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Socio-cultural Context of Postpartum Depression among Neo-local Migrant Women in Nigeria

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Abstract

Studies have focused on postpartum depression among international migrant women, including refugees. However, the study of this phenomenon among internal migrant women often falls through the cracks of existing research. This article, therefore, examines the influence of socio-cultural practice on the development of postpartum depression among neo-local migrant women in

Nigeria. The study used a mixed-methods approach combining quantitative data collected from 388 women through Edinburgh Postnatal Depression Scale questionnaires, with qualitative insights from in-depth interviews with 10 participants. The study engaged with how internal migration experience such as the feeling of isolation, language barriers, family dynamics and cultural disengagement contribute to the development of postpartum depressive symptoms among this group of women. This article is a major contribution to knowledge across several scholarly, policy and practice areas including migration, health and illness behaviour and development studies.

Keywords: *Postpartum Depression among Migrant Women, Depression and Migration, Migration and Mental Health, Migration, Women and Development, Neo-Local Migrant Women*[1]

Introduction

Motherhood marks a significantly transformative phase of women's lives. This phase, starting from pregnancy is characterised by psychological and physiological changes that can leave women feeling vulnerable, and some experiencing emotional upheaval. While some manage to cope with the emotional experiences that accompanies this period, others struggle, resulting in depressive episodes that affects not only the new mother, but also the baby, partners, the family, and ultimately, the society at large. This mental state, commonly referred to as postpartum depression (PPD), remains one of the significant maternal health issues globally (Gelaya *et al*., 2016), with a particularly high prevalence rate in low and middle-income countries.

Specifically, the prevalence of PPD in Nigeria is alarmingly high, with nearly one in five women experiencing depressive symptoms after childbirth (Fisher *et al*., 2012). Research indicates that migrant women are at a greater risk for mental health issues, including depression, due to psychosocial determinants such as forced migration, barriers to accessing healthcare, feelings of insecurity, cultural dislocation, and communication difficulties (Almeida, Costa-Santos, Caldas, Dias, & Ayres-de-Campos,

[1]Neo-local migrant women as used in this paper means women who have migrated away from, and located apart from, their families of orientation to live with their spouses in different communities to form a new family of procreation.

2016). Although neo-local migrant woman falls under this category of women, worrisomely, PPD among them remain under researched.

Neo-local migrant women who engage in internal migration may face unique challenges in their new environments. As they relocate to establish separate households, they may experience significant social isolation and a lack of traditional support systems that are crucial during the postpartum period. As pointed out by Lawal, Lawal, Chidi-Nero and Ogunniyi (2022), several cultural practices in Nigeria serve the dual function of protection against and management of PPD. These includes the communal life in rural areas that enhances solidarity which helps to address difficulties during pregnancy and childbirth.

Hence, without effective *omugwo/olojojo omo*[2], neo-local migrant women/mothers may become vulnerable to PPD (Akanle & Ogunkan, 2021). Internal migration can disrupt established support networks and elevate stress levels for new mothers, making it crucial to examine the prevalence and lived experiences of neo-local migrant women experiencing PPD symptoms. The socio-cultural factors influencing PPD among neo-local migrant women are often more significant than many realise, particularly in a diverse country like Nigeria. With its rich array of traditional practices, beliefs, and languages, new mothers can feel disconnected and isolated. Relocating to a new area often exposes them to customs that differ greatly from their own, complicating their transition into motherhood. This cultural dislocation can heighten feelings of loneliness and vulnerability during an already challenging time.

Beyond Biology: Socio-cultural Factors Influencing PPD among Neo-local Migrant Women

With a significant level of discrepancies in the ranges of prevalence of PPD across countries in the world (Rena, 2008; Agarwal, 2023), researchers claim that the observable low prevalence of PPD in certain culture is perhaps due to cultural protective factors (Fitch, 2002; Miller, 2002). After-all, culture plays an important role in the lives of people

[2]This is a cultural practice in Nigeria where mother of the bride/mother of the groom lives with the family to assist with nursing new baby/babies as a socialisation process and assistance. This practice is also to provide essential support, to the new (usually inexperienced) mother. This facilitates her adjustment to motherhood and reduces stress related to childbirth and childcare (Adeyemo, Oluwole, Kanma-Okafor, Izuka, & Odeyemi, 2020).

(Kirmayer, 1989; Lazarus & Folkman, 1984, both in Rema, 2008). They further emphasised the fact that the emotional condition of an individual is greatly influenced by cultural variables. Additionally, cultural beliefs and practices play a significant preventive role in life transitions, such as pregnancy and birth (Raphael-Leff, 1991), therefore, explaining the rationale behind this, is Leung's (2002) submission- an emphasis that understanding postpartum depression completely requires considering cultural variables in addition to biological, psychological, and social viewpoints.

Also, there have been continuous debates as to whether the significant differences among various cultures impacts the prevalence of postpartum depression (Rena, 2008). In a study by Affonso, Horowitz and Mayberry (2000), it was discovered that Western societies had a lower prevalence of PPD as compared to non-Western societies. Major risk factors for PPD in United States was identified to be of financial or material resources related, likewise, is the culture of "intensive mothering" which led to the subjection of new mothers to judgment of not attaining the expected, unrealistic standard of parenting (Albanese, Geller, Steinksmp, & Barkin, 2020). PPD in the USA exceeds 20% in women who were younger than 19 years (Agarwal, 2023), which has been attributed to the many social roles that adolescent mothers are forced to perform simultaneously- being a daughter, mother, student, girlfriend and so on (Ladores & Corcoran, 2019).

It has also been identified that the social status of being a "migrant" and giving birth to a child overseas remains a risk factor for PPD (Mehta & Mehta, 2014). This is evident in studies such as that which examined Japanese women, who were born and raised in Japan but were birth in Hawai, USA. Findings showed that half of the participants in the study experienced emotional challenges during their pregnancies (Taniguchi & Baruffi, 2007). It has always been that there are different health care behaviours in different cultures. So, the distance from family or place where ones' culture is being practiced may lead to homesickness which can also contribute to PPD after childbirth.

The culture of new mothers can both trigger PPD and help alleviate depressive symptoms (according to Nurhidayah, 2023; Rena, 2008). This aligns with findings by Heh, Coombes and Bartlett (2004), which explored the relationship between depressive symptoms and social support in the context of the traditional Chinese practice known as "doing the month." This practice allows new mothers to rest for a month

post-childbirth while their mothers or mothers-in-law take over household duties. Their study indicated that culture and social support play crucial roles in managing or preventing PPD. These findings resonate with Fitch's (2002) research, which suggested that cultures emphasising social support for new mothers tend to have lower PPD prevalence rates.

Also, a cultural tradition that is not practiced, have a negative impact on PPD. In the study on PPD by Huang and Mathers (2001) set out to compare factors associated with postpartum depression in the United Kingdom and Taiwan cited in Rena (2008), findings showed that UK Group had a higher maternal satisfaction than Taiwanese women. This outcome is suggested to be as a result of modernization in Taiwan which consequently, has affected the carrying out of tradition such as "doing the month". The transition from agrarian to industrial life has weakened the close relationship that typically exists between parents and their married offspring. Consequently, women after giving birth performed cultural ceremonies on their own, without the customary aid of their mothers or mothers-in-law, this brought about stress and, hence, contributed to their depression (Agarwal *et al.*, 2023; Vera, Yakupova, Anna, Suarez, & Liubov *et al.*, 2023; Liu, Wang, & Wang, 2022; Zhao & Zhang, 2020; Upadhyay, Chowdhury, Salehi, Sakar, & Singh *et al.*, 2017). Studies have demonstrated that there is an association between level of education and self-assessment skills (Vera *et al.*, 2023; Lozupone, D'Urso, Copetti, Sardone, & Arcuti *et al.*, 2022).

Research Methodology

The study that informed this paper was conducted in Ilorin, the capital city of Kwara State, and Nigeria. Ilorin has the capacity to provide rich context for studying postpartum depression among the neo-local women (migrants). As pointed out by Mrs. Harriet Oshatimehin, the Kwara State Commissioner for Communication, in an interview with *The Nation* on January 31, 2021, "Kwara State is a miniature of what we have in Nigeria". This shows accordingly, the diversity in the population of Ilorin, the capital city. Over the years, the study area has experienced significant population growth. Aderamo (2002) in Abubakar (2019) highlighted reasons such as the centrality of the city, the creation of states in 1967 and 1976, the rapid growth of commerce, industrialization and other social aspects as those factors that drove and still driving

individuals- Men and Women in large numbers from neighbouring towns and states. Therefore, conducting the study in Ilorin allowed access to varied representatives of women from different backgrounds.

Hence, Ilorin is a strategic location as a gateway between northern and southern Nigeria; it is also cosmopolitan. The study adopted mixed-methods research design to know the prevalence of PPD among the neo-local migrant women and also understand through their lived experience, the influence of socio-cultural factors on PPD. A quantitative instrument, the Edinburgh Postnatal Depression Scale (EPDS), was administered to assess prevalence and aid in participant selection for in-depth interviews (IDIs). For cultural contextualization, the PPDS was administered in Yoruba and English languages depending on the capacity and preference of the respondents. Research insights were also adapted from previous studies that have used the PPDS in similar Nigerian contexts (see Adewuya *et al*., 2006). The PPDS was also validated through pretest before adoption for the main study to ensure validity and reliability. A score of 10 was used as indicator of PPD (see also Adewuya *et al,* 2018, Adewuya *et al.,* 2006).

For the qualitative method, a well-tailored in-depth interview guide was used to provide a lens into the socio-cultural context of PPD. This choice of instrument was adopted to give room for in-depth exploration, description and explanation on the nuances of experiences of PPD among the study population. Due to the unknown population size of neo-local migrant women in Ilorin, Cochran's formula was used to determine a sample size of approximately 384, adjusted for a 10% attrition rate, which resulted to the distribution of 426 questionnaires across four purposively selected areas.

For the qualitative phase, participants scoring 10 or higher on the EPDS were eligible for IDIs, ensuring representation of both high and low depressive symptoms. A total of 10 interviews were conducted until saturation was reached, following guidance from Fischer and Ness (2015) and Saunders *et al.* (2017) on sample size determination based on data richness. Data collection involved administering the EPDS questionnaire without alterations, while a Respondent Identification Sheet (RIS) was used to gather contact information for follow-up IDIs. The data collection process for the study began on October 1, 2024, with the training of research assistants (RAs) at Marklesh Educational Institute in Ilorin, Kwara State.

During this training, the RAs were instructed on how to administer questionnaires and were thoroughly informed about the objectives of the study. This preparation was crucial in ensuring that the RAs understood the research goals and could effectively engage with respondents. A total of 426 questionnaires were prepared and sequentially numbered to facilitate tracking. An accompanying Respondent Identification Sheet (RIS) was created, listing unique numbers from 001 to 426, which allowed for easy identification of participants during follow-up interviews. Fieldwork commenced in the week following the training, with two RAs assigned to each of the four selected areas for questionnaire administration. However, initial results were disappointing, yielding only 50 completed questionnaires over the first two days. To improve response rates, three community entry personnel were recruited to help navigate the areas and access neo-local migrant women.

Additionally, snowball sampling proved effective; many women referred others to the researchers. By the end of the data collection period, a total of 388 questionnaires had been successfully administered. For the qualitative component of the study, participants who scored 10 or above on their questionnaires were purposefully selected for in-depth interviews (IDIs). A total of 10 IDIs were conducted, each lasting between 45 minutes to 1 hour and 10 minutes. Before each interview, participants received a thorough explanation of the research and signed informed consent forms. The interviews were recorded to ensure accurate capture of responses for subsequent analysis.

Data analysis involved both quantitative and qualitative methods. Quantitative data were analysed using Statistical Package for the Social Sciences (SPSS) Version 25.0, while qualitative responses from IDIs underwent thematic content analysis. This analysis process included five steps: transcription of audio recordings into written form, review and editing for accuracy, categorization of themes related to research objectives, and presentation of findings using infographics created with Adobe Illustrator. Ethical considerations were paramount throughout the study. Participants were informed about the study's objectives and assured that their participation was voluntary. Informed consent was obtained prior to participation, and confidentiality was maintained by anonymizing any photographs taken during interviews. The researcher adhered to ethical principles such as non-malfeasance (avoiding harm) and beneficence (promoting well-being).

Results and Discussion

Table 1: *Distribution of Respondents by PPD among Neo-local Migrant Women*

Categories	Frequency	Percentages (%)
Invalid	13	3.4%
Withdraw	10	2.6%
Low levels of postpartum depression (PPD < 10)	137	35.3%
Moderate to higher levels of PPD (PPD ≥10)	228	58.8%
Total	388	100%

Source: *Fieldwork, 2024*

Table 1 presents the distribution of postpartum depression (PPD) among the sampled population of 388 neo-local migrant women. Of these, 13 women (3.4%) provided invalid responses due to omissions of one or more questions, and 10 respondents (2.6%) withdrew from the study. Among the remaining participants, a significant majority of 288 women (58.8%) reported moderate to high levels of clinically relevant PPD symptoms, indicated by scores of 10 or above. This finding depicts a notable prevalence of postpartum depression symptoms within this demographic. Conversely, 137 respondents exhibited low levels of PPD, with scores below 10. There is high prevalence of PPD among neo-local migrant women in the area in consistency with the findings of Jin *et al.* (2016) among chines migrant women.

According to O'Hara (2009), the increased vulnerability of migrant women can be attributed to various challenges encountered during migration and resettlement, with rates of postpartum anxiety and depression among them ranging from 20% to 50%. While much research has focused on immigrant populations, it remains evident that migration itself significantly influences the prevalence of PPD. Furthermore, this study's results reflect a broader trend indicating that developing countries report higher rates of PPD compared to Western nations. This disparity may be due to greater awareness and policy interventions addressing maternal mental health in more developed regions (Catherine *et al.*, 2020). In contrast, low-income countries like Nigeria often lack adequate resources and attention to address these critical issues, hence, the urgent need for data-driven policies aimed at improving the well-being of neo-local migrant women.

Table 2: *Socio Demographic Variable of Respondent and Implication for PPD*

Variable	PPD < 10 (0-9)		PPD ≥ 10		X^2	P
	n	%	N	%		
Age					.000	.
18 - 24years	30	21.9	21	9.2		
25 - 30years	40	29.2	54	23.7		
31 - 36years	35	25.5	92	40.4		
37- 44years	18	13.1	54	23.7		
45years and above	14	10.2	7	3.1		
Total	137	100.0	228	100.0		
Ethnicity					.000	.
Fulani	30	21.9	37	16.2		
Hausa	50	36.5	7	3.1		
Igbo	40	29.2	40	17.5		
Yoruba	12	8.8	41	18.0		
Others	5	3.6	103	45.2		
Total	137	100.0	228	100.0		
Religion					.000	.
Traditional	10	7.3	13	5.7		
Christian	70	51.1	89	39.0		
Muslim	50	36.5	119	52.2		
Others	5	3.6	7	3.1		
Total	137	100.0	228	100.0		
Educational Level					126.003	.
O'Level Certificate	25	18.2	34	14.9		
NCE/ND	30	21.9	153	67.1		
HND/BSc/B.Ed	82	59.9	41	18.0		
Total	137	100.0	228	100.0		
Current employment status					.000	0.000
Employed	65	47.4	14	6.1		
Self-employed	30	21.9	33	14.5		
Unemployed	42	30.7	181	79.4		
Total	137	100.0	228	100.0		
Marital status					.	.
Others	13	9.4	7	3.1		
Widowed	-	-	27	11.8		
Separated	10	7.3	7	3.1		
Married	114	83.8	187	82.0		
Total	137	100.0	228	100.0		
Length of stay					.	.

Less than 1years	18	13.1	41	18.0		
2 - 5years	35	25.5	31	13.6		
6years - 10years	40	29.2	135	59.2		
11 - 15years	25	18.2	14	6.1		
16years and above	19	13.9	7	3.1		
Total	137	100.0	228	100.0		
Mode of delivery					38879.468	0.000
Emergency C-Section	20	14.6	44	19.3		
C-Section (Voluntary)	40	29.2	99	43.4		
Vaginal birth (assistant delivery)	30	21.9	51	22.4		
Vaginal (without medical intervention)	47	34.3	34	14.9		
Total	137	100.0	228	100.0		
Birth of infant					749422.090	0.000
Post-term (more than 42 weeks)	10	7.3	38	16.7		
Term (in 37-42 weeks)	120	87.6	149	65.4		
Premature (Less than 37 weeks)	7	5.1	41	18.0		
Total	137	100.0	228	100.0		

Source: *Fieldwork, 2024*

The findings from socio-demographic variables of respondents to EPDS instrument highlight that PPD is especially common among women from age 31 to 36. The age group also shows a notable distribution in the PPD ≥10 category. This finding is in line with that of the study by Smorti, Ponti and Pancetti (2019), where age in the socio-demographic characteristics was found to be a significant predictor of PPD scores. This, perhaps, stemmed from the challenges of juggling the demands of a newborn alongside older children, along with various socio-cultural pressures that they experienced due to their migration status.

Diverse ethnic backgrounds are also seen to play a role, as higher prevalence of PPD are observed in "others" group-PPD > 10, with 45.2% in this category. The Yoruba and Fulani groups also show a notable prevalence, with 18% and 16.2% respectively. This suggests that different ethnic groups within the broader neo-local migrant women in Ilorin may face unique challenges related to migration and social integration, which can actively increase their vulnerability to PPD after

childbirth. This assumption lent credence to the findings in the IDI where participants stated how they encountered problems such as language barriers, which no doubt, can make integrating hard, thereby bringing about feelings of isolation and loneliness. Similar to this study finding on ethnicity is that of Haque *et al.* (2020) and Toker and Aktas (2021) which suggest that one of the peculiar difficulties that migrant women faces is the struggle to adapt to a different culture and language.

Also, women with lower educational qualification- National Certificate of Education/National Diploma (NCE/ND) appear to be more susceptible to depression, and those who are unemployed face even greater risk. Interestingly, Muslim women in the study show higher rates of PPD, which most likely reflect religious pressures faced by women in the study area that is predominantly Islamic. More so, women who have lived in the city for several years also report feeling more depressed, suggesting that longer-term migrants may struggle with integration and support. Additionally, women who have C-sections tend to experience higher levels of postpartum depression, with the stress of caring for premature infants; this adds another layer of difficulty. From the study it is safe to conclude that there are many factors that may Influence PPD among neo-local migrant women, or any group of women at all, however, there can exist variability in findings owing to the difference in methods adopted, population being studied, location, etc. Therefore, to address issues related to PPD among a certain group of women, a data-informed policy approach should be the 'Go'.

The themes uncovered during data analysis include cultural and traditional postpartum rituals and family dynamics, among others. The experience of PPD among the study population is revealed to have been shaped by various socio-cultural factors, particularly the influence of traditional practices, family expectations, and cultural attitudes toward motherhood and mental health. These factors intersect in complex ways, significantly affecting the emotional and physical well-being of the new mothers. A closer examination reveals how traditional rituals, familial roles, and gendered expectations create an environment that both directly and indirectly contributes to the experience of PPD among the neo-local migrant women. Prominently identified socio-cultural factor influencing postpartum depressive symptoms was the imposition of traditional postpartum ritual practices. These practices in specific terms, include~~s~~ the "hot water therapy" and the forced consumption of lactation concoctions, which were described as "traumatic" by participants.

Deductively from interviews, while the practices are intended to promote recovery or "balance" in the body, it often results in physical discomfort and increased emotional distress. The participants in the study noted that these rituals, far from offering healing, caused severe headaches, sleepless nights, burnt, elevated blood pressure, and regrets of childbirth. The description of the physical aftermath of what a new mother belly becomes after the hot water therapy using a metaphoric phrase "balloon-like" by a participant illustrate the painful toll these practices took. Thereby, pointing at the disconnection between cultural expectations and individual health needs which consequently creates a sense of helplessness and frustration, compounding the emotional strain already present in the postpartum period for the neo-local migrant women.

IDI Responses

Interviewees recalled their experiences of the use of hot water for massage and how it made them feel. An interviewee said:

> For the hot water, it was too hot. There was even a time I got so dizzy in the bathroom. You know, I gave birth during hot season. It was only after the dizziness incident that my caregivers cautioned themselves and reduced the water hotness. The whole hot water thing was traumatic, it stressed me mentally… Another traditional practice that really messed up my head was the one that they forced me to drink the beans water they got from another household. It was a ritual that my husband people believe will help ensure my breast milk is healthy for my child. All these were alien to me being Fulani, but due to so much pressure and the fact that they won't stop saying I do not like my child, I had to drink the beans water.

(P06/32yrs/Fulani/O'Level/LOS: 10yrs/Vaginal Assisted/Self-employed/ EPDS: 19/ 2024)

Interviewee 2:

> The hot water does no good to anyone, all it does is make stomach very black, shrink in and start looking like balloon…I was better off without it…

(P01/27yrs/ Yoruba/B.Sc./LOS:3yrs/Vaginal Assisted/self-employed/EPDS:18/2024)

Interviewee 3:

> When I gave birth, I was pressured to use hot water to take my bath, like, very hot water ooo. The woman massaging my body with the water at the end of the day instructed me to sit on a very hot towel, which she already poured a much-boiled hot water on. I was like, ah! Mama, No! I can't! Last, last, I sha sat on it and ended up getting burnt. I got back home to start treating the burn, plus the fact that I got tears. It's not a nice experience.

(P07/28yrs/Yoruba/Bsc/Vaginal Assisted/self-employed/EPDS: 17/2024)

Interviewee 4:

> I wish they had told me before. Maybe, I would have been more prepared. I felt so overwhelmed by everything, but the hot water bath was the most stressful of them all, and sitting on hot potty. I was made to do it morning, afternoon, night, like, until I could tell that the heat had entered me well, I suffered!

(P03/25yrs/Yoruba/Bsc/Vaginal Assisted/ unemployed/EPDS: 15/2024)

Also, on the traditional postpartum practices is the pressure to adhere to cultural dietary restrictions during the postpartum period that further contributed to the sense of deprivation and discomfort. These dietary limitations reduced the enjoyment of meals and deprived the neo-local migrant women of essential nutrition and psychological comfort. The lack of flexibility in food choices, which is often rooted in cultural beliefs about what is "proper" for a new mother, was discovered to significantly impact both physical and mental well-being of the study population. Additionally, it observed that there was a forced adherence to these norms, which left little room for personal choice or relief, thereby causing a feeling of restriction and distress, and further contributing to the emotional burden of the postpartum experience as it was recalled by interviewees to have made them feel weakened and emotionally drained.

IDI Responses

> During pregnancy, I did not have any food I was asked not to eat, but after childbirth I was not allowed to eat bread, and was given more of Pap, Amala and sometimes Rice. They keep saying it's because of breastfeeding… I think I started eating all these things after I gave birth. I don't eat them before. Normally, I am not the type that eats so much and I don't really like pap that much, so after I gave birth, I was forced, practically forced to be eating all those food items. And if I eat little, they will tell me I am doing a bad thing to my child. They made me feel as if I haven't sacrificed enough for my child…at some point I questioned my decision of becoming a mother, and felt like, perhaps I am not old enough to be a mother.

(P03/25yrs/Yoruba/Bsc/Vaginal Assisted/ unemployed/EPDS: 15/2024)

Furthermore, societal expectations toward motherhood are another critical factor, which have been identified to shape mental health of neo-local migrant women in Ilorin. The responsibility of managing household tasks soon after childbirth, despite the physical exhaustion and mental strain that often accompany the postpartum period, was a major source of stress. This was observed as a socio-cultural factor that influenced PPD among most of the participants. There is a strong expectation from immediate society, and families, particularly the husband's, that these women should return to their domestic roles quickly after giving birth. The participants agreed that it can be overwhelming, as it ignores the reality of recovery and emotional adjustment after childbirth. For neo-local migrant women in Ilorin with postpartum depressive symptoms, this cultural attitude and expectation were noted to bring about feelings of burden, inadequacy and failure.

IDI Responses

> My mother-in-law wakes me up as early as 4:30a.m. because she wants to pray Tahajuud, when she was very much aware that I couldn't pray since I was still bleeding. She would ask me to prepare breakfast immediately, wash clothes, and even help with carrying of the water she used to bath the child, pick his clothes and what's not. The stress was too much. And in fact, there was a day my husband helped carry the waste in the house to dump on his

way to work, you need to see how my mother-in-law warned me to never let her son do that again, that it is my work as a woman.

(P01/27yrs/Yoruba/Bsc/LOS: 3yrs/Vaginal Assisted/self-employed/EPDS: 18/2024)

She also added in another statement:

During that period, I just felt I wasn't ready to be a mum, like, I shouldn't have done this to myself. Even though I know I haven't committed any crime. I was just trying to make sense of all that was happening to me.

Interviewee 2 similarly noted:

I felt pressured. I felt like I am not a good person, like, probably I wasn't ready to give birth. Or like I didn't have what it took to take care of my child.

She further narrated:

My husband was saying that my mother-in-law told him I was not eating, and he went to say, "Don't I know that my mom sacrificed to come all the way to Ilorin for me? That am I not supposed to do the same for my baby by eating?" Imagine! People expect that, okay oo, this is your child and you are supposed to sacrifice for her. You are supposed to love her. But for me, I feel like the child I just gave birth to, I'm just getting to know her. She is just a stranger, I am just getting to know her and I am also recovering. The love can't come immediately.

(P03/25yrs/Yoruba/Bsc/LOS; 13months/Vaginal Assisted/unemployed/EPDS: 15/2024)

Interviewee 3:

Where I come from, we don't do much for naming, all we do is slaughter ram and share. But here, it is complex and stressful. They keep sending me errand and my mother-in-law made me fetch water. I would carry big jerry can from a very long distance to fill big 2 drums in her house during naming, since we were there throughout the postpartum period. After childbirth I am not even allowed to use enough time in bathroom, I get scolded for taking my time to bath, my mother-in-law would tell me as a

mother I have to bath sharp sharp to attend to my baby. Even when I am eating, I am expected to keep rushing my food. I keep feeling pressured.

(P06/32yrs/Fulani/O'Level/LOS; 10yrs/Vaginal Assisted/Self-employed/EPDS: 24/2024)

She also narrated:

See ba, my mother-in-law made me wash my baby's pampers after use, I was made to remove the cotton wool part and wash. She instructed that I must wash it before I dispose it, saying that some fetish people do pick baby shit and use for ritual; this is so inconveniencing for me. I mean, pamper that I have used for days ooo, like, some self, maggots are already coming out of it.

Interviewee 4:

In Kaduna people do not really have issue, they are less concern about how you care for your child, but here, hmmm, they have stupid habits and high expectation. You can just be in a gathering and someone will just choose to start being Mothering police. They will start harassing and insulting how you dress for your child, question why your child is not eating, among other things. Like they will be insulting you as if they are perfect, which everybody is not. So, you know, such always make me think that I am not doing what I ought to do adequately.

(P07/28yrs/Yoruba/Bsc/LOS; 3yrs/Vaginal Assisted/self-employed/EPDS: 17/ 2024)

Interviewer 5:

What really affected me in terms of expectation was the fact that my caregivers here expected me to lose the baby fat I gained in less than 1 week after child birth, I mean, how?!!! The stitches are not even healed yet, everything is still fresh, but I am being told to try to lose weight. It really weighed me down because she was body shaming me.

(P04/24yrs/Yoruba/Bsc/LOS: 13months/CS Emergency/ Unemp loyed/EPDS:19/2024)

Additionally, under socio-cultural factors influencing PPD among neo-local migrant women in Ilorin is the theme, stigmatization. It is an embodiment of participants' narration of comments that dismissed the attempt of neolocal migrant women to be expressive about the mental distress they are going through, comments, or advices which were in fact considered by neo-local migrant women as hurtful, annoying, and unsolicited. Participants in the study reported that attempts to express mental distress were met with misunderstanding or dismissal. Hence, reflecting the societal invalidation of the emotional struggles of this group of women. Therefore, making them to endure hardship without complaining, and blamed for situation that really are beyond them.

This lack of understanding or empathy creates a sense of isolation which ushered in PPD among neo-local migrant women in Ilorin. New mothers interviewed narrated how they grew to remain silence, reduce expressiveness or what I would love to describe as 'bottling-up' because they are made to feel as though their pain is invisible or unworthy of attention, or of no big deal, this they attested drove the postpartum depressive symptoms in them, PPD, worsen the symptoms of PPD and also delayed recovery.

IDI Responses:

> Here in Ilorin, all I can say I noticed is that people most times use you secret against you. So, I have learnt to keep things to myself, because even when I told someone I took as friend, her response was that I should better be grateful to God for my child, that there are lot of people who are hoping to get a child and couldn't. I am really grateful but I am as well going through a lot and just want to let it out to feel at ease.

(P07/28yrs/Yoruba/B.Sc./LOS: 3yrs/Vaginal Assisted/self-employed/EPDS: 17/2024)

Interviewee 2 added:

> I just love keeping things to myself and not share with anyone, be it my husband, friends or even my mum. So, even when I could tell I am depressed I choose to keep it to myself. Better to have it within me than say it out and start getting judged. Because I am scared of feeling unheard, which I am sure will affect me more.

(P10/27Yrs/Nupe/B.Sc./LOS;14months/VoluntaryCs/Employed /EPDS:14/2024)

Interviewee 3:

> When I had my child, I was not lactating and my mother-in-law felt it was a problem. She made a statement that stood out for me, she said I might be Diseased. She said, like, you know, when you are not lactating, people do advice that you keep breastfeeding the child regardless that it helps to bring the milk out. But she forbids me to try that saying I should not come and give her grandchild a disease. I really felt bad with that comment honestly, in fact, it got to the point that I keep hitting my baby any time he cries, that was when it dawns on me that I am going through depression.

(P01/27yrs/Yoruba/B.Sc./LOS:3yrs/Vaginal Assisted/self-employed/EPDS: 18/2024)

Interviewee 4:

> For me, you know this orientation that Nigerians or let me say people, have for women that delivered through CS. That they will be like she did not go through the pain of pushing, pain of labour bla bla bla … it's bad!!!

(P04/24yrs/Yoruba/ B.Sc./LOS: 13months/CS Emergency/Unemployed/EPDS: 19/2024)

More-so, in examining the socio-cultural factors influencing PPD among neo-local migrant women in Ilorin, family dynamics emerge as another significant theme. This is as a result of narratives participants shared which reflected conflicting practices rooted in traditions unfamiliar to them. For instance, a participant described the expectation to name their child after a grandparent, a practice they did not recognise from their own familial backgrounds, and which affected her mental health negatively. She also recounted how her baby received tribal markings, justified by the assertion that "this is how we do it in our house." This same participant, though corroborated with another participant remarked also captured how the families' culture of going for social outing such as naming and weddings against their will while they were still recovering from childbirth impacted their health.

IDI Responses:

> Pertaining to what really get to me, it really related to my baby, like they gave her tribal marks, on her jaw, cheek, sha different part of her body. I really don't like it, and I was not even told that they will do that on her. If you look at my face, you will see that I also have tribal mark (points at her jaw), it is believed that it helps a child to grow teeth well, but honestly, if it is only the jaw it might not really make me break down, but going through all her body, I was so, so mad. At the end I was told 'that's how we do it in our house'.

She also revealed:

> What affected me seriously is going to parties, like going to parties that I am not even in the mood to go, yet I have to go, and when I get there, I have to work. There was a time I made comment about how tiring and frustrating it is, I only got reply like, and "ehnnn and you are doing it for your child." It was then I realised it's just their way of doing things here. Me, I don't like parties and I don't go to any when I dey my papa house.

(P02/35yrs/ Yoruba/ND/Vaginal Assisted/Self-employed/EPDS: 10/2024)

Interviewee 2 similarly said:

> I'm not a type that do attend occasions or go out, stuff like that. But, when I came over to Ilorin, it is a must for me to attend my husband's family's occasion, like any kind of occasion, it is a must, and I must be there very early, if I don't want issues. In fact, there was a time when my baby was purging and I really don't know how to go about it, I had to go to hospital, and this made me to be unable to attend an event that day. Kai!! They started insulting me, and all, saying that am I the only one that will first give birth to a child. It really made me cry. I felt sad because they were just adding to my problem.

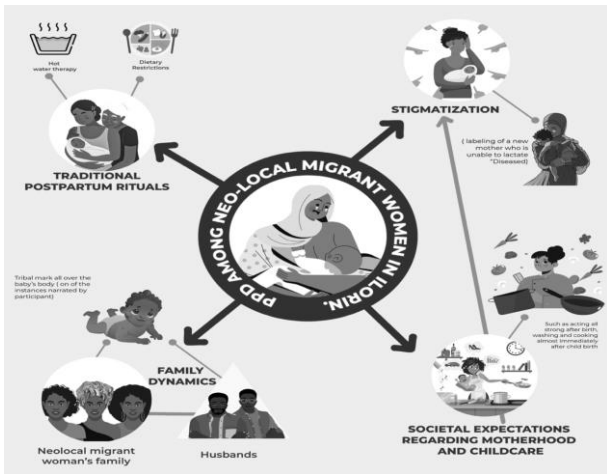
(P07/28yrs/ Yoruba/Bsc/LOS: 3yrs/Vaginal Assisted/self-employed/EPDS: 17/2024)

The neo-local (migrant) women often faced with unique challenges such as language barrier, discrimination, and social isolation, which can lead to inadequate social support, and reinforce the feeling of mistrust or role

confusion that consequently leads to PPD. For instance, going with one of the normal trends in internal migration in Nigeria which involves the movement from rural areas to an urban society, migrant women lose their sense of belonging and hence, have to struggle with the need to adapt to the new environment. This brings within them a feeling of inadequacy which is even worsened by the natural changes that occurs after childbirth, leading to a struggle to reconcile their new roles and responsibilities with pre-pregnancy identity.

In addition, the theory presents the understanding that there is a possibility that cultural norms emphasising the importance of motherhood in their new environment and the need to conform to some societal expectations contribute to PPD among neo-local women. Furthermore, the theory explains the link between migration and PPD. During the PP period, there is usually a reduction in the social support that migrant women gets.They can have one or both of their parents, friends, or relatives, away from where they migrated to, therefore, leading to being more vulnerable to PPD. In a study carried out in China among internal migrants, the findings revealed a positive association between reduced social ties and increased depressive symptoms (Qu, Qi, Wu, Yu, & Zhang, 2023).

Figure 1: *Socio-cultural Factors Influencing PPD among Neo-local Migrant Women in Ilorin*



Source: Fieldwork, 2024

Conclusion

The study revealed a high prevalence of PPD among neo-local migrant women in Ilorin, Kwara State, Nigeria. Also, from the study is the understanding of the socio-cultural context that influences PPD. In this light, responses from interviewees reveal factors such as traditional postpartum ritual practices, family and societal expectations regarding motherhood, stigmatization in different forms and family dynamics as umbrella factors that play active role in causing PPD among neo-local migrant women. While scenarios narrated were not exactly same in most cases, all participants agreed that their experiences affected their emotional well-being. The practices made them feel overwhelmed, brought upon them the feeling of isolation, regret, sadness, inadequacy, and despair. Also, most participants' experiences revealed how deeply ingrained cultural and familial practices negatively impact mental and physical health of neo-local migrant women, thereby, contributing to the onset of PPD in them. It is therefore safe to say that, postpartum care rituals though well-intentioned, present adverse impact on the new mothers, thereby aggravating symptoms of depression in them.

Also from the study, is the fact that there is complex intersect between the two themes; societal expectations on motherhood and stigmatisation. It was discovered that most neo-local migrant women are stigmatised mostly when they do not meet the societal expectations weaved around motherhood and childcare. These findings are in line with the finding in a study carried out by Albanese *et al.* (2020) in the United States to know the major risk factors for PPD, and it revealed how much of a causal factor it is, the judgment of new mother of not attaining the expected, and unrealistic standard of parenting. It was rightly capture in the study as the culture of "intensive mothering". Additionally, an observed active ingredient in the delicacies of socio-cultural factors influencing PPD among the neo-local migrant women was the pressure usage by caregivers and people around in order to make new mothers conform to the traditional PP practices such as the dietary restrictions, and harsh recovery practices. Not only does it make everything overwhelming, and psychologically straining, it also sharpened the sword of regret in the study population. Essentially, women during the postpartum period are quite vulnerable and the last thing they want to experience is feeling unheard or forced to conform.

Future studies on postpartum depression among neo-local migrant

women should consider inclusion of these women spouse, caregivers, and social networks in the study population to provide more comprehensive understanding of the factors influencing PPD. Thereby help to mitigate potential biases in self-reporting, and provide a more balanced understanding of factors that influences PPD among the study population. Nevertheless, this article makes a significant contribution to existing knowledge on PPD in Nigeria. It has generated knowledge about how socio-cultural factors affect neo-local migrant women. It further revealed how traditional rituals, have negative impacts on the mental health of new mother within the study group, society, how contradictions in the new mother family's values and that of caregivers influence PPD. It especially showed how failure to meet societal expectations births feeling of inadequacy in the study group, consequently ushering PPD. Finally, it is needed to say that postpartum care practices as a whole need to be rather adopted to meet unique needs of the new mothers rather than forcing single methods on all, regardless of how they feel about it. Likewise, there should be a sincere consideration of the unique cultural context of neolocal migrant women before providing them with care.

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