Social, Medical, and Psychological Support for Urban Women in Lagos to Alleviate Post-Natal Depression: A Critical Analysis and Academic Rewrite

Precious Hepzibah

44, Hereforward, Basildon, United Kingdom

DOI: https://doi.org/10.51244/IJRSI.2026.1303000166

Received: 19 March 2026; Accepted: 24 March 2026; Published: 10 April 2026

ABSTRACT

Marriage and being a mother are significant life events for women in Africa because the transition to motherhood, characterized by pregnancy and childbirth, can be both exhilarating and challenging. The period of motherhood often involves emotional turmoil for mothers, especially those in urban cities like Lagos. This study explores the social, medical, and psychological assistance available to women in Lagos to alleviate Postnatal Depression (PND). The research used a descriptive qualitative approach with samples of 100 respondents, employing a semi-structured questionnaire through Google Forms sent online and distributed via different social media platforms. Questionnaires were analyzed using statistical tools of data analysis. The study focuses on mothers who are within the reproductive age of 15 years. Also, a literature review of existing research on PND and its treatment was the secondary source of data collection. This study documents the urban women's postnatal experiences in Lagos, meant to serve as a case study for future researchers in Nigeria and the rest of the world as part of the contribution to knowledge in PND treatment and support, ultimately aiming to improve the health and well-being of urban women and their families, especially in Nigeria. This study calls for concern as the awareness and synergy between health workers and urban women is lacking; based on the stigma received by urban women on postnatal depression, the depressed reproductive women population grows, and people will continue to lose their lives in silence for what have both medical and psychological solutions. The study implies that a synergy between the medical, social, and psychological fields that engage urban women during pregnancy, the rate of postnatal depression will be minimal after childbirth. Therefore, the health sector, the general public, and the government should help in creating awareness about help available for urban women in postnatal care to reduce or eradicate the level of postnatal depression in society.

Keywords: Postnatal, Depression, Support, Psychological, Medical, Social, Urban

INTRODUCTION

Urbanization has brought numerous benefits to African women and offered opportunities and access to better services. However, living in urban cities like Lagos entails both advantages and challenges. For women entering motherhood, the urban environment's impact on their well-being should be of particular interest to everyone. Often, women's experiences during this transition go unspoken and unnoticed. This study delves into the experiences and supports systems available to women in the post-pregnancy phase, with a focus on alleviating the potential occurrence of postnatal depression (PND). Pregnancy represents a pivotal phase in a woman's life, involving significant emotional, physiological, and social changes. Failure to navigate this period successfully can lead to various health concerns, including psychiatric illnesses such as depression (Sibel et al., 2006). Engaging in physical exercise during pregnancy among women has become a widespread phenomenon. Nevertheless, women should be careful in their involvement and balance it to avoid potential risks. Conversely, it offers benefits such as improving body fat control and psycho-social interactions (Petrov et al., 2014).

The antenatal period often brings psychological distress to women, stemming from past experiences, childbearing concerns, and current pregnancy-related issues (Christine et al., 2008; Enfermeria, 2019). Factors like maternal years on earth, assistance received and post-traumatic experiences, education level, income,

gestational age, and satisfaction with partner support play a role in prenatal stress (Darwiche et al., 2018; Pajulo et al., 2001). Following childbirth, women's roles and responsibilities undergo significant changes, often leading to setting the priority of their babies' care over self-care (Stern & Bruschweiler, 1998; Winnicott, 1989). Neglecting personal care can result in feelings of distress. Detecting and addressing depression is crucial (Cristescu et al. (2015); Dayan, (2007); Norhayati et al., (2014) argue that the availability of support for urban mothers during this challenging period is under-utilized by the growing number of women living in the cities.

The Postnatal Period

The postnatal period presents unique needs for mothers, including information, psychological support, sharing of experiences, and practical and material support (Slomian et al., 2021). The transition to motherhood constitutes a unique and profound life change for women (Petch & Halford, 2008; Solmeyer & Feinberg, 2011). This phase introduces diverse levels of changes ranging from psychological to physical and social changes (Nystrom, 2004; Javadifar et al., 2016). Feelings of sadness, anxiety, and exhaustion are significant features of mental health issues predominated by Postnatal Depression (PND), significantly affecting a woman's quality of life, particularly in urban areas such as Lagos. This article explores the social, medical, and psychological supports available to urban women to help alleviate PND. Ou CHK et al. (2022) identified that constant intense anger indicates postpartum distress, which does not receive in-depth examination after childbirth. Maternal anger often results from feelings of being on edge, especially concerning infants' sleep and not having enough time as a new mother. The fact remains that receiving support from partners, family, and others can help mothers manage their anger more effectively. Postpartum emotional distress is a state of feeling "numb" and "mechanical" by mothers, which may serve as a signal of the need for support and resources from close individuals (Hagen, 1999; Rahman et al., 2003). Vulnerable mothers, especially those with low social support, are at higher risk of experiencing prenatal stress (Darwiche et al., 2018). The prevalence of PND varies worldwide, with studies indicating varying rates attributed to screening methods, geographical location, socioeconomic status, screening instrument cutoff scores, and associated risk factors (Pajulo et al., 2001; January et al., 2015; Shankar, 2021).

In Nigeria, poor knowledge of PND among postnatal women and healthcare practitioners, as well as the stigma associated with the condition, contribute to missed diagnoses and necessitate further research (nih.gov). **Social Support**: Social support is a crucial element in PND treatment, offering women a sense of belonging and reducing isolation. In Lagos, various organizations have attempted to provide health support to women during and after pregnancy, including the Association for Reproductive and Family Health (ARFH) and the Well-being Foundation Africa (WBFA). ARFH, a non-governmental organization, provides counseling, family planning, and ante/postnatal care for both the mother and the child. These organizations facilitate support for young mothers having PND, led by trained counselors. WBFA, another non-profit organization, focuses on improving maternal and child health outcomes. Their services include antenatal and postnatal care, counseling, and support groups for women experiencing PND. There are several forms of support identified and explained in this study, such as medical and psychological support, Interpersonal Therapy (IPT).

Medical and psychological supports are quiet similar but they minister to different needs of the individual. Medical support for instance is integral to PND treatment, and Lagos provides access to several hospitals and clinics for women who are in need. Adegoke (2018) asserts that "The Lagos University Teaching Hospital (LUTH), a tertiary hospital, offers obstetric and gynecological services, including antenatal and postnatal care." Most of the general hospitals and some private hospitals in Lagos, Nigeria, periodically conduct a session of healthcare teaching for women during pregnancy and after birth; among the areas covered in the lesson is how to manage their affairs after childbirth. The healthcare teaching occurs during antenatal classes made mandatory for pregnant women in Lagos, Nigeria. Following the same trend, Psychological support is essential for women dealing with PND, aiding in the development of coping mechanisms and improved mental health. Urban women in Lagos can access various psychological support options: Cognitive Behavioral Therapy (CBT), an evidence-based with emphasis on changing negative thoughts and negative dispositions provided (drsusanjamieson); it can be provided in individual or group settings, helping women develop coping skills.

Interpersonal Therapy (IPT) as another evidence-based therapy that enhances interpersonal relationships and communications, like CBT. This type of healthcare can be administered individually or in groups. Mindfulness-

Based Cognitive Therapy (MBCT): Combining elements of CBT and mindfulness meditation, MBCT is effective in developing coping skills and improving mental health. In alleviating the causes and risks associated with PND, recognizing the Signs of PND becomes necessary; the following have been highlighted:

1. Persistent sadness: Postnatal depression often manifests as profound and persistent sadness. It is not just feeling physically down after giving birth; it is a deep and enduring emotional state that can significantly affect one's ability to function and enjoy life.

2. Irritability: Many individuals with postnatal depression find themselves easily irritated or angered. They may snap at loved ones or become impatient with even minor inconveniences. This irritability can strain relationships and cause further emotional distress.

3. Fatigue: Fatigue is a common issue for new parents, but in the case of postnatal depression, it is more than just feeling tired from disrupted sleep. It is an overwhelming exhaustion that does not improve with rest and can lead to a sense of helplessness.

4. Changes in sleep patterns: Sleep disturbances are typical for new parents, but postnatal depression can exacerbate these issues. It can lead to insomnia or, conversely, excessive sleep, both of which can worsen overall mood and mental health.

5. Appetite changes: Unusual eating habits are another symptom. Some individuals may lack an appetite for food, leading to weight loss, while others may turn to food for comfort and gain weight. 6. Difficulty bonding with the baby: A significant aspect that is so distressing in postnatal depression is the difficulty in forming a strong emotional bond with the baby. Parents may feel detached, overwhelmed, or even guilty for not feeling the expected sense of maternal or paternal attachment.

7. Withdrawal from social activities: People with postnatal depression often withdraw from social activities and may isolate themselves from friends and family. The feeling of loneliness can lead to withdrawal by the pregnant woman, at this moment exacerbating depression.

8. Sense of guilt and worthlessness are common occurrences with postnatal depression. Individuals may berate themselves for not being the "perfect" parent or not being able to cope with the demands of parenthood.

9. Difficulty concentrating or making decisions: Postnatal depression can impair cognitive function, making it challenging to focus on tasks or make even simple decisions. Postnatal depression can further add to feelings of frustration and inadequacy.

10. Physical symptoms: Some people with postnatal depression experience unexplained physical symptoms like headaches, stomachaches, or muscle pain. These symptoms can be the body's response to prolonged stress and emotional distress.

11. Loss of interest or pleasure: Losing interest in activities that once brought joy can be a distressing aspect of postnatal depression. Hobbies and interests that were once fulfilling may no longer hold any appeal.

12. Anxiety: Postnatal depression can coexist with anxiety disorders. Excessive worry, panic attacks, and an overwhelming sense of fear, especially concerning the baby's health and safety, are regular features.

13. Thoughts of self-harm or harming the baby: In severe cases, individuals may experience thoughts of self-harm or harming their infant. These thoughts are a red flag that requires immediate professional intervention and support.

Causes of Post Natal Depression (PND)

PND is a complex condition with multiple contributing factors. It does not have a single, well-defined cause, but rather, PND results from a combination of physical, emotional, and environmental factors. Postpartum

depression has the following causes and risks challenges with complex condition with multiple contributing factors:

1. Hormonal Changes: The dramatic fluctuations in hormones, particularly estrogen and progesterone, that occur during pregnancy and postpartum may play a role in the development of postpartum depression. These hormonal changes can affect mood regulation and neurotransmitter activity in the brain.

2. Genetic Predisposition: A family history of depression or other mood disorders can increase a woman's risk of developing postpartum depression. Facts abound that reveal a genetic component in some cases.

3. History of Mental Health Issues: Postpartum depression can increase mental health issues, especially when the woman has a history of mental health disorders.

4. Not resting leads to accumulated stress, no social support of any form of rest, and a lack of a support system can contribute to postpartum depression. Stressors may include financial difficulties, marital problems, or other life changes. Women must have adequate support from partners, family, and friends during the postpartum period.

5. Sleep Deprivation: Sleep disturbances are common for new parents, and sleep deprivation can exacerbate mood disturbances and increase the risk of depression. 6. Physical Health Issues: Complications during pregnancy or childbirth, such as difficult labor, a cesarean section, or medical issues with the baby, can contribute to postpartum depression.

7. Psychological Factors: Unrealistic expectations about motherhood, trying to become a perfect mother, and not achieving this may cause psychological pain, or the pressure to conform to societal standards of motherhood can contribute to postpartum depression.

8. Hormone Thyroid Changes: Thyroid dysfunction, such as postpartum thyroiditis, can affect hormone levels and mood and may be associated with postpartum depression.

9. Traumatic Birth Experience: A traumatic birth experience, which may include complications, medical interventions, or a feeling of loss of control, can contribute to postpartum depression.

10. Unplanned Pregnancy: A pregnancy that is unexpected or unwanted can be a risk factor for postpartum depression, as it may be associated with mixed feelings or a lack of preparation.

11. Relationship Issues: Marital or relationship problems, including changes in intimacy and lack of communication, may contribute to feelings of isolation and depression during the postpartum period. Helping and managing postpartum depression in women involves a combination of strategies, support, and interventions. It is essential to seek professional help and have a solid support system.

Here are some steps to consider:

1. Seek Professional Help: · Contact a healthcare provider, such as an obstetrician, psychiatrist, or therapist, who has experience treating postpartum depression. These professionals recommend and give treatment options that are appropriate to the woman.

2. Medication: · In some cases, healthcare providers may prescribe antidepressant medication to help manage the symptoms of postpartum depression. In order to mitigate the state of depression, it becomes essential to discuss the potential benefits and risks with a healthcare provider.

3. Therapy and Counseling: · Psychotherapy, such as cognitive-behavioral therapy (CBT) or interpersonal therapy, can be highly effective in treating postpartum depression. Addressing underlying issues and feelings and developing coping strategies require therapy and counseling.

4. Music Listening: Nweke (2023) reveals that listening to music succors for all women pre/post pregnancy as this helps to balance their altered moods. Listening to music is replete in various literature in history, and its effects dampen depression and create a more conducive atmosphere around the individual.

5. Support Groups: · Joining a postpartum depression support group can be helpful; individuals sharing their experiences, insights gained, and the level of comfort received while in a PND state can provide a supportive environment that assures them of not being alone in the situation.

6. Self-Care: · Encourage self-care by sleeping, eating a balanced diet, and engaging in physical exercise.

7. Set Realistic Expectations: Manage expectations about motherhood and allow room for mistakes. The pressure to be a "perfect" parent can contribute to postpartum depression.

8. Social Support: Reach out to friends and family for help and emotional support to alleviate the stress of caring for the baby alone.

9. Take time to be alone: · It is essential for mothers to have time for themselves and engage in activities they enjoy; this may require scheduling breaks when a partner or family member can care for the baby.

9. Open Communication: Maintaining open and honest communication with one's partner by discussing one's feelings, concerns, and needs. Couples therapy can also be beneficial if the relationship is under strain.

10. Identify Triggers and Coping Strategies: · Recognize specific triggers that worsen symptoms and develop strategies to cope with them. For instance, if sleep deprivation triggers, create a schedule that involves sharing nighttime duties.

11. Limit Stressors: Identify and reduce sources of stress in life by simplifying daily routine, seeking help with household tasks, or delegating responsibilities.

12. Monitoring the treatment Progress: Regularly check with the healthcare provider or therapist and then adjust the progress and treatment plan.

13. Cultural Practices and Barriers: Cultural practices like traditional naming ceremonies and the "omugwo/olojojo omo" support system help mothers adjust to life after childbirth, reducing stress and the risk of PND; however, cultural norms can also pose challenges, as discussion on mental health remains a stigma in some communities.

METHODOLOGY

Part of the methodology applied in this study was descriptive design with 100 respondents. Each urban woman was allowed to participate in a one-time questionnaire on the information related to demographics, social support, medical support, postnatal depression, and psychological support. The participants are those in their reproductive age of 15 years and have had the experience of pregnancy and delivery. The instrument was designed electronically for easy collation and analysis on Google form with all the questions relating to postnatal depression and demographic characteristics. Most questions have dichotomous responses (Yes/No), descriptive statistics were computed and applied, and Chi-square analysis tests the independence of the relationship between social and medical support / medical and psychological support of postnatal depression of urban women in Lagos.

The social variable is "Have you received any practical or emotional support from your family, friends, or neighbors since giving birth?" for medical support is "Have you ever sought medical help for postnatal depression?" and for psychological support is "Have you ever participated in any psychological counseling or therapy sessions to address postnatal depression?". The results gathered are in the table. PND Analysis Postnatal depression could only be allowed to women. Thus, this research is primarily on reproductive women in urban Lagos. Reproductive age in women is the period in which a woman is biologically capable and mature to bear children. This reproductive age commences as soon as the woman begins to menstruate (menarche), which

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue III March 2026

usually occurs around the ages 12 to 14 until menopause, between 45 and 55 years. Although, the age varies from person to person.

Demographic status of respondents

The women's reproductive age in Lagos is between the ages of 15-49 years (Akinbami et at., 2013). The women who participated in this study are women of 15 years and above, which validates that only the reproductive women in urban Lagos participated in the research. However, the majority, 50 percent of the respondents in this study, are between 25 years and 39 years; 48 percent are between 40 and 54 years, while an equal proportion of one percent are 15 – 24 years and 55 years and above (see Table 1.1). The marital status showed that the majority, 98 percent, are married and believed to be living with their partners, while two percent are divorced. The respondents' educational qualifications include professionals who hold A.C.A., which accounts for two percent; Bachelor's Degrees, 30 percent; Higher National Diplomas account for one percent; O.N.D. account for six percent, M.B.B.S. and N.C.E. account for four percent (each), O'Level graduates account for three percent and the Postgraduate degree which is the majority account for 50 percent.

The monthly income of reproductive women in urban Lagos varies where 11 percent claimed to earn below N30,000, four percent earn between N30,000 - N49,000 and N90,000-N109,000, 16 percent earn between N50,000 and N69,000, two percent earn between N70,000 and N89,000, 18 percent earn between N110,000 and N150,000 while 45 percent earn above N150,000. The majority earn a good income of over N100,000 monthly, which reflects their educational qualifications. In addition, the majority, 56 percent, agreed that their monthly earnings meet their needs, while 39 percent disagreed with the claim. Only 5 percent of the women claimed uncertainty about the monthly income meets their needs. Available analysis shows that the Igbo and Yoruba extractions dominate the urban Lagos, as is reflected here. However, the majority, 74 percent, are Yoruba extractions, and 26 percent are Igbo extractions.

Table 1.1. Demographic distribution

Variable	Response	Frequency	Per cent
Age	15 - 24	1	1.0
	25 - 39	50	50.0
	40 - 54	48	48.0
	55 and above	1	1.0
	Total	100	100.0
Marital Status	Divorced	2	2.0
	Married	98	98.0
	Total	100	100.0
What's your educational qualification?	ACA	2	2.0
	Bachelor's Degree	30	30.0
	HND	1	1.0
	MBBS	4	4.0
	NCE	4	4.0

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue III March 2026

	O' Level	3	3.0
	OND	6	6.0
	Postgraduate Degree	50	50.0
	Total	100	100.0
What's the range of your monthly income?	Below N30,000	11	11.0
	N30,000 - N49,000	4	4.0
	N50,000 - N69,000	16	16.0
	N70,000 - N89,000	2	2.0
	N90,000 -N109,000	4	4.0
	N110,000 - N150,000	18	18.0
	Above N150,000	45	45.0
	Total	100	100.0
Does your monthly income meet your needs?	Strongly Disagree	28	28.0
	Agree	28	28.0
	Not Sure	5	5.0
	Disagree	39	39.0
	Total	100	100.0
Ethnic Group	Igbo	26	26.0
	Yoruba	74	74.0
	Total	100	100.0

Source: Survey, 2023

Gestation history and births in urban women

The gestation history of women in urban Lagos ranges from 34 weeks to above 41 weeks based on this research, where the majority, 50 percent, claimed to have their gestation weeks to be 36 weeks (see Table 1.2), according to Omigbodun and Adewuyi, 1997 in research conducted in Ibadan which measures the duration of human singleton pregnancies and concluded that the mean pregnancy duration is 39 weeks and 3, days which equal 274.8 days.

The number of pregnancies by urban women varies between 1 and 6, attributed to their ages. Women who have carried two pregnancies and below account for 35 percent, those who have had between 3 and 4 pregnancies account for 46 percent, while 19 percent claimed to have carried more than four pregnancies (see Table 1.2). Unfortunately, some of the urban women claimed to lose some of their pregnancies in the gestation period. The maximum number of births recorded is 4, meaning that 20 percent of the pregnancies were lost because of some other health challenges, nurturing, or failure of health facilities to provide adequate protection for the pregnancies.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue III March 2026

Table 1.2. Gestation history and births in urban women

Gestation period and births			
Variables		Frequency	Per cent
Gestation age.	34 weeks	1	1.0
	35 weeks	3	3.0
	36 weeks	50	50.0
	37 weeks	1	1.0
	38 - 41 weeks	3	3.0
	38 weeks	12	12.0
	39 weeks	6	6.0
	39 weeks 4days	2	2.0
	40 weeks	14	14.0
	40 weeks and 35 weeks	1	1.0
	Above 41 weeks	3	3.0
	No idea	4	4.0
	Total	100	100.0
How many pregnancies have you had?	1	19	19.0
	2	16	16.0
	3	24	24.0
	4	22	22.0
	5	15	15.0
	6	4	4.0
	Total	100	100.0
How many children have you given birth to?	1	26	26.0
	2	26	26.0
	3	32	32.0
	4	16	16.0
	Total	100	100.0

Source: Survey, 2023

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue III March 2026

Social supports

In considering the social support for reproductive urban women, the participants answered five questions that required explaining their social interactions. The questions included their awareness about support groups, receiving emotional support, engaging in social interaction, comfortable discussing experiences, and participating in community campaigns. The results are in Table 1.3; 93 percent of the reproductive urban women claimed to be unaware of any support group or network specifically designed for new mothers in their community. However, 90 percent of the reproductive urban women claimed that they do receive emotional or practical support from family, friends, and neighbors after childbirth; this could be attributable to the first-timer and some other women. In addition, the majority, 66 percent of the respondents, claimed that they are at least rarely engaging in social interactions with other new mothers in their community.

In comparison, 19 percent claimed they engaged with new mothers daily, seven percent said weekly, and eight percent said monthly. More than half, 63 percent of the reproductive urban women, claimed that they feel comfortable discussing their experience and concerns related to postnatal depression with people in their community after birth, and 37 percent claimed that they are not open to such discussion. Unfortunately, the majority, 84 percent of reproductive urban women, claimed not to have been participating in any community-based workshops or awareness that related to postnatal depression.

Table 1.3. Social support for reproductive urban women

Social supports			
		Frequency	Per cent
Are you aware of any local support group or network specifically designed for new mothers in your community?	No	93	93.0
	Yes	7	7.0
	Total	100	100.0
Have you received emotional or practical support from your family, friends, or neighbours since giving birth?	No	10	10.0
	Yes	90	90.0
	Total	100	100.0
How often do you engage in social interactions with other new mothers in your community?	Daily	19	19.0
	weekly	7	7.0
	Monthly	8	8.0
	Rarely	58	58.0
	Never	8	8.0
	Total	100	100.0
Do you feel comfortable discussing your experiences and concerns related to post-natal depression with people in your community? (The postnatal period commences instantly after the birth of the baby which extends up to six weeks (42 days) beyond birth).	No	37	37.0
	Yes	63	63.0
	Total	100	100.0

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue III March 2026

Have you participated in any community-based workshops or awareness campaigns related to post-natal depression?	No	84	84.0
	Yes	16	16.0
	Total	100	100.0

Source: Survey, 2023

Medical support for reproductive urban women

Birth weight measures fetal and neonatal health (Wubetu et al., 2021). The minimum birth weight of a baby starts at 2.50 kg typically (Shehzad, 2021), and anything less is an indication that the growth in the womb is affected by some factors that could pose a risk of death before birth, disability, etc. It is evident from this investigation that 8 percent of the reproductive urban women gave birth to a baby with low birth weight (see Table 1.4); low birth weight could be attributed to mothers' lifestyles (Xi et al., 2020), nutrition (Muthayya,2009; Girma et al., 2019) and antenatal (Engdaw et al., 2023); 51 percent claimed that their babies weight is between 2.50kg and 3.49kg considered a standard weight, while 41 percent claimed to give birth to babies weighing 3.5kg and above at birth. Nearly 92 percent of the reproductive urban women claimed that they did not have any problems during delivery. Ninety-seven percent claimed that they are not surrogate mothers, while three percent said that they gave birth to someone other than their spouse.

Fifty-eight percent of respondents claimed not to have had postpartum cases, and 42 percent of respondents claimed they have had postpartum with one or more doctors, nurses, and midwives ever since they gave birth. This postpartum period could lead to depression in women (Mughal et al., 2022). Sometimes, the public health sector neglects this phase (Azale et al., 2018), prominent among the urban women in Lagos have this experience. Thus, PND is becoming a concern among women living in cities. Sixty-eight percent of the women used in this study had no prior knowledge of any information about postnatal depression and its symptoms during the postpartum period. Just a few numbers of the women, 32 percent used for this study, knew the information regarding postnatal depression. As a result of this level of information, 40 percent of reproductive women claimed there are mother and childcare facilities in their vicinity that offer postnatal depression assessment and treatment, and 60 percent are not aware that such are in their vicinity where they could seek help.

Unfortunately, the majority of respondents in this study, 97 percent precisely, claimed that they have never sought medical help for postnatal depression linked to some form of stigmas that might make them reluctant to seek help, whereas 3 percent of respondents used in this study affirmed that they have sought medical assistance regarding postnatal depression. The respondents who sought medical help for postnatal depression lamented that PND is a delicate period in their lives. This lamentation could be part of the reasons why most women refuse to seek medical assistance when they are depressed.

Table 1.4. Medical support for reproductive urban women

		Frequency	Per cent
Weight (KG)	1.00-2.49	8	8.0
	2.50-3.49	51	51.0
	3.50-4.49	40	40.0
	4.50 and above	1	1.0
	Total	100	100.0
Was there any problem during delivery?	No	92	92.0

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue III March 2026

	Yes	8	8.0
	Total	100	100.0
Are you a surrogate mother? (A surrogate mother is a woman who, on behalf of another woman or couple, agrees to carry and give birth to a child for the woman or the couple)	No	97	97.0
	Yes	3	3.0
	Total	100	100.0
Have you had postpartum care from a healthcare professional (doctor, nurse, midwife, etc.) since giving birth?	No	58	58.0
	Yes	42	42.0
	Total	100	100.0
Were you provided information about post-natal depression and its symptoms during your postpartum care appointments?	No	68	68.0
	Yes	32	32.0
	Total	100	100.0
Are there any Mother and Child healthcare facilities in your vicinity that offer post-natal depression assessment and treatment?	No	60	60.0
	Yes	40	40.0
	Total	100	100.0
Have you ever sought medical help for post-natal depression?	No	97	97.0
	Yes	3	3.0
	Total	100	100.0

Source: Survey, 2023

Postnatal depression and Psychological supports for reproductive urban women

Postnatal depression and Psychological supports for reproductive urban women

Depression is a form of psychological trauma that might be severe or otherwise does not leave out postnatal depression (PND). Evidence from this investigation reveals that 34 percent of urban women in Lagos have experienced PND, while the majority, 66 percent of respondents in this study, have never experienced PND (see Table 1.5). The majority, 81 percent of the respondents in this study, claimed they feel supported by their partner; 62 percent said they feel stressed most of the time. In addition, 82 percent of the urban women claimed they read books to allay their fears about pregnancy and childbirth- a reflection of their educational qualifications. Nearly 86 percent of the urban women claimed not to be aware of any counseling services or therapy programs specifically designed for new mothers in Lagos, reflected in the access to information regarding postnatal depression and the healthcare facilities in their vicinity. Ninety-two percent of respondents further claimed that they have never participated in any psychological counseling therapy that addresses PND. In comparison, only 8 percent of respondents have taken part in the past. This outcome reflects the medical support received.

Furthermore, 90 percent, or 9 in 10 urban women, claimed that they do not know a professional who specializes in mental health issues.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue III March 2026

Table 1.5. Postnatal depression and psychological supports for reproductive urban women

Psychological Supports			
		Frequency	Per cent
Have you ever experienced post-natal depression?	No	66	66.0
	Yes	34	34.0
	Total	100	100.0
Do you feel supported by your partner?	No	19	19.0
	Yes	81	81.0
	Total	100	100.0
Do you feel stressed?	No	38	38.0
	Yes	62	62.0
	Total	100	100.0
Did you read books to allay your fears about pregnancy and childbirth?	No	18	18.0
	Yes	82	82.0
	Total	100	100.0
Are you aware of any counselling services or therapy programmes specifically designed for new mothers in Lagos?	No	86	86.0
	Yes	14	14.0
	Total	100	100.0
Have you ever participated in any psychological counselling or therapy sessions to address post-natal depression? (The postnatal period commences instantly after the birth of the baby which extends up to six weeks (42 days) beyond birth)	No	92	92.0
	Yes	8	8.0
	Total	100	100.0
Do you know any mental health professional or therapist who specializes in post-natal depression? (The postnatal period commences instantly after the birth of the baby which extends up to six weeks (42 days) beyond birth).	No	90	90.0
	Yes	10	10.0
	Total	100	100.0
Do you believe there is a stigma associated with seeking psychological support for post-natal depression in your community?	No	53	53.0
	Yes	47	47.0
	Total	100	100.0

Source: Survey, 2023

Hypothesis testing

The following decision rule will be used in this research:

Decision Rule: The rule is to reject and classify as null hypothesis where the p-value exceeds the 0.05 threshold;

otherwise, do not reject the null hypothesis.

Hypothesis one

Ho1: There are no significant differences in the social support and medical support in postnatal depression in urban women in Lagos.

Ha1: There is a significant difference in the social support and medical support in postnatal depression in urban women in Lagos.

To understand the relationship between social and medical support in urban women, a chi-square test was performed on the hypothesis stated, and the result is displayed in Table 1.6. The outcome of the analysis showed that the p-value (0.558) is not less than the 0.05 rejection threshold; do not reject the null hypothesis and conclude that there are no significant differences between the social and medical supports in postnatal depression in urban women in Lagos. There is an urgent need to create more awareness for the reproductive women in Lagos. Health workers need to do more in enlightenment and advocacy within their facilities and outside the communities.

Table 1.6. Chi-Square Tests of the relationship between social and medical supports in urban women

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	0.344[a]	1	0.558
Continuity Correction	0.000	1	1.000
Likelihood Ratio	.642	1	.423
N of Valid Cases	100		
a. 2 cells (50.0%) have an expected count of less than 5. The minimum expected count is .30.			
b. Computed only for a 2x2 table			

Source: Survey, 2023

Hypothesis two

Ho1: There is no significant difference in the social support and medical support in postnatal depression in urban women in Lagos.

Ho2: There is no significant difference in the medical support and psychological support in postnatal depression in urban women in Lagos

Ha2: There are significant differences in the medical support and psychological support in postnatal depression in urban women in Lagos. The study further investigates if there are relationships between medical and psychological support of postnatal depression in urban women in Lagos—the results are presented in Table 1.7.

If the p-value (0.604) is not less than the 0.05 rejection threshold, do not reject the null hypothesis. The study finds that there are no significant relationships between medical and psychological support of postnatal depression in urban women in Lagos. Hence, an awareness program becomes necessary, and there should be a synergy between the social, health, and community leaders to avoid the stigma received by urban women on postnatal depression. The depressed reproductive women population grows, and people will continue to lose their lives in silence for what have both medical and psychological solutions.

Table 1.7. Chi-Square Tests of the relationship between medical and psychological supports in urban women

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	0.269[a]	1	0.604
Continuity Correction	0.000	1	1.000
Likelihood Ratio	0.508	1	0.476
N of Valid Cases	100		
a. 2 cells (50.0%) have an expected count of less than 5. The minimum expected count is .24.			
b. Computed only for a 2x2 table			

Source: Survey, 2023

CONCLUSION

Alleviating PND among urban women in Lagos requires a multifaceted approach encompassing social, medical, and psychological support systems. Organizations like A.R.F.H. and W.B.F.A., along with healthcare institutions like LUTH, play vital roles in providing support. Psychological interventions like C.B.T., I.P.T., M.B.C.T., and music therapy offer effective treatment options. Additionally, addressing cultural norms and stigma surrounding mental health is essential to ensure women seek and receive the necessary support. As we continue to learn about PND, further research to enhance the support available to urban women in Lagos and similar settings becomes urgent.

REFERENCES

1. Adeyemo, E. O., Oluwole, E. O., Kanma-Okafor, O. J., Izuka, O. M., and Odeyemi, K. A. (2020). Prevalence and predictors of postpartum depression among postnatal women in Lagos, Nigeria. Afr Health Sci. 2020 Dec; 20(4): 1943–1954. doi 10.4314/ahs.v20i4.53. PMCID: PMC8351853PMID: 34394261.
2. Akinbami, A.A, Ajibola, S.O., Rabiu, K. A., Adewunmi, A. A., Dosunmu, A. O., Adewumi Adediran, A., Osunkalu, V. O, Osikomaiya, B. I., and Kamal A Ismail, K. A. (2013). Hematological profile of normal pregnant women in Lagos, Nigeria. Int J Womens Health. 2013; 5: 227–232. Published online 2013 May 3. doi: 10.2147/IJWH.S42110
3. Ayazbekov A, Nurkhasimova R, Kulbayeva S, Bolat K, Kurmanova AM, Yeskarayeva A, Sarbassova M, Kemelbekov KS. Features of Pregnancy, Childbirth and Postpartum Period of Young Mothers. Electron J Gen Med. 2020;17(6):em260. https://doi.org/10.29333/ejgm/8459
4. Azalea, T., Fekadu, A., and Hanlo, C. (2018). Postpartum depressive symptoms in the context of high social adversity and reproductive health threats: a population-based study. International Journal of Mental Health Systems volume 12, Article number: 42 (2018).
5. Beck C. T. (2002). Postpartum depression: A meta-synthesis. *Qualitative Health Research*, 12(4), 453–472. https://doi.org/10.1177/104973202129120016
6. Christine M. Furber, Debbie Garrod, Eileen Maloney, Karina Lovell, Linda McGowan, A qualitative study of mild to moderate psychological distress during pregnancy, International Journal of Nursing Studies, Volume 46, Issue 5,2009, Pages 669-677, ISSN 0020-7489,https://doi.org/10.1016/j.ijnurstu.2008.12.003.
7. Cristescu T, Behrman S, Jones SV, Chouliaras L, Ebmeier KP. Be vigilant for perinatal mental health problems. Practitioner. 2015;259:19 23 http://www.ncbi.nlm.nih.gov/pubmed/26062269 2–3.

8. Dayan J. Clinical approach and epidemiological aspects of mood and anxiety disorders during pregnancy and postpartum. Review synthesis. J Gynécologie Obs Biol La Reprod. 2007;36:549–61. https://doi.org/10.1016/j.jgyn.2007.06.003.
9. Engdaw, G. T., Tesfaye, A. H., Feleke, M., Negash, A., Yeshiwas, A., Addis, W., Angaw, D. A. and Engidaw, M. T. (2023). Effect of antenatal care on low birth weight: a systematic review and meta-analysis in Africa, 2022. SYSTEMATIC REVIEW article. Front. Public Health, 27 June 2023. Sec. Children and Health. Volume 11 - 2023 | https://doi.org/10.3389/fpubh.2023.1158809
10. Girma, S., Fikadu, T., Agdew, E., Haftu, D., Gedamu, G., Dewana, Z. and Getachew, B. (2019). Factors associated with low birthweight among newborns delivered at public health facilities of Nekemte town, West Ethiopia: a case-control study. BMC Pregnancy Childbirth. 2019; 19: 220. Published online 2019 Jul 2. doi: 10.1186/s12884-019-2372-x. PMCID: PMC6604438PMID: 31266469
11. Gureje, O., Oladeji, B. D., Araya, R., Montgomery, A. A., Kola, L., & Ojagbemi, A. (2019). Expanding mental health care in Africa: Perspectives from a primary health care approach. World Psychiatry, 18(3), 321–322. https://doi.org/10.1002/wps.20669
12. Hagen E. H. (1999). The functions of postpartum depression. *Evolution and Human Behavior*, 20(5), 325–359. https://doi.org/10.1016/S1090-5138(99)00016-1
13. Howard L. M., Khalifeh H. (2020). Perinatal mental health: A review of progress and challenges. *World Psychiatry*, 19(3), 313–327. https://doi.org/10.1002/wps.20769 https://doi.org/10.1016/j.wombi.2018.07.006.
14. January, J.; Chivanhu, H.Chiwara, J;.Denga, T;.Dera, K;.Dube, T.; Chikwasha, V.; Chikwanha, T.M., (2015) Prevalence and the correlates of post-natal depression in an urban high-density suburb of Harare, Central African Journal of Medicine, vol. 61, nos. 1/4, pp. 1-5. Harare: CAJM.
15. Javadifar N, Majlesi F, Nikbakht A, Nedjat S, Montazeri A. Journey to motherhood in the first year after childbirth. J Fam Reprod Heal. 2016;10:146–53 http://www.ncbi.nlm.nih.gov/pubmed/28101116 . Accessed 2 Mar 2017..
16. Jo 毛 lle Darwiche, Anne Milek, Jean-Philippe Antonietti, Yvan Vial, Kısa C, Yıldırım SG (2004) Gebelik postpartum dönem ve ruhsal bozukluklar. Psikiyatri Psikoloji Psikofarmakoloji (3P) Dergisi 12 (Ek 4):0-0.
17. M Pajulo, E Savonlahti, A Sourander, H Helenius, J Piha, “Antenatal depression, substance dependency and social support," Journal of Affective Disorders, Volume 65, Issue 1,2001, Pages 9-17, ISSN 01650327,https://doi.org/10.1016/S0165-0327(00)00265-2.
18. Mauthner N. S. (1999). Feeling low and feeling bad about feeling low": Women's experiences of motherhood and postpartum depression. *Canadian Psychology/Psychologie Canadienne*, 40(2), 143–161. https://doi.org/10.1037/h0086833
19. Mollard E, Kupzyk K, Moore T. Postpartum stress and protective factors in women who gave birth in the United States during the COVID-19 pandemic. *Women’s Health*. 2021;17. doi:10.1177/17455065211042190
20. Mughal, S., Azhar, Y., and Siddiqui, W. (2021). Postpartum Depression. https://www.ncbi.nlm.nih.gov/books/NBK519070/
21. Muthayya, S. (2009). Maternal nutrition & low birth weight - What is important? The Indian Journal of Medical Research 130(5):600-8.
22. Norhayati MN, Nik Hazlina NH, Asrenee AR, Wan Emilin WM. Magnitude and risk factors for postpartum symptoms: A literature review. J Affect Disord. 2014;175c:34–52.
23. Nweke, F.E. (2023). Music Listening in Pregnancy: A Cynosure for Urban Women. Submitted to the African Cities Blog.
24. Nystrom K, Ohrling K. Parenthood experiences during the child's first year: a literature review. J Adv Nurs. 2004;46:319–30. doi:https://doi.org/10.1111/j.1365-2648.2004.02991.x
25. Ogunnubi, O. P., & Ojofeitimi, E. O. (2017). Postpartum depression among women in Lagos, Nigeria: A pilot study. Journal of Public Health in Africa, 8(2), 663. https://doi.org/10.4081/jphia.2017.663
26. Olagunju, A. T., Adeyemi, J. D., & Ogbolu, Y. (2017). Postpartum depression in Nigeria: A public health concern. Journal of Nursing Education and Practice, 7(9), 1–5. https://doi.org/10.5430/jnep.v7n9p1
27. Omigbodun, A. O. and Adewuyi, A. (1997). Duration of human singleton pregnancies in Ibadan, Nigeria. J Natl Med Assoc. 1997 Sep; 89(9): 617–621. PMCID: PMC2608264PMID: 9302859

28. Ou CHK, Hall WA, Rodney P, Stremler R. Seeing Red: A Grounded Theory Study of Women's Anger after Childbirth. *Qualitative Health Research*. 2022;32(12):1780-1794. doi:10.1177/10497323221120173. Partner support during the prenatal testing period after assisted conception,
29. Petch J, Halford WK. Psycho-education to enhance couples' transition to parenthood. Clin Psychol Rev. 2008;28:1125–37. doi:https://doi.org/10.1016/j.cpr.2008.03.005.
30. Rahman, A. IQBAL, Z; & Harrington, R. (2003). "Life Events, Social Support and Depression in Childbirth: Perspectives from a Rural Community in the Developing World. Psychological Medicine, 33(7). 1161-1167. doi: 10.1017/S0033291703008286.
31. Shehzad, K. (2011). Neonatal birth-weights and reference intervals in sonographically monitored normal fetuses. Int J Health Sci (Qassim). 2011 Jul; 5(2 Suppl 1): 27. PMCID: PMC3533353PMID: 23284568.
32. Slomian, J., Reginster, JY., Emonts, P. *et al.* Identifying maternal needs following childbirth: comparison between pregnant women and recent mothers. *BMC Pregnancy Childbirth* 21, 405 (2021). https://doi.org/10.1186/s12884-021-03858-7.
33. Solmeyer AR, Feinberg ME. Mother and father adjustment during early parenthood: the roles of infant temperament and co-parenting relationship quality. Infant Behav Dev. 2011; 34:504–14. doi:https://doi.org/10.1016/j.infbeh.2011.07.006.
34. Stern DN, Bruschweiler-Stern N. The Birth of a Mother. Odile Jaco. 1998.
35. Winnicott DW. De la pédiatrie à la psychanalyse. Payot. Payot; 1989.Women and Birth,Volume 32, Issue 2,2019,Pages e264-e271,ISSN 1871-5192,
36. Wubetu, A. D., Amare, Y. E., Haile, A, B., and Degu, M. W. (2021). Newborn Birth Weight and Associated Factors Among Mother-Neonate Pairs in Public Hospitals, North Wollo, Ethiopia. Pediatric Health Med Ther. 2021; 12: 111–118. Published online 2021 Mar 9. doi 10.2147/PHMT.S299202. PMCID: PMC7955756PMID: 33727882.
37. Xi, C., Luo, M., Wang, T., Wang, Y., Wang, S., Guo, L. and Lu, C. (2020). Association between maternal lifestyle factors and low birth weight in preterm and term births: a case-control study. Reproductive Health volume 17, Article number: 93 (2020)
38. Yıldız M, Ünal S (1996) Gebelik ve psikiyatrik sorunlar. Psycho Med, 2: 141-146.
39. Zengin, Hamide; Bafali, Icten Olgu; Caka, Sinem Yalnizoglu; Tiryaki, Oznur; Cinar, Nursan (2020) Childbirth and Postpartum Period Fear and the Related Factors in Pregnancy. Sakarya University, www.doi.org/https://hdl.handle.net/20.500.12619/95344
40. Recognizing and Treating Seasonal Affective Disorder - Hong Kong Integrative Medical Practice. https://www.drsusanjamieson.com/emotional-health/seasonal-affective-disorder/
41. Adegoke, O., Awolola, N. A., & Ajuluchukwu, J. N. (2018). Prevalence and pattern of cardiovascular-related causes of out-of- hospital deaths in Lagos, Nigeria. https://core.ac.uk/download/543377591.pdf.