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Exploring the Experiences of Jordanian Rural Women with Postpartum Depression: A Qualitative Study

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ABSTRACT

Background & aim: Childbirth sometimes arouses intense emotional and psychosocial distress among the mothers, known as postpartum depression, reducing quality of life and health outcomes for mothers and their newborns. However, little is known about the experience of women living in rural settings with this condition. This study explores the experiences of women with postpartum depression in the rural areas of Jordan.

Methods: In this qualitative descriptive study, face-to-face semi-structured interviews were held with 12 women residing in rural Jordan, who were initially selected through purposive sampling at primary healthcare centers followed by snowball sampling to reach women in isolated rural areas. Data was audio-recorded, and analyzed using content analysis technique proposed by Hsieh and Shannon.

Results: Three overarching themes were identified, with various subthemes, as follows. (A) "Emotional and psychosocial status" including subthemes of (1) sadness and emotional instability, (2) fear and anxiety, and (3) loss of identity. (B) "Effects on Daily Life" consisting subthemes of (1) disrupted sleep and persistent fatigue, (2) disrupted relationship with partner, and (3) social withdrawal. (C) "Coping and Support" embracing subthemes of (1) support from partner, family and friends, (2) poor understanding by society, (3) professional healthcare support and therapy, (4) spirituality and religion, and (5) stigma and fear of seeking conventional support.

Conclusion: Postpartum depression inflicts negative psychosocial implications among the Jordanian rural women, and despite the available coping mechanisms, such as social support and spirituality, there is still evidence that societal stigma and a lack of understanding often hindered effective help-seeking.

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Introduction

Postpartum depression (PPD) is a significant public health concern that produces myriad negative effects on mothers and the development of the baby (1). Global epidemiological reports estimate that PPD affects between 10-20 % of women (2, 3). However, there seems to be regional heterogeneity in the distribution of prevalence; according to a systematic review conducted by Liu et al. (2022), the prevalence of PPD highly varied across regions with the highest figures reported in developed countries, like China (4). On the contrary, the study by Wang et al. (2021) reported that "varied

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prevalence rates were noted in geographic regions with the highest rate found in Southern Africa (39.96%) (3)."

Studies that examined the risk factors of PPD highlight issues like poor access to healthcare facilities, social stigma, and low economic capacity as some of the leading risks for the development of PPD (4-5). In many health service contexts, including rural areas of Jordan, medicalized childbirth and the stigmatization of mental health problems mean that PPD is not given significant recognition, and rates are underreported, despite PPD being more likely to arise in such circumstances (6). According to Taybeh, PPD flourishes in contexts that are characterized by strong cultural beliefs, traditional gender roles, limited awareness of the disease condition, and poor access to healthcare facilities (6). Under such conditions, most women with PPD are compelled to suffer in silence, cut off from access to support from healthcare professionals and community support networks (which are usually more germane to PPD support in developed countries).

Some of the notable challenges women with PPD face include emotional distress (i.e., PPD *per se*), poor infant-mother relationship, poor breastfeeding practices, negative health outcomes of the infant, and overall reduced quality of life (7-9). According to Paddy, Asamoah-Gyimah and Nkyi: "Mothers who suffer from PPD have changes in their diet, sleep, and activity levels and this can result in the mother being malnourished, exhausted, and overly or less energetic than usual; just as it is with general depression (10).

These effects can collectively discourage help-seeking behaviors and treatment outcomes.

Concerning existing research, on PPD among women, many researchers have concentrated on quantifying aspects of the condition and its impacts (11-12), and have explored prevalence and management efforts (13). In this vein, previous studies in Jordan predominantly concentrated on issues like disease prevalence, and the effects of the condition in either urban setting or both, thereby building little evidence for the population in the rural settings (6, 14-15). However, limited studies have comprehensively addressed the personal, cultural and emotional dimension of PPD among women living in rural settings. In exploratory investigations, qualitative approaches can uncover hitherto neglected aspects of healthcare needs, including to explore the lived experience and coping mechanisms. Communities living in the rural setting often face critical healthcare challenges, including poor access to healthcare facilities and strong influence of the traditional practices, which slightly differ from the population living in the urban setting.

In addressing the existent research gap, this study can help to understand how PPD affects women in rural settings, the effects on their relationships, and how they seek help and obtain support. The outcomes might help healthcare policymakers to design more contextualized intervention measures to help women in the rural setting overcome hurdles towards help-seeking and receive convenient care. This study thus aimed to explore the experiences of women with PPD in rural areas of Jordan through a qualitative design.

Materials and Methods

This study applied a qualitative descriptive study design. This was considered to be the most appropriate design, as it helps to explore the experience of Jordanian women suffering from PPD in the context of rural settings (16).

Specifically, the researchers selected only women who had never had previous cases of mental health problems, living in the rural setup, of Jordan. The participants were recruited from their home setting, where face-to-face interviews were conducted. To identify these participants, they were initially identified through purposive sampling at primary healthcare centers, followed by snowball sampling to reach women in more isolated rural areas. Therefore, all the cases of depression had been medically diagnosed in the related community health clinics (centers). Sample size was determined based on the data saturation; the point when no new significant outcome was recorded from the participants' responses (17). Hence, a total of 12 women took part in this study.

The collection of data was done through semi-structured interviews, which were done on a face-to-face basis. Three broad interview questions were developed by the researchers to explocit participants' own narratives and

experiences, guided by previous research studies on the same phenomenon. This approach was selected to allow women to express their own experiences in their own way, without confining them to narrowly defined concepts and multiple, specific questions. Accordingly, the researcher developed three principal interview questions, which covered three domains, including emotional and psychosocial status, impact on daily life, and coping strategies. Although a formal pilot study was not conducted, the interview questions were reviewed by qualitative research experts and refined for clarity and cultural appropriateness prior to data collection. The interviews lasted for between 30 and 45 minutes for each participants. The questions were:

1. Can you please describe for me how you felt, mentally and emotionally after giving birth;
2. In what ways did your daily life activities change after giving birth?
3. How did you cope with the challenges, and did you seek help from others to help you recover, if yes, how?

Moreover, the researchers also collected data on the women's basic sociodemographic features, which were considered essential to help contextualize the participants' experiences with PPD. Accordingly, basic features, such as age, education level, employment, number of children, and marital status were recorded. These elements were considered crucial to help enrich the data and provide a comprehensive view of the phenomenon. Nevertheless, it is vital to note that the participants' personal identifying information, such as names, were not recorded, as per the ethical observances; they were only referred to using participant codes (i.e., P1-P12). Anonymity helps to ensure that data is rich and honest, especially when studying deeply personal and potentially sensitive and controversial subjects (17), such as PPD in rural communities.

Data was audio recorded and transcribed verbatim preceding the analysis. Data reduction was a prerequisite step in this, a process that involved systematically organizing and simplifying raw data to focus on the answers to the research question. This process commenced with familiarization with the data, generating initial codes, grouping codes into categories, identifying key themes, and condensing information without losing its meaning (17). This was vital so as to make the data more manageable and meaningful, ultimately allowing the researchers to present clear, evidence-based findings that reflect participants' experiences.

Analysis of data was then done using the inductive content analysis technique. The analysis followed Hsieh HF, Shannon (2005) approach through three main stages: (1) repeated reading of interview transcripts to familiarize with the data; (2) generation of initial codes derived directly from participants' responses; and (3) grouping of similar codes to form categories and overarching themes (18).

Table 1 illustrates the process of data reduction and the generation of themes. The following subsections explain the identified themes, interspersed with relevant excerpts from participants' own accounts (i.e., interview data).

Trustworthiness was established based on Lincoln and Guba's framework of credibility, transferability, dependability, and confirmability (19). Credibility was ensured by using a consistent data collection procedure, providing a detailed description of the entire research process, and continuing data collection until data saturation was achieved. Transferability was supported by providing sufficient contextual information so that other researchers or readers could assess the applicability of the findings to their own settings. Dependability was maintained through inter-coder agreement to ensure consistency, as well as the active involvement of all researchers in the data analysis process. Confirmability was achieved by adhering to a rigorous, analytical procedure and documenting the research steps to minimize researcher bias (Table 1).

Table 1. The process of data reduction and generation of themes

Interview transcript extract	Code	Initial subtheme	Final subtheme	Theme
"After birth, I found myself crying all the time and didn't know why... I just felt so low."	Persistent sadness, crying spells	Emotional instability	A.1 Sadness and emotional instability	A. Emotional and psychosocial status
"In most cases, I found myself afraid that something bad would happen to my baby even when things were fine."	Constant worry, unexplainable fear	Anxiety	A.2 Fear and anxiety	
"So, just like that, I no longer felt like myself... You know, it was like I had totally changed, not the person I was before."	Loss of self-identity	Altered self-perception	A.3 Loss of identity	
"Sleeping at night was only by chance. I barely slept in most cases. Always tired, and this could even happen during the day anyway."	Insomnia, exhaustion	Sleep disturbance and fatigue	B.1 Disrupted sleep and persistent fatigue	B. Effects on daily life
"... too much arguments, sometimes quarrelling; I don't know why he could not understand my situation."	Conflicts with partner	Relationship strain	B.2 Disrupted relationship with partner	
"I really found it hard to be with my friends. And in most cases, I didn't even want to talk to anyone or leave the house"	Avoidance, isolation	Social withdrawal	B.3 Social withdrawal	
"My mother and sister were the only ones who helped me through this phase."	Family support	Informal support system	C.1 Support from partner, family and friends	C. Coping and support
"Quite frustrating that some people just kept saying that I was just being lazy or overreacting over nothing serious"	Lack of empathy, misunderstanding	Societal judgment	C.2 Poor understanding by society	
"at least one time, I managed to visit a professional, a therapist and started on medication"	Therapy, medical help	Professional intervention	C.3 Professional healthcare support and therapy	
In many occasions, I was on my knees, praying, a lot. That was the only weapon left within my reach... at least it gave me reason to carry on"	Reliance on faith	Religious coping	C.4 Spirituality and religion	
"I felt ashamed to go to a clinic... what would people say?"	Shame, fear of judgment	Stigma around mental health	C.5 Stigma and fear of seeking conventional support	

Results

Sociodemographic Characteristics

A total of 12 Jordanian women diagnosed with PPD took part in this study. Their basic demographic features were recorded to help contextualize their responses and to make the study more comprehensive (Table 2). Accordingly, it was noted that relatively more women had a normal vaginal delivery (58.3%) than those who delivered via caesarean section (41.7%). Only a quarter of the participants (25%) had just experienced their first delivery. The majority of participants were married (91.7%).

Table 2. Sociodemographic characteristics of participants

Participants' features	Frequencies (%)
Age (years)	
18–24	3 (25%)
25–29	4 (33.3%)
30–34	3 (25%)
35+	2 (16.7%)
Educational level	
Primary school	2 (16.7%)
Secondary school	6 (50%)
Diploma/Bachelor's degree	4 (33.3%)
Employment	
Unemployed/housewives	9 (75%)
Employed	2 (16.7%)
Informal work	1 (8.3%)
Number of children	
1	3 (25%)
2–3	5 (41.7%)
4+	4 (33.3%)
Marital status	
Married	11 (91.7%)
Separated or divorced	1 (8.3%)
Type of delivery	
Vaginal	7 (58.3%)
Cesarean section	5 (41.7%)

Thematic Outcomes

Results were obtained under three domains based on the interview question prompts, as summarized in Table 3.

Table 3. Summary of themes and subthemes emerged from data analysis

Theme (A) "Emotional and psychosocial status"
(A.1) Sadness and emotional instability
(A.2) Fear and anxiety
(A.3) Loss of identity
Theme (B) "Effects on daily life"
(B.1) Disrupted sleep and persistent fatigue
(B.2) Disrupted relationship with partner
(B.3) Social withdrawal
Theme (C) "Coping and support"
(C.1) Support from partner, family and friends
(C.2) Poor understanding by society
(C.3) Professional healthcare support and therapy
(C.4) Spirituality and religion
(C.5) Stigma and fear of seeking conventional support

Theme 1: Emotional and Psychosocial Status

Regarding emotional and psychosocial status, this study found three major subthemes: (1.1) "sadness and emotional instability," (1.2) "fear and anxiety," and (1.3) "loss of identity."

1.1: "Sadness and emotional instability"

The participants expressed that giving birth made them feel distressed, making them sad and emotionally overridden. Notably, the participant who was unmarried (P11) highlighted how economic solitude compounded her emotional distress. She explained that her sadness was worsened by the economic burden that weighs on her, all alone (without spousal, family, or state support).

"After birth, I found myself crying all the time and didn't know why... I just felt so low" (P11).

1.2: "Fear and anxiety"

It was also established that these women had developed a lot of fear of the responsibilities awaiting their motherhood roles, especially among those with first birth.

"...it is almost all the time about the baby, and I had never experienced such before... it was frightening! And in most cases, I found myself afraid that something bad would happen to my baby even when things were fine" (P9).

1.3: "Loss of identity"

Moreover, it was also noted that some women felt like they had lost their true identity in society, feeling like they had been reduced in terms of their societal performance and roles, as narrated by a mother of one:

"I am, most of the time, scared of whether I would be able to meet the responsibilities in front of me as a mother... was so scary. So, just like that, I no longer felt like myself... You know, it was like I had totally changed, not the person I was before" (P4).

Theme 2: Effects on Daily Life

This study also observed that PPD mostly affected the daily lives of these women negatively. Three main subthemes emerged here: (2.1) "disrupted sleep and persistent fatigue," (2.2) "disrupted relationship with partner," and (2.3) "social withdrawal"

2.1: "Disrupted sleep and persistent fatigue"

This challenge was most apparent among those who had just experienced their first birth. Participants felt overburdened by the baby care at night, making them constantly fatigued.

"I didn't know I would have my sleep reversed... even when the baby was asleep, still, I would never catch sleep. Sleeping at night was only by chance. I barely slept in most cases. Always tired, and this could even happen during the day anyway" (P9).

2.2: "Disrupted relationship with partner"

The women explained that their partners do not understand their burden, something that leaves them emotionally torn, making their relationships lose their grip.

"My partner... [taking a deep sigh]. He totally couldn't understand what I go through" (P12).

2.3: "Social withdrawal"

Lastly, others also felt socially withdrawn, not wanting to mix with their peers. This behavior was notable among those with employment, such as P2.

"I stopped answering calls even from my close friends. I just had to avoid people" (P2).

Theme 3: Coping and Support

Regarding strategies for coping and support, this study came up with five notable subthemes: (3.1) "Support from partner, family and friends," (3.2) "Poor understanding by society," (3.3) "Professional healthcare support and therapy," (3.4) "Spirituality and religion," and (3.5) "Stigma and fear of seeking conventional support."

3.1: "Support from partner, family and friends"

This study noted that these women obtained support from their friends, family members, and partners. The psychosocial support helped them to cope with the distress of PPD. Poor understanding by society was also an apparent theme, indicating that these women have inadequate expected support from their societies. Some participants expressed the perception that PPD was normalized and not a serious concern, as expressed by P4.

"Everyone around me just kept saying it is all about hormones, it will disappear... I felt frustrated" (P4).

3.2: "Poor understanding by society"

This expression indicates that some women did not get societal support. Nevertheless, these women with PPD suffer from societal stigma and fear. They shy from seeking professional assistance due to the fear of being ridiculed. A participant who had not attended school expressed the perception that PPD and related symptoms were not real illnesses worthy of healthcare attention:

"I could but... won't they only laugh at me, how would they view me, is it even a sickness?" (P5)

3.3: "Professional healthcare support and therapy"

Still on coping strategies, this subtheme revealed that women did indeed obtain some form of help from the professional healthcare system, such as counseling, conventional therapy, and medication to treat their conditions. However, this was by default (as they were recruited via local health clinics), and it was apparent that the interviewees nevertheless experienced difficulties in accessing health centers, as most of them lived far away from any regular healthcare facilities.

3.4: "Spirituality and religion"

Many participants referred to coping and support strategies leveraging their spiritual and religious beliefs and practices, including prayers and meditations to affirm their hopes that the problem of PPD would end. Others also sought help from religious leaders and traditional healers to cleanse them, believing that their distress was related to metaphysical, spiritual entities and forces.

3.5: "Stigma and fear of seeking conventional support"

Some participants expressed a feeling of shame and fear of judgment due to experiencing PPD, and the stigma around mental health in their communities in general. This prevented them from seeking support, due to the fear of exposure among their families and social networks (as discussed with regard to C.2, above), in addition to healthcare professionals themselves.

"I felt ashamed to go to a clinic... what would people say?" (P10).

Discussion

The findings of this study revealed complex emotional, psychological, and social dimensions affecting women with PPD that mostly go unnoticed. Despite research over the years underlining recurring themes in women's experiences, which are essential for informing healthcare practice, support systems, and policy,

their needs continue to go unmet (20), as was evident in participants' accounts in this study. It was found that women experiencing PPD typically report feelings of guilt, shame, loss of identity, fear, overwhelming sadness, and a sense of disconnection from their newborn babies. Emotional instability and the related struggles stood out as a salient theme. This corroborates international studies. In the UK, Akhtar et al. (2024) identified that most women describe feeling inadequate as mothers plus being overwhelmed by new responsibilities (21). Similarly, studies have reported feelings of emotional numbness and detachment. Additionally, such feelings mostly conflict with societal expectations of motherhood as a joyful experience compounding their distress (22).

Several previous studies stress the intensity of emotional instability and turmoil these women face. A cross-sectional study by Asadi et al. (2023) identified themes including a "sense of loss," "feeling trapped," and a "downward spiral (23)." In this study, most of the participating women registered irritability, anxiety, and overwhelming sadness. Such psychological instability characterized the participants as feeling out of control. The themes noted by the present study were mostly accompanied by intrusive thoughts, such as those reported in previous studies of fearing that they might harm themselves or their newborns (24). Asadi et al. (2023) reviewed qualitative literature exploring the first-person accounts of women diagnosed with PPD, and highlighted increased fear and isolation among the patients (23). However, they recommended social support as the most effective way to protect women from this negative experience, particularly from friends, family, and spouses. Analogous studies, done in other developed countries like Sweden, have found increased anxiety levels characterized by disrupted sleep patterns and misfunctioning relationships (23, 25).

Studies have confirmed the widespread prevalence of stigma and isolation among postpartum mothers. A study in Uganda summarized five major themes surrounding the subject, including physical symptoms such as insomnia and headache, breast pain, and poor breast milk production, alongside social and familial difficulties in homes and families, such as negative emotions (including anger and self-blame), and feelings of suicide and homicide (26, 27). According to similar research, suicidal and homicidal thoughts are significant aspects of PPD, which can endanger the lives of mothers, their partners, and their unborn children. Poor relationship quality, intimate partner violence, and lack of financial resources contribute significantly to the negative emotional experiences of mothers with PPD in Sweden and Finland (25, 28).

Elmore (2023) explored the lived experiences of PPD among Jamaican women through a phenomenological research design and noted five themes including helplessness, loneliness due to feelings of isolation and fear of failure, and being labeled as a bad mother (29). Ellis (2023) elsewhere, established that prevalence rates of postpartum psychiatric morbidity and its risk factors in the Arab cultures are similar to those in industrialized countries (30).

Similarly, Johansson et al. (2020) through quantitative interviews, noted that mothers experience inadequacy, and PPD while some of the mothers described varying experiences of child healthcare support (24). Additionally, PPD affects the spouses' relationships, and both mothers and fathers experience loneliness and spouse relationship problems (31-32). Studies highlight that experiences of emotional problems and troubled upbringing in the parent's family of origin may contribute to vulnerability from previous trauma and to long-term depressive symptoms for mothers (33). Findings across the literature emphasize the significant impact of PPD and parental stress on parents' everyday lives and the spouse relationship, while advocating a change from an individual parental focus to couples' transition to parenthood in child health care (34).

Participants in this study revealed that a lack of support from healthcare providers (mainly attributable to their geographical distance from healthcare facilities) plays a significant role in enhancing the postpartum negative experiences. Studies have shown that women often report feeling dismissed by healthcare professionals. For example, a qualitative study by Amjad et al. (2025) noted that most women expressed dissatisfaction with the healthcare services provided propagated by rushed appointments

coupled with a lack of empathy (35). Similarly, this study revealed that the failure to properly screen for PPD and undertake follow-up for emotional well-being among women led to delayed diagnosis and treatment. Indeed, some participants did not even consider psychological wellbeing to be a matter of concern for healthcare contexts.

In studies with limited healthcare resources, studies stress the particular significance of peer social support as a remedying strategy. For instance, Ladd (2021) highlighted the role of supportive relationships in coping and recovery (36). Analogously, Fusar-Poli et al. (2025) showed that emotional support from partners, family, and peer groups significantly promotes women's ability to manage PPD (37). Nonetheless, peer support groups are ranked since they provide a non-judgmental space for mothers to share their experiences (38). Elsewhere, Maxwell et al. (2019) through a qualitative meta-interpretive synthesis highlighted several themes surrounding the topic; the themes included intersection of PPD and poverty, culture and PPD, pressure of mothering and strengths and coping mechanisms (39), similar to the findings of Tesfaye et al. (2023) (40). Hanach et al. (2024) reported that mothers become particularly vulnerable to mental health problems after successful delivery, including PPD. Their findings underlined the importance of considering the unique cultural and societal factors that impact maternal mental health (32).

Elmore (2023) explored the lived experiences of Jamaican women with PPD, and the findings affirmed that maternal mental health and PPD are global public health concerns. According to the study, a mother's lived experiences, such as personal and child health issues during pregnancy and after giving birth, as well as other stressors, had an impact on the symptoms of PPD. The majority of the mothers in the study research had no diagnosis and had no idea what PPD was (29). Elmore revealed that the ability to manage or cope with PPD is connected to support (29). Mothers' experiences of support included self, social, and technological support. Positive coping strategies and social support were key protective factors in Jamaican mother's experience (29). Other studies highlighted depressed mood, often accompanied by anxiety; markedly diminished pleasure in activities; loss of appetite and weight; sleep disturbances (often insomnia); physical agitation or psychomotor slowing; fatigue and low energy; feelings of worthlessness or inappropriate guilt; decreased concentration and decision-making ability; and recurrent suicidal ideation or thoughts of death (41, 42).

Previous studies indicate that PPD is a deeply personal and frequently isolating experience defined by emotional distress, societal expectations, identity disruption, and several shortcomings in the healthcare systems (40-42). However, there are a few cultural and contextual differences when comparing the cases in Jordan and those in other regions. In many rural Jordanian communities, Islamic beliefs and traditional practices, such as fear of metaphysical forces like the evil eye, significantly shape mothers' experiences of PPD. This cultural framing often influences help-seeking behavior, with some women turning first to religious practices, such as prayer, reading the Quran, or seeking spiritual healing, before accessing formal healthcare.

The study highlights culturally specific insights into PPD in rural Jordan, which are underrepresented in the global literature. Additionally, the study followed rigorous trustworthiness procedures (credibility, transferability, dependability, and confirmability) to ensure that the findings are grounded in participants' authentic experiences. The use of in-depth, open-ended interviews allowed participants to freely express their experiences, providing rich and detailed data.

This study did not consider the minor sociocultural differences that could exist among participants, which may have influenced their views on PPD. All participants were treated as uniformly observant of Jordanian culture, disregarding potential intra-cultural variation. In addition, snowball sampling was used, which may introduce selection bias because participants are more likely to recruit individuals with similar characteristics or experiences. The small sample size, typical of qualitative research, may also limit the generalizability of the findings and the ability to achieve full saturation across all rural regions of Jordan.

It is recommended that healthcare practitioners undertake to provide visiting nurses in community settings in rural areas, given that many of the problems identified in this research were attributable to geographical barriers to healthcare service access. Simple community visits, possibly in group settings, could be a cost-effective way to improve outcomes for PPD. Indeed, this could span the journey from antenatal care to successful infancy (for neonates), improving health outcomes for mothers and children due to increased contact and compliance with public health recommendations (e.g., vaccination schedules etc.).

This study offers a narrow (albeit in-depth) insight into the experiences of a small group of women living in rural areas of Jordan. Future research could explore experiences of women in other contexts, such as urban and small town residents, to see commonalities and differences in their experiences and needs. Quantitative studies with larger samples could explore the generalizability of the themes identified in this study, which could provide a more substantial evidence base to support healthcare decision-making.

Conclusions

PPD presents diverse negative psychosocial complications among women. The challenge is even more burdensome for mothers experiencing their first birth, and those living alone (without partners). The burden arises from a drastic change in roles, from a free lifestyle to parenthood, with highly demanding responsibilities and elevated financial needs. The long distance from healthcare facilities coupled with a strong influence of traditional belief systems may have severe negative implications on the recovery trajectories of women with PPD among women living in the rural setting of Jordan. Still, more evidence is needed to unveil and affirm the relationship between various socioeconomic and demographic elements with the experiences of PPD.

Declarations

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Conflicts of interest

The authors declared no conflicts of interest.

Ethical considerations

Verbal and written informed consent were acquired from all participants prior to the interviews, emphasizing that participation was completely voluntary, and participants had the right to withdraw at any time, without giving a reason, with the assurance that this would not affect their healthcare services or statutory rights. Additionally, the research participants, who were women suffering from postpartum depression, were sampled using the snowballing technique, with no implied coercion. They were assured that all date would be anonymized, and that no personally identifying information would be reported.

Code of Ethics

This study was conducted in accordance with the Declaration of Helsinki, as per the ethical approval granted from relevant authorities (Ref: IRB0015), which was obtained prior to recruiting the participants.

Use of Artificial Intelligence (AI)

Generative AI was used for English grammar proofreading, which helped in improving sentence structures and the basic English language use in academic work.

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Authors' contributions

Design: MNA, RSM, NMA and HYA; Data collection: DMA, SA, HYA, and RSM; Data analysis: MNA, SA RSM, and HYA; Preparing the manuscripts for publication: MNA, NMA and RSM; Revising the manuscript: MNA. All authors have read and approved the final manuscript, and agreed to be accountable for all aspects of the work, in ensuring that questions related to

the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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