies, domestic abuse, lower income and poorer educational status are some risk factors that predispose to depression after childbirth. Other risk factors include age and marital status[6]. Many of the respondents expressed worry about their ability to manage with the infant, although few reported any health issues throughout their pregnancies and even fewer admitted to using drugs, alcohol, or other substances to cope. This supports who found that "Depression during child nursing may diminish one's capacity for self-care, including inadequate nutrition, drug or alcohol abuse, and poor postnatal clinic attendance, all of which may compromise a woman's physical and mental health and may reduce optimal baby monitoring or affect the growth and development of the baby.

Summary of Findings

This study was conducted with 300 respondents to examine various factors related to postpartum depression. The highest number of respondents fell into the age range of 25-29 years (31.3%), followed closely by the age range of 30-34 years (25%). The majority of the

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respondents (77%) belonged to the Yoruba ethnic group, and 97% of the participants were married. Among the married participants, 79.4% were in monogamous marriages. Self-employed workers constituted 35.3% of the respondents, while 49.7% had a secondary school education. The study also revealed that a significant majority of respondents were non-smokers (94.7%) and non-drinkers (77.3%).

In terms of emotional well-being, the respondents reported high rates of positive experiences such as being able to laugh and see the funny side of things (85.3%), looking forward to enjoyment (78%), and blaming oneself unnecessarily when things go wrong (87%). However, they also experienced negative emotions, with a considerable proportion reporting feeling sad or miserable (77.3%) and being so unhappy that they cried (72.3%). Rates of feeling scared or panicky for no good reason (51.3%) and having difficulty sleeping due to unhappiness (66%) were moderate. The study found lower rates of thoughts of self-harm (49%) and feeling overwhelmed (38%) compared to other negative emotions.

Regarding satisfaction and dissatisfaction with different aspects of their lives, respondents expressed high dissatisfaction with the amount of sleep they received (98%), breast appearance (93%), and surgical incisions (88%). They reported moderate levels of dissatisfaction in areas such as the amount of worries (43%), sex life (62%), and physical appearance (62%). However, they showed the highest satisfaction (or lowest dissatisfaction) in their personal faith in God.

This study examined various factors associated with postpartum depression. It found no significant associations between maternal well-being, age, religion, drinking, and smoking with postpartum depression. However, there were significant associations between ethnic groups and level of education. Respondents practicing traditional religion were found to be less likely to experience postpartum depression compared to Christians and Muslims. Married respondents were also less likely to experience postpartum depression compared to unmarried individuals. Additionally, joint delivery arrangements and being anxious about coping with the baby were associated with a lower likelihood of experiencing postpartum depression. Overall, this study revealed that good maternal well-being, being married, having joint delivery arrangements, and being anxious about coping with the baby were factors associated with a reduced risk of postpartum depression. Ethnicity and level of education also played a role in the prevalence of postpartum depression, with respondents practicing traditional religion and those with higher levels of education being less likely to experience it.

CONCLUSION

Postpartum Depression (PPD), a depressive disorder, is a public health problem that has an intense effect on maternal health and well-being. This phenomenon has however received little or no attention in our social environment, especially our health settings. A major issue is the scarcity of postpartum depression research and the lack of postpartum depression

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statistics. As a result, postpartum depression is frequently under diagnosed both locally and internationally. It is also perceived by the general public and the medical community as a time of emotional health that is immune to mental disorder. As a result, the initial and ongoing task is to immerse oneself in data collection and statistics so that postpartum depression cannot be disregarded as being normal or merely symptoms of nursing mothers. The prevalence of postpartum depression is relatively high (83%) in Ibadan. This demonstrates that the symptoms are merely disregarded or that little effort is being made to address them. Women who said their babies were not intended were more depressed than respondents who said their babies were intended, indicating that the intention to become pregnant is a significant risk factor for depression. Other important risk factors include level of income, experience of financial difficulties, experience of stressful life events, low education, and low physical activity. One of the main causes of postpartum depression is also a bad or unsatisfactory connection between the couple. One-fourth of the respondents said they did not get along well with their spouses. Therefore, it is crucial to step up efforts to support healthy marriages between partners.

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