Postpartum depression in Jamaica: Exploring the lived experiences.

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https://doi.org/10.18297/etd/4107

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POSTPARTUM DEPRESSION IN JAMAICA: EXPLORING THE LIVED EXPERIENCES

By

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A Dissertation
Submitted to the Faculty of the
School of Public Health and Information Sciences of the University of Louisville
in Partial Fulfillment of the Requirements
for the Degree of

Doctor of Philosophy in Public Health Sciences

Department of Health Promotion and Behavioral Sciences
University of Louisville
Louisville, Kentucky

May 2023
POSTPARTUM DEPRESSION IN JAMAICA: EXPLORING THE LIVED EXPERIENCES

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March 31, 2023
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DEDICATION

This dissertation is dedicated to

My ancestors, my angels, my grandmother Orlinda Jabbar, my aunt Brenda Elmore, and my loved ones who continue to protect me along this journey. Whose prayers, works and love, I am a manifestation!

My Mom, Kenya Elmore
My Brother, Raheem Elmore
Thank you both for inspiring, encouraging, motivating, and loving me! I love and appreciate you both so much!

To all mothers, the foundation of all existence and creation, whom we all must credit for our ascension into this world and growth through life.

To the mothers of Jamaica, for your love, sacrifices, and inspiration for this study!
ACKNOWLEDGEMENTS

God is able to do exceedingly, abundantly above all that we ask or think, according to the power that works within us (*Ephesians 3:20*).

All praise and glory to God, who can do anything!! I am thankful to God for guiding me through an opportunity beyond my wildest dreams!! I thank God for all the grace, love, resources, support, protection, and divine favor through this journey!!

To my amazing committee, a group of phenomenal women, who I am honored to be a legacy! Dr. Brown, my advisor, dissertation chair, mentor — you have been everything to me in this process! I appreciate you always going above and beyond for me!! I cannot thank you enough for your time, wisdom, and love!! For always believing in me and advocating for me!! I honestly could not have done this without you!! Dr. Harris, you’ve been there for me from the start!! Thank you for your guidance and love throughout this process!! I appreciate you always checking in on me and encouraging me along the way!! Thank you!! Dr. Hines-Martin, I appreciate your advice and making sure I had the right qualitative skills and resources for this project and beyond! Thank you for your time, energy, and expertise!! Dr. Sterrett-Hong, thank you for your anchoring this study with your clinical expertise in mental health and making sure I understood more in this area!! Thank you for making space and time to be a part of this project!!
I am thankful for all my support in Jamaica!!! To the faculty and staff at the University of the West Indies- Mona, Caribbean Institute of Health Research (CAIHR) for accepting as a visiting scholar. Professor Marshall-Tulloch-Reid, Professor Susan Walker, Dr. Gillian Lowe, and Dr. Althea Bailey, who went above and beyond to help me on this project while in Jamaica. Thank you to the UHWI Well Child Staff. To Mrs. Paula Ann Porter-Jones, I cannot thank you enough for your love and kindness!!

Thank you to my family, friends, and loved ones!!! There are too many too list, but you know who you are, and I am deeply grateful for your love and support you provided throughout in numerous ways. I could not have done this without you all!!

Additionally thank you to my PhD cohort, SPHIS faculty, staff and students, University of Louisville Graduate School, Fulbright-Fogarty Scholars, Global Health Equity Scholars- University of Arizona, Southern Regional Education Board (SREB), and Mary Craik Foundation. Last, but certainly not least, Thank You to the 11 women who provided important and necessary information for maternal and mental health. You all are amazing, brave, and a motivation and inspiration to others!
ABSTRACT

POSTPARTUM DEPRESSION IN JAMAICA: EXPLORING THE LIVED EXPERIENCES

Shakeyrah Elmore, MS, CHES

March 31, 2023

The purpose of this study was to explore the lived experiences of Jamaican women with postpartum depression (PPD). It is estimated globally, postpartum depression impacts 10-20% of women. In Jamaica, rates exceed global averages, with 26-60% of women experiencing PPD. Untreated maternal depression poses a significant physical, social, and economic threat to Jamaican women, children, and society as a whole. This study affirms that maternal mental health and postpartum depression are global public health concerns.

There are limited studies that have examined PPD in Jamaican women, especially qualitatively. This research study utilized a qualitative descriptive approach to examine PPD experiences with eleven Jamaican mothers. Data was collected using individual semi-structured interviews with mothers in Kingston, Jamaica.

Key findings from this research study confirm that PPD exists in Jamaica, though experiences varied. Postpartum depression symptoms were influenced by maternal lived
experience including personal and children’s health concerns pregnancy to postpartum, and various stressors. Mothers in the study were generally undiagnosed and unaware of what postpartum depression was. Both PPD knowledge including the lack of or limited education/awareness and PPD perceptions including stigma impacted mothers’ identification with PPD and coping. The results, also reveal that the ability to manage or cope with PPD was connected to support. 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. Technological support such as apps and websites were described favorably by mothers in the study for practical support. Additionally, Jamaican women described a culture of coping which included beliefs, values, and practices related to religion/spirituality, strength/responsibility and gender imbalances experienced by mothers.

These findings indicate the need for strengthening social and economic supports for mothers. Practical implications for the study, recommend maternal and paternal support groups and more education related to maternal mental health issues within healthcare settings. Moreover, policies for maternity, paternity and family leave should continue to be offered and expanded in Jamaica. Future research focusing on holistic care, coping, and Jamaican mothers from various backgrounds including gender, diversity, disability, healthcare access, and life experiences is necessary.
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CHAPTER 1: INTRODUCTION

Introduction

Mental health is a critical part of our overall personal and societal health outcomes. Globally, issues in maternal mental health, primarily depression, pose a significant threat to mothers, children, and society in both human and economic costs (Atif et al., 2015; World Health Organization (WHO), 2016). Depression is the most common, serious health complication of pregnancy and childbirth (Atif et al., 2015; WHO, 2016). Globally, it is estimated that 10-20% of women who are pregnant or who have given birth experience maternal mental illness, primarily depression (Atif, 2015; Dadi, Miller, Bisetegn, et al., 2020; WHO, 2016). In Jamaica, rates of maternal depression exceed global averages, with 20-60% of women experiencing maternal depression (Bernard et al., 2018; Davidson 1972; Palmer 1996; Wissart et al., 2005). Postpartum depression is highly treatable, but many women are undiagnosed or untreated (Beck, 2006; Stuart, 2012). To better understand ways to address disparities that exist within postpartum depression in Jamaica, qualitative research is necessary to recognize how women identify, cope, and manage postpartum depression symptoms. This study utilized a 5-level social ecological and feminist theoretical framework to examine postpartum depression experiences. Intrapersonal/individual, interpersonal, community/institutional, public policy, and cultural factors related to maternal mental health experiences were examined. This research study sought to explore how these
various factors are actualized in the maternal and mental health experiences of Jamaican mothers to inform programs and policies to address PPD. To date, there has been a limited amount of research contributing to our understanding of maternal depression in Jamaica, especially qualitative research. Descriptive qualitative methods were used to examine the personal lived experiences of Jamaican women who have experienced postpartum depression. Individual in-depth interviews were conducted with mothers to explore how they identify, manage and cope with their postpartum depression experiences.

Jamaican women’s lived experiences of postpartum depression reveal sufficient ways to mitigate risk and increase protection. The ultimate goal of this study was to center Jamaican women’s voices and experiences within the area of maternal mental health and postpartum depression. Additionally, addressing maternal mental health informs sustainable solutions to equitable policies and interventions that seek to reduce health disparities amongst mothers in Jamaica. In summary, this research study is an important contribution to the body of research on postpartum depression and maternal mental health in Jamaican women.

**Statement of the Problem**

Maternal depression presents a significant health and economic risk. Maternal depression increases healthcare utilization and cost for both mother and baby, and risk for premature death (Slomian et al., 2019; Vliegen, Casalin, & Luyten, 2014). Additionally, symptoms of depression reduces quality of life, social relationships, and productivity in society, which further exacerbates social and economic disparities amongst mothers.
Maternal mental health issues have been associated with negative physical and psychological health outcomes for mothers, as well as infant and child health and development (Slomian et al., 2019; Vliegen, Casalin, & Luyten, 2014).

While there is no known cause of PPD, social ecological factors of maternal and mental health experiences are important predictors (Beck, 2001; Schaffir, 2016; Soma et al., 2016; Yim et al., 2015). Understanding risk and protective factors is imperative to improve health outcomes and reduce health disparities that exist for mothers. Often overlooked and stigmatized, prioritizing identification and treatment strategies is imperative.

Untreated maternal depression poses a significant physical, social, environmental, and economic threat to Jamaican women, children, and society as a whole (Bernard et al., 2018; Pan American Health Organization (PAHO), 2019). Investments in maternal mental health in Jamaica, can produce immediate social and economic returns (PAHO, 2019). Social returns in the form of improved health and well-being of individuals and the return of billions of dollars lost to the burden of this illness in society (PAHO, 2019; Wissart et al., 2005).

From a social ecological perspective, mental health disparities amongst Jamaican women are shaped by social and cultural factors. These include discrimination against women, community violence, and socioeconomic status, which are byproducts of larger social and economic systems and structures such as sexism and classism (Beck, 2002; Bernard et al., 2018; Kilanowski, 2017; Stewart et al., 2003). Postpartum depression research contributes to a larger goal to address fundamental issues of human rights.
Theoretical Foundation

The current research study is grounded in theoretical models that challenge power dynamics. These models center mothers’ experiences as an important and necessary inclusion in creating change and improving overall health outcomes in Jamaican women. Theoretical foundations for the study utilize postmodern feminist epistemology and the social ecological model.

Epistemology is the theory of knowledge and how people understand what they know (Ardovini-Brooker, 2002); what is known and how is it known (Anderson, 2020). Feminist epistemology examines the ways in which gender influences our interpretations and understanding of knowledge, theory, practices, and justification (Olesen, 2011). Contrary to traditional epistemologies, feminist epistemologies, describes women’s ways of knowing, women’s experiences, and women’s knowledge (Ardovini-Brooker, 2002; Olesen, 2011).

There are three basic feminist epistemologies including feminist standpoint, feminist empiricism, and feminist postmodernism (Anderson, 2020; Harding, 1991). Feminist standpoint epistemology represents the perspectives of women and applies the knowledge of oppression experienced by women towards social change (Anderson, 2020; Harding, 1991). Feminist empiricism is how scientific claims are justified and consist of data on women’s life experiences (Anderson, 2020; Harding, 1991). Feminist postmodernism, challenges patriarchal norms or sexist practices, and posits that gender is constructed through social and cultural factors, which can be disrupted or changed (Anderson, 2020; Harding, 1991).
The current study followed a postmodern feminist epistemological approach to examine the lived experiences of women with PPD. Lived experiences refers to women’s personal representation and knowledge based on direct experience, choices, perspective, intersecting identities, hierarchies, and history. (Collins, 2000; Guerrero Ramirez et al., 2022). Postmodern feminist researchers acknowledge that lived experiences are highly influenced by cultural meanings implicit in daily living (Ardovini-Brooker, 2002; Olesen, 2011).

This method of inquiry is useful in conjunction with the 5-level social ecological model presented by Golden and Wendel (2020) to describe the social and cultural influences on individual and interpersonal experiences. This model shifts from the biomedical focus of genetics and personal behaviors, which prioritizes the individual and interpersonal experiences; and shifts to a health equity focus, which prioritizes policies and structures that impact choice, knowledge, and access to resources (Golden & Wendel, 2020). The social ecological approach examines 5 levels of influence on health outcomes. These includes the individual level, interpersonal, community/institutional, policy, and cultural levels. The 5-level social ecological model is useful in conjunction with a feminist theoretical perspective to center mothers’ experiences, choices, and behaviors within context of social and cultural factors. This includes policies, practices, and beliefs in Jamaica.

Postmodern feminism and the social ecological model theoretical frameworks challenge injustices in women’s health. The social ecological model provides a strong framework to explore social and cultural factors that impact health outcomes. Researchers of feminist inquiry challenge dominating structures by researching oppression against
women (Ardovini-Brooker, 2002; Olesen, 2011). Utilizing feminist theory and the social ecological model in tandem, creates a transformative model of research. Feminism is unique, in that feminist epistemology, theory, methodology, and methods have similar goals toward gender equality compared to other research methods (Ardovini-Brooker, 2002).

Another important concept that anchors this study within feminist theory is intersectionality. A term coined by legal scholar Kimberle Crenshaw to describe how overlapping social identities interact to influence disadvantage, power, and privilege (Crenshaw 1991). In postmodern feminist frameworks, intersecting social experiences are important to acknowledge.

Feminist research and theoretical approaches require the researcher to situate themselves within the research, in that the researcher’s lived experience is an important aspect of how the research is conducted through planning and analysis (Ardovini-Brooker, 2002; Olesen, 2011). Feminist research is different in this way, compared to other theoretical approaches that promote the objective position of the researcher. The researcher’s orientation within this study is explained in the positionality statement, presented in the methodology section.

In summary, a feminist epistemological approach situated within the social ecological model is useful for the current research study. The combined model helps to better explain the impact that systems of power and injustice have on women’s health outcomes. The model also informs evidence to support a multisectoral response to addressing postpartum depression. Additionally, there is an urgency to address gender equity in global health research (UN Human Rights, 2021). Considering feminist
frameworks to address human rights issues related to gender equity and the social and cultural structures of society is important. The goal of adopting qualitative feminist methodology for this study was to validate and understand unique experiences of postpartum depression in Jamaica.

**Research Questions**

The aim of this study was to explore Jamaican women’s lived experiences with PPD. This included identification, management and coping with PPD. Descriptive qualitative research methods were used to answer the following research questions:

- Question: What are Jamaican women’s experiences with postpartum depression?
- Sub-question: How do Jamaican women manage and cope with postpartum depression?

**Rationale and Significance of the Study**

Given the severity of negative social and economic consequences associated with PPD, understanding women’s experiences in Jamaica is imperative. Postpartum depression negatively impacts women, children, and families presenting a social and economic burden on society. Understanding the lived experiences is imperative to improve health outcomes amongst mothers and children through targeted programs and policies.

This study sought to address a gap in the literature related to maternal mental illness and the experiences with PPD in Jamaican women. This study was significant
because it is the first of its kind to address this gap qualitatively. The value of understanding the personal lived experiences of women with PPD can be monumental in addressing the complexity of mental health issues. Additionally, centering the voices of women in Jamaica can begin a dialogue around significant social and cultural issues that contribute to PPD experiences. This research is aligned with the Jamaican government’s commitment to achieving health and gender equity, and the emerging emphasis on mental health (UN Human Rights, 2021). Improved knowledge in this area is imperative and essential to protecting maternal and child health outcomes and the investment in achieving long-term, sustainable changes. The results of the study will help researchers, practitioners, and the community better understand how Jamaican women identify, manage and cope with PPD.
CHAPTER 2: OVERVIEW OF THE LITERATURE

Maternal Mental Health

Maternal mental illness remains a global public health concern. Globally, it is estimated that 10-20% of women who are pregnant or who have given birth experience maternal mental illness, primarily depression (Atif et al., 2015; Dadi, Miller, Bisetegn, et al., 2020; World Health Organization (WHO), 2016). Maternal depression is the most common obstetric morbidity globally (Atif et al., 2015; WHO, 2016). The rates of depression amongst women living in low to middle income countries are higher than those in high income countries, with some populations experiencing rates as high as 65% for postpartum depression (Biaggi et al., 2016; Dadi, Miller, Bisetegn, et al., 2020; WHO, 2016).

Maternal mental health is an important area of public health because it includes emotional, psychological, and social well-being in current and expecting mothers (Centers for Disease Control and Prevention (CDC), 2018; CDC, 2020). While, maternal mental illness or disorders focuses on conditions that affect the mother’s thinking, feeling, mood, or behavior (CDC, 2018; Postpartum Support International (PSI), 2021; Yeaton-Massey & Herrero, 2019). These could include both short and long-term perinatal illnesses such as depression, anxiety, bipolar disorder, or psychosis (PSI, 2021; Yeaton-Massey & Herrero, 2019).
It is also important to recognize the impact of stress, particularly distress during the perinatal period. There is no criteria or diagnosis for when stress becomes clinically significant, except for post-traumatic stress or adjustment disorders (Phillips, 2009). Stress is frequently listed within the criteria as a symptom or marker for other disorders such as depression, anxiety, sleep, or personality disorders in the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) 5th edition and The International Classification of Diseases (ICD) 10th edition, both of which are considered the ‘gold standard’ for mental illness diagnosis (Phillips, 2009; Wilson et al., 2019). Inconsistent and varied definitions make it difficult for practitioners to include stress as a disorder or illness (Phillips, 2009). Nevertheless, distress plays a significant role in maternal mental health and birth outcomes (Miller et al., 2006; Wilson et al., 2019).

**Maternal Depression**

While stress as a symptom or marker is present in all mothers, the most recognized maternal mental illness is depression (American College of Obstetricians and Gynecologists (ACOG), 2018b; PSI, 2021; Yeaton-Massey & Herrero, 2019). Depression is the leading cause of disability among women of reproductive age and one of the most common serious medical complications during pregnancy and postpartum (ACOG, 2018b; Ferrari et al., 2013; PSI, 2021).

Currently, the ICD, 10th edition (ICD-10), which is utilized internationally classifies maternal depression as depression associated with the puerperium period, onset within 6 weeks after birth (Cox, 2004; WHO, 1992; Wisner et al., 2010). The DSM, 5th edition (DSM-5), which is utilized primarily in the U.S defines maternal depression as a
Major Depressive Disorder with peripartum onset, which includes onset of depression during pregnancy, up until 4 weeks after birth (American Psychiatric Association (APA), 2013; Wisner et al., 2010; Wisner et al, 2013). This only differs from a Major Depressive Disorder, due to the maternal specifier and timeframe. The clinical definition excludes anyone outside of this timeframe within the specifier for example new mothers who experience these symptoms after 6 weeks and beyond are not considered clinically to have postpartum depression according to the DSM-5 or ICD-10 (APA, 2013; WHO, 1992).

Addressing more clear definitions, including the timing of PPD is an important area of discussion. Researchers and organizations have proposed revisions to expand the clinical time of onset to up to 3-6 months (Cox, 2004; PSI, 2013; Wisner et al., 2010). Other researchers and organizations support that maternal depression can develop up to one year after childbirth (ACOG, 2015; CDC, 2020; PSI, 2021), and a recent study from the National Institutes of Health support that women may experience depressive symptoms up to 3 years after childbirth (Putnik et al., 2020). Men and non-biological parents can also experience postpartum depression, which broadly categorizes the disorder as depression experienced after the birth or adoption of a child (Paulson & Bazemore, 2010; Yeaton-Massey & Herrero, 2019). The DSM and ICD are considered the ‘gold standard’ for diagnosis of mental illness; however, definitions vary greatly from researchers and organization in the field of maternal mental health, whose results and findings are contrary to clinical definitions.

Additionally, clinical definitions do not offer a distinction between depression which occurs during or after pregnancy. Maternal depression can be further broken down
by time of onset from pregnancy to childbirth. Broadly, perinatal depression includes 
depression symptoms experienced during and after pregnancy (National Institute of 
Mental Health (NIMH), 2021). While depression symptoms during pregnancy are 
commonly defined as antenatal, antepartum, or prenatal depression, depression symptoms 
after birth are commonly defined as postpartum or postnatal depression (NIMH, 2021; 
PSI, 2021).

This study will focus on postpartum depression, because most women are 
diagnosed after childbirth (Wisner et al, 2013). The postpartum period, sometimes known 
as the “fourth trimester” is the most critical period to determine long term health 
outcomes for both mother and baby (Paladine et al., 2019). Additionally, during the 
postpartum period, mothers have the added stress of caring for a newborn, which can be a 
time of high vulnerability (Zauderer, 2009).

Postpartum Depression

Postpartum depression (PPD) can be further categorized based on time of onset 
and severity. Baby blues is commonly present within the first couple of weeks after 
giving birth and usually subsides within the first few weeks after birth without formal 
treatment (NIMH, 2021). Depression after childbirth can be thought to exist on a 
continuum based on time of onset and severity, ranging from mild to severe (NIMH, 
2021).

Baby blues and PPD share a number of the same symptoms and are sometimes 
difficult to distinguish. These illnesses differ in the time of onset after birth, how long the 
symptoms last, the intensity of symptoms, and the necessity of formal treatment to
resolve. These aspects are longer, and more intense in PPD, and may require some type of formal treatment to resolve symptoms (NIMH, 2021).

**Symptoms**

Both baby blues and PPD present an array of symptoms postpartum including, but not limited to, issues with sleep, mood or mood swings, crying, difficulty bonding with the baby, withdrawal from family and friends, loss of interest in activities, changes in appetite, overwhelming fatigue or loss of energy, irritability and anger, fear and feelings of inadequacy, shame, guilt, worthlessness, or hopelessness, cognitive changes such as diminished ability to think clearly, concentrate or make decisions, anxiety and panic attacks (MayoClinic, 2018; NIMH, 2021). These symptoms are milder and seen less in those experiencing baby blues as opposed to those experiencing PPD. In more severe cases these symptoms are seen in addition to more critical symptoms such as suicidal tendencies, hallucinations or thoughts and attempts of harming oneself or your child (NIMH, 2021). This is known as postpartum psychosis and accompanies other symptoms such as confusion and disorientation, obsessive thoughts about the baby, delusions, excessive energy, agitation, and paranoia (Mayo Clinic, 2018; NIMH, 2021).

The length of time women experience postpartum depression symptoms varies based on a variety of different factors (Cooper & Murray, 1998; Vliegen, Casalin, & Luyten, 2014). Some researchers suggest PPD can be resolved within weeks to years (Vliegen, Casalin, & Luyten, 2014). One review examining the course of PPD amongst various studies, found PPD symptoms improve over time, and many cases resolve within 3-6 months after onset (Vliegen, Casalin, & Luyten, 2014). However, various studies found several women who had symptoms beyond 6 months, even lasting as long as 3.5
years after onset, with anywhere from 30-50% of women experiencing symptoms beyond one year (Vliegen, Casalin, & Luyten, 2014). Given the timeline of PPD, with onset and recovery, women can potentially be dealing with postpartum depression years after childbirth (PSI, 2021; Vliegen, Casalin, & Luyten, 2014). Some research studies have even examined the impact of postpartum depression 7-12 years after childbirth (Campbell, Matestic, et al., 2007; Campbell, Morgan-Lopez, et al., 2009). For some women, this experience can become a chronic long-term issue (Campbell, Morgan-Lopez, et al., 2009; Vliegen, Casalin, & Luyten, 2014). These timeframes are based on various risk factors of the illness as well as an individual’s decision to manage and ability to cope (Holden et al., 1989; Vliegen, Casalin, & Luyten, 2014; Vliegen, Casalin, Luyten, Docx, et al., 2013). It is important to note that the research examining these timeframes are scarce and varied, so continuous research in this area is important to understand points of vulnerability for women and the complexity of risk factors, particularly social factors, life course history and treatment including coping strategies (Vliegen, Casalin, & Luyten, 2014). Depressed mothers are not a homogenous group, and careful consideration of varying experiences is necessary (Vliegen, Casalin, & Luyten, 2014). Additionally, these symptoms can present themselves prior to or at the same time as other mental health conditions including anxiety, obsessive-compulsive disorder, or post-traumatic stress disorder, which can make it difficult to distinguish or isolate PPD and the course of the experience (Howard & Khalifeh, 2020; Vliegen, Casalin, & Luyten, 2014; Yeaton-Massey & Herrero, 2019). This is why examining risk factors and causation within disease outcomes are important.
Risk Factors

The social ecological model is helpful in describing risk factors. The social ecological model also known as the ecological perspective is useful in examining multiple factors at various levels that influence disease outcomes (Sallis et al., 2008). This approach takes on a holistic view of health by emphasizing the interaction between and the interdependence of factors both within and across all levels of a health outcome (Golden & Wendel, 2020; McLeRoy et al., 1988). Public health has a goal of achieving health equity and this model, begins to navigate in that direction for various health behaviors and interventions (Golden & Wendel, 2020; McLeRoy et al., 1988).

Additionally, utilizing the model to address PPD frames the study to focus on social and cultural aspects of maternal mental health, as opposed to focusing solely on biomedical or individual level factors (Golden & Earp, 2012; Golden & Wendel, 2020; Thompson & Fox, 2010). There is significant evidence to support that individual choice and behaviors result from social and cultural factors such policies, structures and systems that direct behavior, knowledge, and access (Golden & Wendel, 2020; Sallis et al., 2008). While impacting change at the social and cultural levels may prove to be difficult, it is imperative to address in PPD (Braveman & Gottlieb, 2014; Golden & Earp, 2012). Thinking more broadly about contexts and multi-levels of influence can expand how we think about health and the mechanisms in which we use to change it (Golden & Wendel, 2020). It is necessary to address these levels to prevent and treat PPD. (McLeRoy et al., 1988; Thompson & Fox, 2010).

There is no single cause of PPD, so the social ecological model is useful framework to describe how risk and protective factors at various levels influence the
likelihood and expression of postpartum depression (Thompson & Fox, 2010). The current study will utilize the 5 level sociological model adapted by Golden (2019) to examine factors related to PPD. The levels of this model include intrapersonal/individual, interpersonal, community/organizational/institutional, public policy, and cultural factors.

*Intrapersonal/Individual level factors*

The strongest predictors of PPD are commonly present on the intra- and interpersonal levels. Certain factors are significant predictors that directly influence the likelihood of experiencing PPD, as well as the severity of the experience (Mayo Clinic, 2018; Vliegen, Casalin, & Luyten, 2014; Yim et al., 2015). The intrapersonal level, also known as the individual level, is the innermost layer of the model (Golden, 2019). Individual level factors include personal characteristics, knowledge, attitude, beliefs, and history (McLeroy et al., 1988). Significant individual factors related to PPD include pregnancy and postpartum changes such as hormonal imbalances, psychological factors including history of depression (personal or family), stress, and coping (Beck, 2001; Schaffir, 2016; Soma et al., 2016; Yim et al., 2015).

*Interpersonal level factors*

Interpersonal level factors are directly related to an individual’s social networks (McLeroy et al., 1988). Significant interpersonal level factors are social supports, including support or lack thereof from the women’s spouse, the child’s father, family, friends, co-workers, neighbors, congregation, community, amongst other social entities women are connected to (O’Hara, 1994; O’Hara & Swain, 1996). Social support is one of the single most important factors in postpartum depression experiences (Kim et al., 2014; O’Hara, 1994; Stewart et al., 2003).
Community/institutional level factors

The most immediate impact on intra and interpersonal level factors are community or institutional level factors. Different social ecological models, use these terms interchangeably, along with organizational level factors, and have been used both as separate and collective factors related to health (McLeroy et al., 1988). This level collectively described resources, standards, and networks of individuals and groups that influence women’s postpartum experiences within community and institutions (Werner et al., 2015). Institutions include hospitals, social service organizations, workplaces, and schools, who are positioned to implement strategies and policies that can both prevent and treat women experiencing PPD (Stewart et al., 2003; Werner et al., 2015).

Policy level

The policy level is the fourth level in this model (Golden, 2019). Policies and laws are very critical as they have significant influence on both supporting and restricting actions and practices that contribute to prevention or management of individual behaviors (Golden, 2019; McLeroy et al., 1988). Policies in relation to PPD include those that directly impact identification and treatment, but also more broadly those that indirectly increase risk for PPD (Rhodes & Segre, 2013; UN Human Rights, 2021).

Cultural factors

The outermost layer of the social ecological model presented for this study is culture (Golden, 2019). This model is unique in adding the outer layer to focus on culture. This emphasizes the influence of macro-level, cultural systems that are important for progress toward health equity (Chandra et al., 2017; Golden, 2019). The model posits that in order to reverse the widespread impact of unnatural causes of inequity and health
disparities, we must start with the cultural influence, interrogating shared norms, power
dynamics, beliefs, histories, values, biases, perceptions, behaviors, and practices
(Adelman, 2007; Amankwaa, 2003b; Golden 2019). This is particularly important for
public health research to widen the lens to create more innovative solutions to complex
health issues (Golden and Wendel, 2020). While the traditional model and adaptations
include cultural factors, these are often loosely grouped within other layers of the model
depending on the health outcome being studied (Golden 2019; Kilanowski, 2017;
McLeroy et al., 1988).

Cultural factors are important to understand PPD, particularly ideals and beliefs
about depression, the definition and etiology of depression, treatment/cop ing and
behaviors and practices related to PPD, which dictates the expression of the disease
(Amankwaa, 2003b; Bina, 2008). The exploration of familial and gender roles, and
societal expectations of mothering help to explain how culture influences maternal
experiences and childrearing (Amankwaa, 2003b). In addition, cultural stigma associated
with mental illness, cultural values of women, and practices of discrimination support the
argument that discrimination against women in its many forms highly influences PPD;
which has both direct and indirect consequences for women, children, and society as a
whole (Arthur et al., 2010; Bina, 2008; Gibson et al, 2008). Cultural factors are
interconnected (Amankwaa, 2003b).

**Consequences**

Despite what the causes may be for postpartum depression, with various and
extensive symptoms, these disorders can be debilitating and have critical consequences if
not properly addressed (Ghaedrahmati et al., 2017; Mayo Clinic, 2018). Postpartum depression is the most common obstetric complication however, rates are highly underdiagnosed, underreported, and left untreated (CDC, 2020; Earls et al., 2010; Sit & Wisner, 2009). More than half of the women with PPD go undetected due to a number of factors, and of those who are diagnosed a significant number are untreated (CDC, 2020; Ko et al., 2017).

**Individual level consequences**

Evidence shows that if left untreated maternal mental illness can negatively impact the mother psychologically and physiologically (March of Dimes, 2019; Sit & Wisner, 2009; Slomian et al., 2019). Maternal depression impacts the quality of life in women, functional capacity, and could lead to chronic depression later in life (March of Dimes, 2019; WHO, 2009). Mothers often experience physical health issues associated with PPD. These experiences of PPD, can also be a precursor to risky behaviors including increased substance abuse (Chapman and Wu, 2013).

**Interpersonal level consequences**

The mother’s illness can also lead to adverse health outcomes in infants and children. This may include a disruption in mother-baby bonding, breastfeeding activities, sleeping, and eating patterns in babies, physical, cognitive, and social developmental delays, and maltreatment in children (Madlala & Kassier, 2017; Sit & Wisner, 2009; Slomian et al., 2019; WHO 2019). Studies have also found children, whose mothers experienced PPD were more likely to have behavioral issues, impairment in the stress response, impeded brain development, and depression as an adolescent (Madlala & Kassier, 2017; Netsi et al., 2018). These consequences are higher and more severe in
mothers and children from low socioeconomic backgrounds (Campbell, Morgan-Lopez, et al., 2009; Garfield et al., 2015; Marquez & Dutta, 2018).

Another significant consequence, which can have additive impacts on children’s experiences with postpartum depression, is depression amongst fathers (Lewis et al., 2017; Ramchandani et al., 2008). A meta-analysis examining approximately 28,000 participants across 43 studies found about one in ten men experience PPD (Paulson & Bazemore, 2010). However, the rates of PPD amongst men within the first year after childbirth can vary widely from 1-25% (Goodman, 2004). While the literature is limited on PPD studies amongst men, there is sufficient evidence to support that PPD in fathers is also a growing public health concern (Lewis et al., 2017; Paulson & Bazemore, 2010). A significant predictor of fathers with PPD is when the child’s mother has PPD, which has been shown to impact these experiences and relationships (Edward et al., 2015; Gray et al., 2018; Paulson & Bazemore, 2010). A qualitative study exploring the experiences of men whose partners had postpartum depression found that men articulated the significant impact of their partner’s PPD experience on their own health outcomes (Ierardi et al., 2019). This is an important concern because fathers play a significant role in maternal and child mental health experiences (Lewis et al., 2017; Pihlakoski et al., 2013). PPD experiences in both parents could lead to the interference of daily activities and responsibilities for partners and their families, as well as negative parenting behaviors (Lewis et al., 2017; Mayo Clinic, 2018).

Social consequences

Untreated PPD increases social and economic disparities globally (Patel et al., 2016; Sit and Wisner, 2009; Stein et al., 2014). The economic burden of PPD is estimated
to be billions of dollars in excess healthcare costs and loss of productivity (Epperson et al., 2020; Mathematica, 2019; Luca et al., 2020). Though there are limited estimations of the economic burden of PPD, depression specifically accounts for the highest global burden of disability (Greenberg et al. 2015). These economic costs both for PPD and depression can be attributed to direct healthcare and pharmaceutical costs for mothers, children, and families impacted by depression (Chisholm et al., 2016; Greenberg et al. 2015). Additionally work related costs including unemployment, disability, absenteeism (missed days of work), and presenteeism (loss of productivity), were important economic and social burdens associated with depression, attributing to trillions of dollars globally (Birnbaum et al., 2010; Chisholm et al., 2016; Greenberg et al. 2015; Kessler, 2012; Patel et al., 2016). Moreover, a recent *Lancet Commission report* on mental health estimates mental health globally is on the rise and global economic cost is expected to reach $16 trillion dollars by 2030 (Patel et al., 2016). Studies support the need to scale up investments in mental health including maternal mental health, which shows significant returns on the investment in economic and social returns (Chisholm et al., 2016). Treatment and prevention of maternal mental illness could have a monumental impact on the social and economic health and well-being of women, children, and society as a whole (Chisholm et al., 2016; Sit and Wisner, 2009).

*Treatment and Coping*

The most common treatment options for PPD from the literature on the topic include psychotherapy/talk therapy, and more recently interpersonal psychotherapy, and medication (Mayo Clinic, 2018; Stuart, 2012). One article discusses psychotherapy being a preferred choice over medication due to the infant’s exposure (Stuart, 2012). Emerging
Researchers and organizations have focused efforts on screening protocols and recommendations to conduct these throughout pregnancy and after childbirth multiple times so that changes are recognized sooner (ACOG, 2018b; Earls et al., 2010; Siu et al., 2016; Yeaton-Massey & Herrero, 2019). This is very important because a significant number of women are missed due to lack of screening, and even though treatment is important the ACOG suggests screening alone can have clinical benefits for women (ACOG, 2018b; Bauman et al., 2020).

There are limited studies that address coping strategies related to postpartum depression. Women’s ability to cope is an important indicator of postpartum experiences, especially with risk factors such as abuse, chronic stress, severe life events, and other experiences that women must cope with during pregnancy and after childbirth (Demyttenaere et al., 1995; Biaggi et al., 2016; Ghaedrahmati et al., 2017). Positive coping serves as an important protective factor for women experiencing maternal depression (Doucet & Letourneau, 2009; Gutiérrez-Zotes et al., 2015). Additionally, negative coping can worsen symptoms of maternal depression (Azale et al., 2018).

Jamaican women and postpartum depression

Jamaican women experience high levels of depression both during pregnancy and postpartum (Bernard et al., 2018; Wissart et al., 2005). Antenatal depression, a significant predictor of postpartum depression, was reported in more than 20-60% of Jamaican women across four studies (Bernard et al., 2018; Davidson 1972; Pottinger et al., 2009; Wissart et al., 2005). Postpartum depression in Jamaican women was approximately 26-60% (Davidson 1972; Palmer, 1996; Wissart et al., 2005). Studies conducted on maternal
depression amongst Jamaican women have been mainly quantitative in nature. (Bernard et al., 2018; Wissart et al., 2005).

Though limited research has been conducted on the issue in Jamaica, these studies provide evidence that there is a significant risk for maternal depression in Jamaica. Additionally, these studies reveal that social factors are significant risk factors for maternal mental health experiences in Jamaica (Bernard et al., 2018; Davidson 1972). Significant risk factors included socioeconomic status, with studies indicating low income, education, unemployment, and financial difficulties were associated with depression, and violence including domestic, sexual, and physical (Bernard et al., 2018; Davidson 1972; Pottinger et al., 2009). Consistent with global research on maternal depression, perceived social support was a significant factor in women’s experiences in Jamaica, which served as a protective factor (Bernard et al., 2018). It is important to note that risk and protective factors amongst Jamaican women have to be explored in tandem, because the interconnectedness of these different factors on their experience both increase vulnerability, but also could serve to mitigate risk (Bernard et al., 2018). Research examining these factors in Jamaican women is necessary, given the high vulnerability of depression. Currently, there have been no peer-reviewed studies on maternal depression in Jamaica that utilize qualitative methods. However, in 2019 students at the University of West Indies-Mona created a documentary to explore PPD in Jamaican women (Lewis, 2019). This documentary revealed that postpartum depression was highly under and undiagnosed in Jamaican women, and that many women were not even aware of what postpartum depression was (Lewis, 2019). It is important to conduct
this research to understand Jamaican women’s personal experiences with PPD symptoms, and understand how they identify, manage and cope with their experience.

Culture and PPD in Jamaican women

Exploring culture in terms of maternal and mental health experiences in Jamaica is imperative to understanding PPD in mothers. Cultural factors including relationships, gender roles amongst men and women, and stigma are important aspects to consider in PPD experiences (Amankwaa, 2003b; Bernard et al., 2018). Here we can appreciate the fluidity of the social ecological model in understanding the complexity of this issue, and the impact of culture on individual experiences (Golden, 2019).

In Jamaica, relationships play a significant role in maternal mental health experiences. The variability of sexual and social relationships between men and women is important to consider in PPD experiences in Jamaican women (Bernard et al., 2018; Leo-Rhynie, 1993). According to Leo-Rhynie (1993), there are three common relationship structures in Jamaica. First is the most common, the visiting relationship. This type of relationship occurs when partners reside at different residences as it is not uncommon for partners in this type of union to see other people.

This relationship type is the most unstable of the three, and children are commonly born into these unions in Jamaica (Roopnarine, 2004). Visiting relationships can sometimes evolve into common law unions, where partners live together but they are not legally married; and the final type of relationship is the legally married (Evans & Davies 1994; Leo-Rhynie, 1993). Relationship status was predictive of PPD and women in polygamous relationships or those who experienced infidelity were more likely to also
experience PPD (Bernard et al., 2018). Furthermore, relationship quality was found to be an important indicator of PPD in both Jamaican men and women (Bernard et al., 2018; Gray et al., 2018). As well as social support, particularly the lack thereof was indicative of depression symptoms in both men and women in Jamaica (Gray et al., 2018).

The variability in relationships contributes to unplanned pregnancies and women playing significant roles in child-rearing (Roopnarine, 2004). These are both significant risk factors for maternal mental health experiences (Bernard et al., 2018). Due to the changing nature of relationships, men often are expected to serve a financial role, but due to economic restraints this is often difficult (Roopnarine, 2013).

The Women’s Health Survey in Jamaica found women’s perspectives on gender roles were varied. The Women’s Health Survey in Jamaica, a study published by the Statistical Institute of Jamaica, Inter-American Development Bank, and the United Nations Entity for Gender Equality and the Empowerment of Women, provided important information on reproductive and women’s health, attitudes towards gender roles, and experience with violence with intimate partners and non-partners.

Related to gender roles most women in the survey agreed with the statements that it is natural (God-intended) that a man should be the head of his family and that a woman’s main role is to take care of the home, 77.4% and 70.2 respectively (Watson Williams, 2018). While approximately one third agreed that a wife should obey her husband even if she disagrees with him and similarly the wife is obligated to have sex with her husband whenever he wants (except when she is sick or menstruating) (Watson Williams, 2018). Traditional ideals about gender roles are deeply rooted in Jamaican culture, and confirms the complexity of gender equity (Watson Williams, 2018).
Another important cultural consideration in Jamaica is stigma. Understanding the cultural acceptance of mental health issues is imperative. Mental health issues in Jamaica is highly stigmatized, some people even indicate discomfort around people who are mentally ill (Arthur et al., 2010; Gibson et al, 2008). Strategic plans are necessary to create campaigns and information to educate individuals about mental health and to normalize seeking help for mental health issues including PPD (Arthur et al., 2010; Gibson et al, 2008; Hickling et al., 2011).

*Maternal Health and Social Factors*

Cultural factors are a part of larger social factors that contribute to individual health outcomes (Golden, 2019). Social factors include social determinants of health (U.S. Office of Disease Prevention and Health Promotion, 2020). Social determinants of health are the social conditions in which people live, work, play, worship, and age, this includes environmental, healthcare, education, economic, and social factors that impact health outcomes (U.S. Office of Disease Prevention and Health Promotion, 2020). Social determinants of health are byproducts of broader social and economic issues that are rooted in historical, structural, and systemic inequities on the bases of race, gender, and income (Artiga, 2020; Hood et al., 2016). Research shows that social determinants of health are the primary drivers of health, accounting for more than 80% of modifiable contributions to health outcomes, more important than biological and clinical factors (Hood et al., 2016). There are significant social determinants of health or social stressors in Jamaica that influence women’s experiences with PPD. Social stressors are deeply rooted in gender inequality, racism/colorism, and power dynamics amongst men and
women, influencing underlying social and economic inequities in Jamaica (Kelly & Bailey, 2018; UN Women, n.d.).

Underlying social and cultural norms contribute to gender-based violence (Amnesty International, 2006; Brown, 2018; Watson Williams, 2018). Violence against women and girls (VAWG) is one of the most prevalent and inhumane issues of human rights globally (Sardinha et al., 2022). VAWG impacts millions of women and girls all over the world on a daily basis, contributing to serious physical, emotional, economic, and psychological consequences (Sardinha et al., 2022). A global call to action to address this issue is outlined in the United Nations, Sustainable Development Goals (SDG). The SDGs were adopted by the United Nations General Assembly in September 2015 and look to 2030 for improvement on global health issues (United Nations, n.d). The United Nations, Sustainable Development Goal (SDG) 5, specifically calls to action the global challenge to achieve gender equality. The first two objectives address VAWG directly, with the goals to “5.1 End all forms of discrimination against all women and girls everywhere and 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation”, while additional targets impact VAWG indirectly (United Nations, n.d).

UN Women, the branch of the United Nations that specifically addresses advocacy of gender equality and women’s empowerment defines “Violence against women and girls as any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women and girls, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life. Violence against women and girls encompasses, but is not limited to,
There are various forms of violence, the most common form in Jamaica is domestic violence, also known as domestic abuse or intimate partner violence and femicide (UN Women, n.d.; UN Women, 2018). Domestic violence includes behaviors that are used to gain or maintain power and/or control within a domestic partnership, which includes physical, sexual, emotional, economic, and psychological actions or threats (UN Women n.d.; Watson Williams, 2018). Femicide is the intentional murder of women based on their gender and in Jamaica usually includes situations with intimate partners (UN Women, n.d.).

Femicide in Jamaica has remained amongst the top 3 highest in the world and has been steadily rising since 2014 (Amnesty International, 2006; UN Office on Drugs and Crime, 2021). In Jamaica, approximately 30% of women experience physical and/or sexual violence in their lifetime (Amnesty International, 2006; Watson Williams, 2018). In addition to experiences of psychological, emotional, and/or economic violence including dependency or deprivation, ranging from 8.5-28.8% of Jamaican women across various demographics (Amnesty International, 2006; UN Women, 2018; Watson Williams, 2018). Sexual assault is the second leading cause of injury in Jamaican women (Crawford et al, 2014; UN Women, n.d.). Additionally, abused women in Jamaica experience injuries, some of which results in death or the need for medical care (Crawford et al, 2014; UN Women, n.d.). Another consideration is the attitudes towards, sexual violence, in The Women’s Health survey approximately 16% of women felt that female rape victims had contributed in some way to being raped (Watson Williams,

The Women’s Health survey found that pregnant women were at risk to experience physical abuse, even during pregnancy (Watson Williams, 2018). Pregnant women are also at an increased risk for femicide (WHO & PAHO, 2012). Violence has also been associated with an increase in reproductive problems and short- and long-term mental health issues (Crawford et al, 2014; Lacey et al., 2016). Evidence supports that violent experiences amongst Jamaican women contribute to maternal mental health experiences (Bernard et al, 2018).

Sexual based violence also influences unintended pregnancy, which is approximately 70% in Jamaica women, and 87% in adolescents (Amnesty International, 2006), this is a significant risk factor in postpartum depression experiences (Mayo Clinic, 2018). Additionally, women who are victims of Intimate Partner Violence (IPV) and have children, are more likely to return to an abusive relationship for the sake of their children, adversely impacting mental health experiences in women and children (Watson Williams, 2018).

Another important social factor is socioeconomic status. Socioeconomic status both exacerbates and contributes to PPD, with women of lower income and education being more likely to experience PPD (Bernard et al, 2018). As well as consequences of PPD increases the economic and social burden on individuals and families (Bernard et al, 2018). One study found that women with partners who were less educated and unemployed, were more likely to be victims of violence (UN Women, 2018). Gender-
based violence and maternal health disparities amongst Jamaican women span across education and income levels (Amnesty International, 2006).

Violence against women and the impact on maternal mental health, places an enormous burden on the financial and human resources of the health care facilities and the national economy, costing billions of dollars globally and in Jamaica (Epperson et al., 2020; Mathematica, 2019; The Gleaner-Jamaica, 2020a; Ward et al., 2009). Additionally, while mental health services are underfunded, the government as of last year has cut funding related to mental health services in Jamaica, posing an additional threat for women seeking maternal mental health services (PAHO, 2019; The Gleaner-Jamaica, 2020a).

In summary, the literature examining maternal mental health and PPD both globally and in Jamaica, shows an emerging public health concern. The condition, PPD in its identification, diagnosis, and treatment can be very complex and multifaceted. Individual, interpersonal, and social factors for Jamaican women influence the increased rates of PPD in Jamaica. The necessity to address these various factors and the impact on maternal mental health is imperative. Interpersonal and social factors are presented to create context in which individual level experiences exist. The current study focused on women’s personal experiences with PPD, including individual level factors such as knowledge, attitudes, beliefs, history, behaviors, and practices that influence how they experience, manage and cope with their symptoms and experiences of PPD. The current research study used qualitative methodology to better understand the lived experiences of Jamaican women with PPD.
CHAPTER 3: METHODOLOGY

The purpose of the study was to explore Jamaican women’s experiences with PPD. Qualitative research methods were determined to be the most appropriate to facilitate the exploration of women’s experiences with PPD. This chapter explains the qualitative methodological approaches utilized to understand the experiences and coping strategies of women in Jamaica with PPD.

Country Profile

Figure 1: Map of Jamaica
Jamaica is the third largest English-speaking country in the Caribbean. The democratic island, which was previously ruled by the Spanish and British, gained independence in 1962 (Jamaica Information Services, 2019; McNish, 2002). Today, Jamaica is home to nearly 3 million people, and the population has been steadily growing over the last 65 years (United Nations Department of Economic and Social Affairs, Population Division, 2019). In Jamaica, the population growth is due to a combination of births, deaths, and migration (which includes both immigrations, of individuals coming into Jamaica, and emigration for Jamaicans moving to other countries). Table 1 below shows the annual births, deaths, and migration in Jamaica from 2014-2019 (Statistical Institute of Jamaica, 2019). It is also important to note that deaths include infant and maternal deaths, but the data on these figures have not been consistent in relation to reporting (Statistical Institute of Jamaica, 2019).

Table 1: Annual births, deaths and migration in Jamaica

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<tbody>
<tr>
<td>Births</td>
<td>36,996</td>
<td>37,900</td>
<td>36,160</td>
<td>34,423</td>
<td>34,209</td>
<td>34,632</td>
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<tr>
<td>Deaths</td>
<td>19,557</td>
<td>19,249</td>
<td>19,761</td>
<td>19,661</td>
<td>19,762</td>
<td>18,233</td>
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<tr>
<td>Migration</td>
<td>-15,252</td>
<td>-14,926</td>
<td>-14,296</td>
<td>-10,647</td>
<td>-9,474</td>
<td>-11,775</td>
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In 2019 males accounted for approximately 49.5% and females 50.5% of the population. (Statistical Institute of Jamaica, 2019). Geographically the island is divided into 14 parishes within 3 counties and there are two main urban cities: Kingston, the island’s capital, located on the Southeast, and Montego Bay, located on the Northwest sections of the island (Statistical Institute of Jamaica, 2019). This study focused on recruitment in the city of Kingston. In Jamaica, the population is more than 90% Black,
the remaining inhabitants identify as European, Asian (primarily East Indian or Chinese), mixed race, or other (Statistical Institute of Jamaica, 2012).

Race in Jamaica is deeply rooted in the country’s history of slavery and colonialism (Kelly, 2020; Kelly & Bailey, 2018; Klein, 1978). The transatlantic slave trade which brought Africans to Jamaica and other areas in the Americas and Caribbean from the 16th to 19th centuries, was one of the most inhumane and cruel systems of economic growth in Jamaica (Burnard & Morgan, 2001; Lewis, n.d.).

The British Slavery Abolition Act of 1833, abolished slavery in 1834, however many slaves were not free until 1838, and even after many faced economic and social burdens after being released (Bolland, 1981; "Slave trade legislation”, 1833). Jamaica gained independence in 1962, but the lasting impact for Black Jamaicans after slavery and colonialism is evident (Kelly, 2019; Mcnish, 2002).

In a predominantly Black country, some may argue race is not an issue in Jamaica. However, researchers challenge this notion by showing that colorism in Jamaica during slavery and present-day was/is associated with social inequality, with Black, dark-skinned individuals experiencing more disparities (Kelly, 2019; Kelly, 2020; Kelly & Bailey, 2018). Furthermore, colorism in Jamaica, has been associated with social mobility, and the desire to be lighter which has led to harmful practices such as skin bleaching for example (Altink, 2019; Charles, 2003). Skin bleaching has been associated with low self-esteem, abuse, and depression (Charles, 2003; James et al., 2016). While this study does not specifically address colorism or the long-term impacts of slavery, these health inequities are important to note in context.
Another important aspect of Jamaica is religion and spirituality, which is an inextricable part of Jamaican society. The majority of the country’s religious affiliation includes Christianity from a variety of denominations, Judaism, Hinduism, Buddhism, Islam and Rastafarianism, are also represented across the island (World Atlas, 2018). Christianity is a major part of Jamaican culture, but it is important to discuss Rastafarianism. This religion and sociocultural movement started in Jamaica, in the 1930s and is still active today (Buisseret et al., 2021). Those who identify as Rastas, form a small proportion of the population (less than 2%), but the religion/movement is important to discuss because of its historical and present influence on Jamaica’s culture and social and political climate (Buisseret et al., 2021). Considering the sociocultural, historical, and religious context helps to better understand PPD experiences in Jamaican women. The research design used approaches and methods that support the exploration of PPD in relation to the social and cultural experiences in Jamaica.

**Research Design**

This study utilized a descriptive qualitative approach to examine Jamaican women’s experiences with PPD. Descriptive qualitative methodology recognizes the varied shared experiences and the nature of human interactions and engagement (Lincoln & Guba, 1985; Sandelowski, 2000). The purpose of utilizing this methodology in the current study was to describe and contribute to our understanding of various experiences with PPD.

Descriptive qualitative methodology is most appropriate to describe varied experiences, in which the topic is emerging or has little to no history, as it provides a
descriptive summary of the phenomenon (Sandelowski, 2000). Examining different experiences of PPD, helps to better understand cultural and social factors that influence PPD. Additionally capturing the range of experiences in relation to mental health is essential. Qualitative research is necessary to facilitate a deeper understanding of PPD.

It is important the research findings are reflective of the women’s experience in Jamaica. Further it is important to understand that this reflection is still being interpreted by the researcher. The researcher in practice must understand what the participants are describing as their understanding of their experiences, or simply put the researcher interprets the participant’s interpretations of their personal experiences of postpartum depression (Sutton & Austin, 2015). This creates a duality for the researcher but is essential in qualitative methodology (Sutton & Austin, 2015).

The current study used a descriptive qualitative method to describe and understand the experiences of Jamaican women who have experienced PPD. This study gained a deeper interpretation of how Jamaican women have experienced PPD as it relates to their diagnosis (self-reported or clinical) and coping. Drawing from a feminist epistemological assumption and descriptive framework, this study utilized sampling and recruitment methods that centered women’s experiences. Feminist theoretical perspectives are used as an attempt to decolonize the research process by acknowledging that women know and understand their own bodies and experiences without clinical oversight related to their experiences, diagnosis, or coping/treatment (Evans-Winters, 2019). Descriptive qualitative methods utilize various data collection and analysis strategies to facilitate participants to draw knowledge from their experiences (Kim et al., 2017).
Inclusion/Exclusion

The study sample included Jamaican women between the ages of 18-49, who speak English and have experienced postpartum depression (self-reported or clinical), with a recent childbirth 6 weeks to 3 years postpartum. Participants were excluded if they did not meet these factors listed above, if they were currently pregnant, and/or experiencing a mental health crisis or suicidal ideation (as determined by the prescreening eligibility, see Appendix B).

The ages of 18-49 were chosen to encompass adult women within reproductive age. The postpartum timeline was selected based on the variability of onset and recovery of PPD. Onset of PPD usually occurs, with most women receiving a diagnosis within 6 weeks to 1 year, however symptoms can take more than 3 years to resolve, but some women will see symptoms improve within 3-6 months (CDC, 2020; PSI, 2021; Vliegen, Casalin, & Luyten, 2014). These timelines are varied based on a variety of factors and there is no standard experience or course for postpartum depression (Vliegen, Casalin, & Luyten, 2014). The target population was chosen, based on 6 weeks to 3 years postpartum, because women are more likely to have received a diagnosis or acknowledge their experience. Additionally, this timeline clearly distinguishes baby blues, and women who may have begun taking steps to resolve their PPD. We recruited women who felt they were in a ‘good’ mental state. Women who were experiencing a current mental health crisis or suicidal ideation (self-reported), were excluded. This inclusion/exclusion criteria protected women from worsening their symptoms if applicable, particularly because the researcher is not a licensed or trained psychologist. Lastly currently pregnant
women were excluded, due to the differences in prenatal and postpartum experiences in mental health.

Both participants and non-participants, were offered a resource guide. The resource guide, compiled by researchers in maternal and child health in Jamaica outlined relevant contacts and information for local organizations, hospitals, and clinics. It was decided by the research team, that if during the interview a participant was in distress, they would be offered emergency services or assistance with contacting a relative, or friend. There was also support staff, including a clinically trained psychiatrist on call to assist with these potential issues. None of the participants in the study needed to utilize either of these services. There were women who completed the pre-screening questionnaire that were offered follow up and/or emergency services.

Participant recruitment/sampling

A purposive sampling strategy was utilized to identify potential study participants. The selected strategy identified potential study participants who provided information-rich cases in relationship to the study topic (Creswell 2013). Criterion sampling was used to select only individuals who were best suited to speak on the personal experience of PPD (Creswell 2013). The researchers purposely recruited women who met the criteria described in the inclusion/exclusion section above. This included Jamaican women, over the age of 18, who are currently 6 weeks to 3 years postpartum, who have a clinical or self-reported diagnosis of PPD, and who are not currently pregnant or experiencing a mental health crisis.
Researchers utilized in-person and virtual recruitment strategies, including flyers distributed in-person and on social media. Women were able to enroll in the study in-person or online. Additionally, women had the option to call or email, as flyers included the researcher’s contact information, telephone number and email.

Paper screening questionnaires were distributed in-person to check eligibility for the study. Additionally, interested individuals also had the option to use an online data collection system, Qualtrics, accessed through a link on the flyer. Individuals who met the criteria were invited to participate in the study. Individuals who agreed to participate received detailed information on the study verbally and written through a review of the informed consent and data privacy forms.

The prescreening eligibility questions (Appendix B) were informed by the diagnostic criteria for PPD as described in the DSM-5 and ICD-10, as well as widely used PPD screening tools including the Edinburgh Postnatal Depression Scale (EPDS) and Patient Health Questionnaire-9 (PHQ-9) (APA, 2013; Cox & Holden, 1987; Kroenke et al., 2001; Levis, 2020; WHO, 1992). Standardized PPD scales were chosen not to be utilized because the limitations associated with using a standardized scale for the target population. This includes capturing current and past experiences of PPD. Additionally the historical use of standardized PPD scales in healthcare or community in this population is limited. Lastly, it was not the researcher's intention to diagnose women with PPD. In all, prescreening questions were considered sufficient for this study.

Utilizing symptom-based questions allowed for the participant to describe their experience more freely, because women were self-selected into the study this was an important aspect. Lastly, there is still work to be done about what qualifies as a ‘normal’
part of motherhood and what is abnormal and requires attention. Even more difficult is that these two are not necessarily mutually exclusive, therefore understanding women’s experiences and knowledge helps us to better understand these differences in PPD experiences.

In summary, a purposeful sampling technique was employed using criterion sampling methods to better understand postpartum depression in Jamaican women. Due to the nature of the study, women recruited for the study, completed a brief pre-screening questionnaire to determine eligibility. The researcher recruited from a variety of locations, to get a range of experiences of women from various backgrounds. Recruitment took place at both clinical and community sites, though the primary recruitment site was the University Hospital of the West Indies (UHWI). Snowball sampling and word of mouth recruitment included the researcher receiving calls and/or text from perspective participants.

**Sample size**

In qualitative research, less emphasis is placed on sample size, as the researcher is more concerned with the depth of the information included (Creswell, 2013). However, acknowledging and justifying sampling decisions is an essential aspect of data results in qualitative research (Vasileiou et al., 2018). Descriptive qualitative research recruitment can include a range of participants to describe their experiences, and sample sizes are highly variable (Creswell, 2013; Kim et al., 2017; Vasileiou et al., 2018). To ensure adequate information was gained from the participants, data collection continued until
data saturation occurred, where additional interviews no longer yielded new insights or information (Fusch & Ness, 2015; Glaser & Strauss, 1967).

Data collection

Qualitative data collection activities extends with the purpose of collecting rich and accurate data related to the topic (Sutton & Austin, 2015). Data collection included the use of in-depth, semi-structured interviews, which is a common effective method in qualitative studies (Creswell, 2013; Kim et al., 2017). The use of in-depth, semi-structured interviews allows the researcher to gain a better understanding of women’s experiences and perceptions of PPD using open-ended questions. The researcher used the interview protocol (Appendix C) to engage participants. The interview protocol was developed using the study’s proposed research questions, to ensure interview questions reflected the study’s primary objectives.

In qualitative descriptive methodology, interview questions capture experiences and knowledge about the issue. The study included 60-90 minute interviews to engage women with PPD experiences. In addition to core research questions on women’s experiences, demographic information including age, relationship status, level of education, employment, and number of children was collected during the research interview. This data provided useful information on sociodemographic factors that influence PPD experiences in Jamaica. These factors were summarized in the final analysis.

The interview protocol is an important tool to allow the researcher to organize thoughts and ideas, and ensures the researcher is going into the interview with a
determined purpose to understand the participant (Jamshed, 2014). Adequate spacing was provided after each question to record written notes. This ensured the research had logistical structures in place to record notes in the event the audio recorder failed and also a place to capture non-verbal observations and field notes. Notes may be partial or incomplete, because of the difficulty of asking questions, listening, and capturing written notes (Creswell 2013). It is important to note that qualitative interviews require the researcher to be a good listener. Interview questions were asked after the researcher set the tone of the interview by making the participant feel comfortable and to gain rapport. This is important in that one challenge of interviewing can be engaging with participants who have difficulty opening up or speaking about their experiences (Creswell, 2013).

The interview protocol was reviewed and edited by faculty members at the University of the West Indies-Mona, maternal health nurses, and a mental health professional. The instrument was piloted with a potential study participant to ascertain if the flow of questions and prompts were effective. Following the pilot interview, modifications were made as necessary. The pilot test data was not included in the final analysis.

Participants were given the option to select the location in which they felt most comfortable conducting the interview. The researcher recommended the selection of the location be private and safe. Participants’ preferences for the interview date, time, and location were highly considered, however safe and comfortable alternatives were provided as necessary. Safety measures were put into place through an agreed upon plan by the researchers, including safety check-ins prior to entering and exiting fieldwork. Specifics about the interview date, time, and location (i.e., the name of the building and
details about the room) were recorded in the field notes. If face-to-face interviews were not possible, the interview took place over Zoom, the approved video platform for the study. A field notes template (Appendix D) was used to capture observations and notes after each interview for the current study for both in-person and virtual interviews.

Qualitative research utilizing multiple data sources is a common strategy to create a fuller picture of the issue (Creswell, 2013). Timeline mapping was used to aid in recall and managing emotions through the interview. Timeline mapping is a qualitative research method that provides visual representation related to experiences, usually conducted during an interview (Marshall, 2017). Timeline mapping is particularly useful for sensitive and complex topics such as postpartum depression (Amankwaa, 2003a; Marshall, 2017). This technique also provides participants a way to engage with their stories, help create meaning, and be an anchor to their experiences (Amankwaa, 2003a; Kolar et al., 2015; Marshall, 2017; Pell et al., 2020). This strategy works to minimize distress that may be experienced during the interview, ensures participants know they are the navigator of their experiences, and builds rapport with the participants (Kolar et al., 2015). For the proposed study, timeline mapping was offered during the interview.

Participants for in-person interviews were given paper and a writing instrument, those for virtual interviews were asked to get these materials on their own. Participants were given this as an optional tool and instructed to draw a timeline if desired as it related to certain research questions. Participants were given instructions on ‘how’ to draw the timeline and it was left open to the participant. Most participants chose not to engage in this method and spoke freely about their experiences in reference to time periods. Timeline maps were not included in the final analysis of this study. Participants were allowed to
keep their papers. Other data sources, in addition to interviews and timeline maps in this study, included field notes, memos, photos, journals, and other relevant documents and items.

Training

Before data collection began, the researcher met with a qualitative researcher in Jamaica to review cultural instruction related to interviewing. Cultural instruction consisted of training which focused on culturally acceptable research practices. Additionally, the meeting addressed cultural competence and cultural humility. Cultural competence and cultural humility are related concepts that describe the process of understanding, interacting, self-evaluating and critiquing cultures that are different than your own on the basis of race, social and familial statuses, experiences, and other culture underpinnings, and is a very important practice in public health research (Betancourt et al., 2003; Tervalon & Murray-Garcia, 1998). This meeting was a specific step undertaken by the researcher to ensure findings and results are based on the experiences of the participants.

The researcher regularly met and engaged with community and health personnel in the mental and maternal health sectors. This included volunteering and observing at the University of West Indies Hospital in the well child and antenatal clinics. Additionally, the researcher met and spoke with individuals of interest to the research. This included multiple researchers in the maternal, child, and mental health sectors, psychiatrists, psychologists, primary care physicians, obstetrician/gynecologists, nurses, a doula/midwife, a natural healer specializing in maternal child health, and members of
parliament in Jamaica. This also included the researcher identifying and engaging with community members and mothers throughout the research project.

Data analysis

This study used a thematic analysis with phenomenological techniques. Thematic analysis is useful in qualitative research to identify themes and to analyze and interpret patterns of meaning (Braun & Clark, 2006). Thematic analysis is used in conjunction with phenomenological techniques to focus on participants subjective experiences and to make sense of the data from the position of the participant (Chang & Wang, 2021; Guest et al., 2012). Phenomenological techniques as a feminist researcher were used to describe mothers’ experiences rather than provide explanation. Transcendental phenomenological techniques were used to examine the researcher’s position, in that biases and preconceptions were continually evaluated and bracketed (Neubauer, Witkop, & Varpio, 2019).

After the data was transcribed verbatim, by a university approved transcription service in Jamaica, data analysis began. The first step in this analysis included bracketing. Bracketing required the researcher to bracket out their preconceptions and biases before beginning data analysis (Moustakas, 1994). Memos were used to bracket out the researcher’s thoughts and ideals related to the topic and study data. The analytic process of this study included multiple cycles of review, coding, and evaluation of the data. The researcher begin by completing an initial review of the transcript. After the initial review, the transcript was re-read for clarity, and common words and patterns were noted by the researcher. After each transcript was read over multiple times, the researcher begin with open coding followed by focus coding to begin to identify and select emerging themes.
and subthemes from the data. Coding followed three cycles, which included broad codes then the second cycle reduced these codes even further, the final stage resulted in the core essence of the study participant’s responses, that the data was narrowed into themes. Codes were continually added and reviewed through the data collection process.

The computer-assisted qualitative analysis software, Dedoose, was used for data management and analysis. Focused codes were transferred to the software Dedoose and collapsed into families and themes with descriptions. Dedoose was used to strengthen data analysis and not as the fundamental coding source. The final codebook contained in the Dedoose software, included the final study themes with their associated codes. This included a description of final study themes, and a description of each code.

**Rigor in qualitative research**

Rigor in qualitative research is essential to safeguard qualitative research results and interpretations, in that specific steps are taken to ensure the meanings, perceptions, and beliefs of participants are accurate in the context in which they are written and reported (Lincoln & Guba, 1985). One important aspect is trustworthiness (Lincoln & Guba, 1985). Trustworthiness described in qualitative research was imperative to ensure rigor of the current research study in data collection and analysis. Four dimensions of trustworthiness are outlined in qualitative research including credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Credibility activities in the current research study included peer debriefing. Peer debriefing is a technique used to increase credibility of the research study and involves the researcher engaging with a peer, not connected to the research to continually examine
the researchers’ inquiries throughout the process (Lincoln & Guba, 1985). This process serves to enhance the researcher’s positionality to the study by continually questioning the researcher’s intention, biases, and experiences throughout the process, as well as a basis to begin to identify emerging themes and meanings (Lincoln & Guba, 1985). Additionally, the debriefer can serve to help the researcher cope with emotions, feelings, and conclusions that might arise from the study (Lincoln & Guba, 1985). For the current study, the researcher identified multiple peer debriefers. Each encounter with a peer debriefer was captured. This included memoing and journaling after each debrief session. The memos and journals served the purpose to record what was learned from each session, how this information was to be used to move forward in the research process, and why inquiries emerged the way that they did. These accounts were utilized in the audit trail described in more detail within the confirmability section.

In qualitative research to establish transferability, the researcher can provide the thick description necessary to provide interested individuals with the context and concepts of the topic to draw conclusions on whether transfer of data is possible (Lincoln & Guba, 1985; Merriam, 1988). For the current study, thick description of the data was provided to address transferability. The thick description included a detailed report of the participants and the context/setting in which the research was conducted. This also included a description of the activities undertaken by the researcher and participants including reporting on their actions and physical representations in the research. Lastly, emphasis was given to provide detailed information on the participant’s voices and experiences. Descriptions were compiled using study findings as well as field notes and other informal methods of collection that provide deeper meanings to these descriptions.
For the current study, dependability was established through source triangulation (Lincoln & Guba, 1985). The study used multiple sources of data including multiple interviews, field notes, timeline maps, documents, and other relevant artifacts. As multiple sources of data were collected and analyzed, steps were taken to validate each of the sources against one another, as no single item would be sufficient unless it can be triangulated (Lincoln & Guba, 1985). Triangulation of these data sources was used to provide a fuller picture of PPD in Jamaica.

An audit trail was established to provide verification of study processes and accuracy of the data, (Lincoln and Guba, 1985). The audit trail is replicable and traceable by others, in the processes that were undertaken by the researcher (Lincoln and Guba, 1985). For this study the audit trail consist of memos and journals by the researcher to capture daily activities, challenges, project and methodological changes, personal events, emotions/feelings throughout the process, and overall experiences.

**Positionality**

In continuing to address rigor in qualitative research, it is important to consider the researchers positionality, as described within the context of trustworthiness. It is important that for the accurate interpretations of results, interested readers must be able to identify the researcher’s context. Additionally, responsible qualitative researchers continually examine their subjectivity and positionality throughout the research process, as lived experiences and perceptions change regularly. While subjectivity is considered one of the weaknesses of qualitative research by some quantitative researchers, qualitative researchers consider this a strength (Ratner, 2002).
Research situated in feminist theoretical frameworks posits that the researcher is an essential part of the research study and therefore complete objectivity is not possible (Ardovini-Brooker, 2002). In feminist research and qualitative methodology in general, the researchers lived experiences, values, biases, and prejudices are an integral part of how the research is conducted, analyzed, and later disseminated (Ardovini-Brooker, 2002; Creswell 2013). In acknowledging this, it is imperative the researcher explicitly state their position within and motivations for conducting the research. This is important for global health researchers, who have a responsibility to address and examine their position to the research within a global context, especially research in low and middle income countries (Gautier et al., 2018; Snounu, 2021).

As a global mental health researcher, it was important that I first acknowledge my position to this topic within my own experiences. My curiosity to engage in the area of mental health came from my own experiences of grief and chronic stress. In addition to seeking to better understand my own experiences as a Black woman in the United States and the societal pressures facing certain groups due to power dynamics and injustices that place a level of mental stressors for African populations across the diaspora.

I first became interested in global health, through my international travels to Asia and Africa, and it was here I further begin to question the health impacts of global racism, sexism, and classism. Particularly the apparent health disparities and inequities which exist for African populations across the diaspora, especially for Black women across the globe, whose oppressions are integrally linked to their health outcomes. It was important for me to peel back the layers in understanding the direct and indirect impact on mental health experiences for Black women globally. I begin to critically research these systemic
health disparities. In this search, it became clear that there were severe gaps in understanding of mental health globally, especially for marginalized and vulnerable populations. I became passionate about pursuing research to address this gap by centering the voices of women. So, this research to focus on maternal mental health in a country within the Caribbean became an extension of this focus to address mental health in African women across the diaspora. Mothers and infants are central and integral to our society. We all use the process of birth to get here and have to transition from infants to adults, so the protection of these groups, equates literally to the protection of our future. Moreover, as a feminist, I feel indebted to the cause of feminism to support research, interventions, and policies that support gender equity. I believe it is important to be a part of the necessary deconstruction of systems and norms that give root and rise to injustices amongst women globally. This is a human rights issue, that calls for immediate change.

The research study was completed as a part of a Fulbright-Fogarty Fellowship award received by the researcher in Fall 2021. The partnership between the Fulbright Program, administered by the Department of State’s Bureau of Educational and Cultural Affairs, and the Fogarty International Center of the U.S. National Institutes of Health is an expansion of international public health research. The decision to pursue the Fulbright-Fogarty award came from a cumulation of experiences, and my interest and passion to address global maternal health and mental health disparities. Learning about the partnership and opportunity made me excited to be a part of a necessary and huge gap to addressing maternal and mental health. Additionally, to be a part of a distinguished group of alumni who have changed the world in the global health sector is an honor.
The University of the West Indies Mona Campus was listed as one of the 2021-2022 institutional partners for the Fulbright-Fogarty award. Prior to applying for the award, I had no prior affiliation with the University of the West Indies. I had also never been to Jamaica.

Building a relationship with the institution and host country, began early on during the application process and continued after being accepted for the award in June 2021. Lastly, the partnership with the Global Health Equity Scholars, connected researchers from the University of Arizona to the project, to which I also had no prior affiliation.

I am an “outsider” and “insider” to this research in various ways. Though I have no Jamaican heritage, I identify as Black/African-American, my shared heritage as a Black woman in a global context presented “insider” privilege to some extent, but being born in the United States, and having lived there all my life made me an “outsider”. At the time of this study, I had never had children or been pregnant, which makes me an “outsider” to maternal experiences. As a foreign researcher from the United States being an outsider and insider can equally pose both privilege and limitations within various contexts. These privileges and limitations were documented and shared throughout the research process. By mapping my positionality and engaging in this reflexive exercise I affirm that I am situated within my research and not a passive, objective witness to it. I aim to be as transparent with my readers and research participants as possible.
Ethical Considerations

This study sought ethical approval from the University of Louisville Institutional Review Board and the University of West Indies Mona Campus Research Ethics Committee, in Fall 2021/Spring 2022. In addition to approval from these ethics’ boards, permission was sought from individual recruitment sites including maternal and child health clinics and women’s organizations. Ethical considerations were an important aspect of the study.

Informed consent

Participants agreed to participate in the study by signing an informed consent form. Participants were assessed for understanding of the research project and what it entailed before they were asked to sign the informed consent form. Additionally, each participant received verbal and written information regarding their right to withdraw from the research study at any point during data collection through data analysis. If participants decided to withdraw from the study, the information they provided would have been removed. Participation in the study was completely voluntary. Participants were given ample time to ask questions regarding their participation or any concerns they may have had.

Given the nature of the research project, participants were informed that if they express intent to harm themselves, others, or their children, and/or if there was verbalization of suicidal intentions there is a duty to report according to Jamaican law. In such cases, emergency psychiatric care may have been required, and the principal investigator would have contacted the local authorities who would contact the emergency
department of the local mental health institution. There were no instances where this needed to occur.

**Data storage**

Safeguarding and securing research data in qualitative research is imperative and is especially important with regards to sensitive topics (Baez, 2002; Kaiser, 2009). Protecting participants personal information and maintaining the integrity of the data to provide a rich description is essential, but can be difficult (Kaiser, 2009; Saunders et al., 2015). Careful consideration was taken in this study. Due to the sensitive nature of the topic, all participants were given pseudonyms to ensure confidentiality during each stage of the research process including data collection, analysis, and dissemination. All interviews were transcribed verbatim by a professional transcription service in Jamaica and analyzed by the principal investigator. All data including digital recordings, interview notes, consent forms, and recruitment/contact information are stored on secured encrypted USB key and backed up on a secured, university approved data storage service. Consent forms were collected digitally for most participants, paper consent forms were digitized and stored with all the other data. No personal identifying information will be used within any dissemination activities including presentations and publications. All data and analysis are only accessible by the principal investigator and individuals cleared by the ethics committees described above. Analysis of the data was conducted in both Jamaica and the United States. When traveling from one country to another, the USB key traveled on person at all times with the principal investigator. This data will be kept for seven years after which time the data will be destroyed by deletion.
Minimizing Risks

Potential risks involved in this research study include emotional and/or psychological risks or potential breach of confidentiality. Deliberate steps were taken to protect emotional distress and confidentiality. There may have been feelings of discomfort, and/or distress in relation to emotions that came out during the interview. To reduce these possible risks the researcher employed sensitive research techniques and provided a resource guide that was given to participants after the interview.

Additionally, steps were taken before the interview to ensure the researcher was equipped with the skills to engage should distress occur during an interview. The researcher engaged with a mental health professional before recruitment and through data collection to ensure the proper steps would be taken. To address the risk of confidentiality of the data, specific steps were taken by the research team. Data that included identifying information were de-identified and placed on a secure encrypted USB key and backed up on a secure university approved data storage service.

Benefits

While there may not be any direct benefits to participants involved in this research, findings from the study can provide useful information. This information could be helpful to others, and to create knowledge about Jamaican women’s experience with postpartum depression. Additionally, participants in past qualitative studies of postpartum depression in Black women, report the interview may be therapeutic (Jackson, 2015). The information gained in this study may lead to an improvement in the health of Jamaican
women, especially as it relates to maternal mental health including programs, policies, and laws for Jamaican women.

**Human Subjects Protection**

This study was conducted according to the rules and regulations of the Institutional Review Board at the University of Louisville, the University of West Indies Mona Campus Research Ethics Committee, and in accordance with state and federal agencies. All participation was strictly voluntary and those involved were not asked to change any of their daily activities. Once data was collected and transcribed the complete dataset was de-identified.
CHAPTER 4: RESULTS

Introduction

This chapter summarizes the results of this study, which includes descriptions of the study site/location, participants, and study themes. The results outline the study’s primary objective to better understand Jamaican women’s experiences with postpartum depression. Study themes include ‘Maternal Lived Experience’, ‘Postpartum Depression’, ‘Support’, and ‘Culture of Coping’. The goal of the study was to center mothers’ voices in this area of maternal mental health research to inform support for programs, organizations and policies that benefit Jamaican mothers, children, and families.

This section includes quotes from mothers in Jamaica. The quotes were written verbatim by a professional Jamaican transcription service. Quotes include patois, the local language. Translations into standard American English are provided for this paper. English translations are bracketed under the original quote.

Description of study site and location

Most of the research activities for this study took place in the city of Kingston, Jamaica within the parishes of St. Andrew and Kingston, located on the southeast region of the island. All participants from the study were recruited within the city of Kingston.
Recruitment took place at both clinical and community sites, though the bulk of participants were recruited from the University Hospital of the West Indies (UHWI) in Kingston, Jamaica, St. Andrew parish. Interviews were held virtually or in-person in the city of Kingston on the University of the West Indies Mona campus at the Caribbean Institute for Health Research (CAIHR).

Description of study participants

Eleven (11) mothers participated in the study. A total of 75 mothers completed the prescreening eligibility. A total of 21 mothers that met the prescreening eligibility were invited to participate in the study. 17 of those mothers responded to the invitation and a total of 11 scheduled and completed the interview.

Demographic information reflects participants’ information at the time of data collection. Approximately 45% of the mothers ranged from ages 18-29 and approximately 55% ranged from ages 30-39, none of the mothers were over the age of 40. Women in the study had one to three children, with 64% having one child, 27% with two children and 9% with three children. Children’s ages ranged from 7 months to 18 years of age, but majority (75%) were age 3 and under.

For marital status 55% of mothers were single/in a relationship and 45% were married. The highest level of education in this sample ranged from 10th grade to master’s degree, 64% of participants reported tertiary level experiences and 36% reported high school level. 73% of participants were employed within various positions in public and private sectors, as well as self-employment and 27% were unemployed at the time of data collection. At the time of data collection, most mothers (82%) reported living in city of
Kingston (Kingston/St. Andrew Parishes) while a small percentage (18%) reported living in nearby St. Catherine and Clarendon Parishes.

A summary of demographic data of the participants in the study is presented in Table 2 below. A brief overview of the participant in the study is presented in Table 3 below. Participant information were de-identified, pseudonyms are presented for all mothers in the study. Information is included for participants at the time of data collection.

Table 2: Demographics

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N=11</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age (Years)</strong></td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>45%</td>
</tr>
<tr>
<td>30-39</td>
<td>55%</td>
</tr>
<tr>
<td>40-49</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>64%</td>
</tr>
<tr>
<td>2</td>
<td>27%</td>
</tr>
<tr>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Ages of children (Years)</strong></td>
<td></td>
</tr>
<tr>
<td>0-3 (study population)</td>
<td>75%</td>
</tr>
<tr>
<td>4-18</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Single/In a relationship</td>
<td>55%</td>
</tr>
<tr>
<td>Married</td>
<td>45%</td>
</tr>
<tr>
<td><strong>Highest level of education</strong></td>
<td></td>
</tr>
<tr>
<td>Secondary (High School)</td>
<td>36%</td>
</tr>
<tr>
<td>Tertiary (College, includes some college and college graduates)</td>
<td>64%</td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>73%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Parishes (current residence)</strong></td>
<td></td>
</tr>
<tr>
<td>Kingston/St. Andrew</td>
<td>82%</td>
</tr>
<tr>
<td>St. Catherine</td>
<td>9%</td>
</tr>
<tr>
<td>Clarendon</td>
<td>9%</td>
</tr>
</tbody>
</table>
Table 3: Brief overview of participants

<table>
<thead>
<tr>
<th>Participant / Pseudonym</th>
<th>Age</th>
<th>Number of children</th>
<th>Age of child(ren)</th>
<th>Marital status</th>
<th>Education</th>
<th>Employment</th>
<th>Parish/ current residence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serene</td>
<td>35</td>
<td>1</td>
<td>3yrs</td>
<td>Married</td>
<td>Tertiary</td>
<td>Employed</td>
<td>Kingston/ St. Andrew</td>
</tr>
<tr>
<td>Grace</td>
<td>28</td>
<td>1</td>
<td>2yrs</td>
<td>Married</td>
<td>Tertiary</td>
<td>Employed</td>
<td>Kingston/ St. Andrew</td>
</tr>
<tr>
<td>Kim</td>
<td>28</td>
<td>1</td>
<td>3yrs</td>
<td>Single/in-relationship</td>
<td>High School</td>
<td>Employed</td>
<td>Kingston/ St. Andrew</td>
</tr>
<tr>
<td>Kimberly</td>
<td>37</td>
<td>1</td>
<td>1yr</td>
<td>Married</td>
<td>High School</td>
<td>Unemployed/Stay at home mom</td>
<td>Clarendon</td>
</tr>
<tr>
<td>Ann</td>
<td>30</td>
<td>1</td>
<td>1yr</td>
<td>In a Relationship</td>
<td>Tertiary</td>
<td>Employed</td>
<td>St. Catherine</td>
</tr>
<tr>
<td>Louise</td>
<td>30</td>
<td>2</td>
<td>3yrs and 18yrs</td>
<td>Married</td>
<td>Tertiary</td>
<td>Employed</td>
<td>Kingston/ St. Andrew</td>
</tr>
<tr>
<td>Kerry</td>
<td>36</td>
<td>3</td>
<td>7 mon, 23mon, and 16yrs</td>
<td>Single</td>
<td>Tertiary</td>
<td>Employed</td>
<td>Kingston/ St. Andrew</td>
</tr>
<tr>
<td>Dolly</td>
<td>29</td>
<td>2</td>
<td>7mon, 4 1/2yrs</td>
<td>Single</td>
<td>Tertiary</td>
<td>Employed</td>
<td>Kingston/ St. Andrew</td>
</tr>
<tr>
<td>Kayla</td>
<td>19</td>
<td>1</td>
<td>2yrs</td>
<td>Single</td>
<td>High School</td>
<td>Unemployed</td>
<td>Kingston/ St. Andrew</td>
</tr>
<tr>
<td>Lisa</td>
<td>19</td>
<td>1</td>
<td>1yr</td>
<td>Single</td>
<td>High School</td>
<td>Unemployed</td>
<td>Kingston/ St. Andrew</td>
</tr>
<tr>
<td>Pamela</td>
<td>37</td>
<td>2</td>
<td>1yr and 4yrs</td>
<td>Married</td>
<td>Tertiary</td>
<td>Self-employed</td>
<td>Kingston/ St. Andrew</td>
</tr>
</tbody>
</table>

**Study Themes**

Four major themes emerged from the study. The study themes revealed ‘Maternal Lived Experience’, ‘Postpartum Depression’, ‘Support’, and ‘Culture of Coping’. These
themes were found to influence maternal mental health and postpartum depression symptoms. Figure 2 below, shows the relationship between the various themes expressed by mothers in the study.

**Figure 2: Postpartum Depression in Jamaican mothers**

![Diagram showing relationships between maternal lived experience, postpartum depression, culture of coping, social and technological support, and health and stressors.]

**Theme 1: Maternal Lived Experience**

Motherhood “I don't think anything really prepares you for it until you're in it” (Pamela, Age 37)

The ‘Maternal Lived Experience’ theme described participants lived experience as a mother in Jamaica. They discussed their physical and mental health in relation to their maternal journey. The theme is comprised of two sub themes: ‘Health’ and ‘Stressors’. The ‘Health’ subtheme described the mothers physical, mental, and emotional health related to pregnancy, labor/delivery, postpartum care/recovery, and caring for their child(ren)’s health. The ‘Stressors’ subtheme described mother’s mental
health related to internal and external stressors they experienced. The subthemes are summarized below.

**Subthemes:**

**1.1 Health**

Mothers in the study described individual and interpersonal health experiences related to their maternal mental health. Pregnancy, labor/delivery, and postpartum recovery were defining moments, both physically and mentally, for mothers. Physical health outcomes impacted mothers’ mental health, and depressive symptoms.

Mothers reflected on their pregnancy describing initial reactions, how they felt, and their life at the time. Experiences with the overall pregnancy influenced their maternal mental health and PPD symptoms. Mothers described both negative and positive experiences during pregnancy. Women reflected on sharing the news of their pregnancy with and acceptance from the spouse/child’s father, friends, family, and others; positive and negative reactions were recounted. Pregnancy experiences included those which were planned, unplanned, wanted, and unwanted. Mothers with unplanned and/or unwanted pregnancies discussed more depressive symptoms, including their mental/emotional health to accept and keep the pregnancy.

Dolly aged 29 reflects on her pregnancy with her son, and the experience telling her family, she said,

*To be honest my daughter was more planned for in the sense...but for my son now, it was not a planned pregnancy. So, it was really difficult accepting the pregnancy*
at first, It took mi [me] months, a lot of encouragement, a lot of support family
and friends. Because at first, I tell you, when I told my mother, it's very, very
funny story because my mother called my big sister and said that she had a boil.
What Jamaica, people call a boil, so yuh know di story once yuh get a boil
somebody's pregnant...Suh when I actually told my mother, I tell yuh, a called my
mother, I said Mommy yuh gonna be a grandma again. And she cursed and she
carry on she was eating my head off and then hang up, as she hang up di phone
not even 30 minutes later, she called. ‘Oh, I got some onesies, yuh want to si
dem?’, ‘You know what it is boy or girl?’ A seh a don't know... (Participant
laughing)...She accepted it really quick [To be honest my daughter was more
planned for in the sense...but for my son now, it was not a planned pregnancy. So
it was really difficult accepting the pregnancy at first, It took me months, a lot of
encouragement, a lot of support family and friends. Because at first, I tell you,
when I told my mother, it's very, very funny story because my mother called my
big sister and said that she had a boil. What Jamaica, people call a boil, so you
know the story once you get a boil, somebody's pregnant...So when I actually told
my mother, I tell you, I called my mother, I said Mommy you’re going to be a
grandma again. And she was yelling at me and then hang up, as she hang up the
phone not even 30 minutes later, she called. ‘Oh, I got some onesies, you want to
see them?’, ‘You know what it is, boy or girl?’. I said I don't know... (Participant
laughing)...She accepted it really quick] (Dolly, Age 29)
Mothers described their personal acceptance of their pregnancy. Some participants considered abortions, or had doubts with the baby, while others expressed they were happy to be pregnant. Maternal mental health during pregnancy and the likelihood of experiencing depressive symptoms varied throughout their journey. Both mothers who were at first doubtful and those who were excited, discussed the positive impacts of the baby, and some described how they felt hearing heartbeat for the first time. Special populations including teenage pregnancy or high-risk pregnancies discussed the challenges of their maternal lived experience.

Kayla aged 19, shares her experience during pregnancy as a teen mom. She said,

_I got pregnant when I was 16 so I found out that I was pregnant when I was in 10th grade. I was finishing exam and everything...And when mi find out now mi just stop guh school and everything, mi did kind a depressed at a time because yuh nuh family, well mi madda did supportive but mi father side them did just...Di world, like di world just a tumble dung pon mi and like mi did ashamed of the pregnancy all of that time. And then, until mi start guh clinic and yuh know, mi meet this nice nurse and she always a encouraging mi and them thing deh. And my baby father was very supportive throughout all of di time, but it was just emotional at the first part but after a while, like when mi duh di first ultrasound and mi hear di heartbeat and si him body is like mi neva really care bout weh nuh body waan seh anymore [I got pregnant when I was 16 so I found out that I was pregnant when I was in 10th grade. I was finishing exam and everything...And_
when I found out now, I just stop going to school and everything, I was kind of depressed at a time because you know family, well my mother was supportive but my father side they did just...The world, like the world just a tumble upon me and like I was ashamed of the pregnancy all of that time. And then, until I start going to the clinic and you know, I met this nice nurse, and she was always encouraging me and things. And my baby father was very supportive throughout all of the time but it was just emotional at the first part but after a while, like when I first did the ultrasound and I hear the heartbeat and see his body it’s like I never really cared about what nobody said anymore] (Kayla, Age 19)

Grace aged 28, described her first trimester and experience with sickness during pregnancy. She said,

I never had a good first trimester because literally not even water I could have kept, not even water. So literally I would be on the veranda and my mouth just keep going like a pipe, you know I would just be puking, puking, puking, puking, puking like everything was just, that happened until I ended up in the hospital because I got dehydrated and I think they say they had to do something quickly before the baby would be malnourished so you know that was in my in my earliest stage of the pregnancy in my first trimester. So, I was admitted for one week, they do a ultrasound and that I think it was at the six week or something like and...I had to have some of those drips you know...(Grace, Age 28)
First time mothers discussed their journey of being pregnant and experiencing labor/delivery for the first time. While women who had more than one child compared and contrasted their pregnancy/childbirth experiences. Mothers reflected on painful moments during their journey that impacted them physically and mentally. Topics discussed by mothers included, physical health concerns such as sickness during pregnancy, unforgettable labor pain, and traumatic birth experiences. There were a variety of labor/delivery experiences, including difficult, early/premature, and long/lengthy labor/deliveries, as well vaginal births, Cesarean-sections (C-sections), and emergency deliveries. Most mothers expressed labor pains and not being prepared for what they experienced. Mothers also discussed experiences with being swept, induced, and receiving pain medication and management during labor. Mothers expressed the mental and physical challenges of pregnancy and labor/delivery.

Kimberly aged 37, described a traumatic pregnancy and challenges she faced. She said,

> It was just a traumatizing situation because it's my first time getting pregnant, and I was sick all through. Up until the third trimester...maybe 30 weeks or 28 weeks. Really sick, I had to be going to the doctor all the time to get the IV. So, I can get fluid because I was throwing up a lot. (Kimberly, Age 37)

Dolly aged 29 recounts her experience with a difficult labor/delivery. She said,

> So, for this delivery, I actually, I almost lost this baby. So was over 14 hours going, when I was to go in active labor, they realized that I couldn't deliver baby, but he was already almost out. And then he had some complications...they did
different maneuvers to dislodge his shoulder. In the process, it took some time, and he was without oxygen. So, he was basically born without anything...they basically revive him, took him down to the nursery and sorted him out...he had to spend quite a while on the ward...he was there for over a month (Dolly, Age 29)

After delivery, mothers discussed their maternal health during the postpartum period and recovery, including hospital discharge and going home. Some mothers described quick recovery after their childbirth, others describe lasting issues, even years later. Mothers described mental changes during the postpartum period and what it was like navigating mental health experiences as a mother of a newborn. Mothers discussed postpartum topics such as weight/body changes, painful scars, sexual recovery, hormonal imbalances, blood pressure issues, and challenges of breastfeeding, eating/sleeping patterns and general healing/recovery after childbirth. Furthermore, mothers describe a link between their physical health postpartum and their mental health.

Kerry aged 36, articulated her experiences. She said,

My baby born and a week after his birth he got sick. So, he was admitted to [state hospital] for three weeks or three and a half weeks. And it was rough because I mean after you have baby, after your delivery that’s when you go into the postnatal stage. And to know that your body don’t even start to heal, and your child gets sick. And you have to be going back and forth, you don’t have a car, you have to be taking taxi...and you know you have to be taking things, you have
to have the bags...You have to carry the feeding or the formula and then their bottles (Kerry, Age 36).

Mothers discussed health concerns regarding their children. Experiences with healthy children, as well as children who experienced illness was described. Mothers described the challenges and concerns of caring for a child who was not well, they discussed traveling back and forth to the hospital for children who were hospitalized, limited visitation policies, and Coronavirus disease (COVID-19) restrictions.

Lisa aged 19, describes her experience with her daughter’s illness and the challenges faced. She said,

Well, after I had her, she was admitted in the nursery because her jaundice was very high. So, she was in the hospital for a week. Her bilirubin--bilirubin, jaundice, same thing. And then after I take her home, it wasn't that bad, it was much better for me. Because every day during that week, I had to be on the road heading to the hospital every day...because of COVID the visiting time was 1 o’clock to 3 o’clock (Lisa, Age 19)

Concerns about their child(ren)'s mental health were focused on whether they were experiencing happiness or depression. Mothers described these concerns as leading to both positive and negative emotions. Mothers' social health concerns for their child(ren) focused on social skill development and meeting educational milestones. Physical health concerns discussed by mothers were related to developmental delays,
such as teething, walking, physical impairments, children who needed to be resuscitated after delivery, jaundice, colic, fever, general sickness/discomfort, excessive crying, reactions to vaccinations, and food, sleep, and behavior challenges. The health experiences of the child were described to have a direct impact on the mother’s mental and physical health.

Kim aged 28, explained, As a mom I don’t think you have your own emotions. When your child is stressed, trust mi [me] you are stressed” She adds that, When your child is crying, you’re so frustrated and you’re so miserable. You just want her to stop, want it to be better, you know. Because when they’re young, you tend to not know what wrong (Kim, Age 28).

Dolly aged 29, who experienced having a sick child in the hospital said she could agree with this as a mom. She said,

Sometimes you don’t imagine that baby just being born or being in that condition is horrible...it’s heartbreaking, sometimes you want to bargain and say let it be me and not them because it’s difficult (Dolly, Age 29)

Physical, mental, and emotional health concerns during pregnancy through postpartum were described by mothers. Mothers also reflected on their physical and mental health in relation to their children’s health outcomes. PPD symptoms experienced by mothers were highly influenced by children who experienced sickness. Stressors
impacted mental and physical health outcomes in mothers. Stressors are described in the next section.

1.2 Stressors

Mothers described stressors they experienced during pregnancy to postpartum. Stressors were experienced by mothers from both internal and external factors, which included personal expectations and feelings, grief/loss, finances, school, employment, and current events such as COVID-19. Stressors were both positive and negative related to mothers’ individual experiences.

Dolly aged 29, a mother of two, described her experiences with stressors she faced during postpartum and caring for her children. She expressed there were both ups and downs but the joy of knowing her children were okay outweighed it all. She described her story when her son came home from the hospital and the reaction she got from her daughter who was four at the time. She said,

Kids...they are very resilient and from the day I came from the hospital ah felt okay. Suh when he was coming home, now. Wow a tell yuh that little girl she grabbed him from the nurse, and she hugged him, and she went walking over....she was like, this is my baby brother, to every one coming. She was so excited and happy. It was just joy knowing that he had overcome, he had recovered. He had, a tell yuh a lot of battle scars, as I would call them...but despite all of that we were just so happy. And I can tell yuh di feeling. Yeah [And I can tell you the feeling. Yeah] (Dolly, Age 29).
Mothers describe their education and school experiences as stressors. Mothers described the impact on their mental health. Experiences with education included both secondary (high school) and tertiary (college/vocational) levels. Some mothers describe their experience being in school at the time during pregnancy through postpartum. Some mothers explained that they had to stop schooling due to their pregnancy and the impact of this on their mental health and PPD symptoms.

Lisa aged 19, explained she felt emotional and had to stop. She began a vocational school, The Human Employment and Resource Training Trust/National Training Agency (HEART) institute but she had to stop because of pregnancy sickness. She explained,

\[\text{I was 17 then, it was depressing. I didn't really finish school. I had exam in that time and a lot of things was going on with me when I find out...I stopped even though I was almost through...So yeah, I had to stop because my uniform was getting tight. And I was having bad feeling, so I had to stop. I was attending HEART, but then I had to stop also because the journey is far from where I used to live, and I used to throw up on the bus and I couldn't manage all a that, so I had to stop (Lisa, Age 19).}\]

Kayla aged 19 explains she had to stop school for her mental and emotional health. She said,

\[\text{Well, I had to stop doing high school...Because mi did try fi like the first two months but then yuh know young people like myself, high school dem a guh talk a lot and all of these things [Well, I had to stop doing high school...Because I did}\]
try for like the first two months but then you know young people like myself, high school they talk a lot and all of these things] (Kayla, Age 19).

In addition to education, finance was also a significant stressor for mothers in the study. Mothers described their experiences with finances including co-parenting financially, childcare costs, child needs (i.e., shoes, clothes, schools fees, other support etc.), saving/budgeting, being resourceful, asking for help, being financially prepared for the baby, increased utility cost, food, and housing cost (inflation) and transportation cost. Mothers discussed the impact of financial stressors on their mental health and depressive symptoms.

Kim aged 28, described her financial experiences with her child’s father. She said,

*I am a saver...I hate to have to ask for money...it’s nonexistent for me, I hate it.

But as a mother I realized that I cleared all of my bills alone. And this child is only taking because best believe she not giving anything for now. She just taking.

So, I had to understand that and say hey look here, yuh daughter need shoes. Yuh daughter school fee need to pay, I paid two terms this needs to duh. I started to verbally express what I was going through. You know and is either yuh duh it or yuh don’t do it, but I didn’t stand and say okay I’m doing this all alone, I’m just doing...no, don’t just duh, mek dem know what is happening [I am a saver...I hate to have to ask for money...it’s nonexistent for me, I hate it. But as a mother I realized that I cleared all of my bills alone. And this child is only taking because best believe she not giving anything for now. She just taking. So, I had to
understand that and say hey look here, your daughter need shoes. Your daughter’s school fee needs to be paid, I paid two terms, now you need to do it. I started to verbally express what I was going through. You know, and is either you do it or you don’t do it, but I didn't stand and say okay I'm doing this all alone, I’m just doing...no, don’t just do, make them know what is happening] (Kim, Age 28)

Mothers described changing or losing jobs, and the limitations for making money during the COVID-19 pandemic. Mothers discussed the impact their finance had on their ability to care for their children. Finances also included employment and other sources of income. Mothers discussed the impact of paid and unpaid maternity leave or time off after childbirth. Mothers with paid maternity leave discussed the benefits of their time off and the impact on their mental health.

Kerry, aged 36 explained she had to work up until the birth of her child, and received eight weeks paid maternity leave after her childbirth...She said,

Right, I worked up to as much as I could because for leave, in terms of maternity, you have the maternity really after birth and not before...you have maternity leave, eight weeks with pay...four weeks with pay no, but I can’t afford no pay leave because I have to take care of my kids (Kerry, Age 36)

Serene, aged 35, describes her maternity leave experience and the positive impact on her mental and emotional health. She said,
Well as soon as I was able to go on two week sick leave before she was born. And immediately when she is born, then the maternity leave...it round off to about six months...Right. So wasn’t at work, I was off for those times, and I still get monthly salary. It feels good, it was actually my first time being away from work for so long. It feels really nice. I mean, I could just get up, don’t have work. I just get up and do my normal routine every morning. Like, you know, bathe her, feed her, cleaned the house, you know I'll cook until my husband gets home and stuff like that. Bonding was great. I felt good I have time on my hands for her.

A subgroup of participants had experiences of grief and loss through pregnancy, childbirth and/or postpartum. Participants described their experiences with grief and loss including death, loss of a child/adoption, still births, miscarriages, and loss of family/friends. It was difficult for women to discuss grief experiences. These experiences contributed to depressive symptoms mothers experienced.

Kimberly aged 37, describes her experience losing one of her twins. She expressed,

Actually, it was twins, but only one came...They were both still born, and they resuscitated the one I have now. The smaller one came and the big one die...you know when I had the baby and I lost one, I was really, really depressed when I was at the hospital. I was like super depressed...(Kimberly, Age 37)

Mothers also discussed their personal expectations for themselves and motherhood. Some of the topics included what they thought motherhood would be, and
also reflected on their thoughts before their children, such as never wanting to have children, as well as the age in which they had their children (not wanting to have children so early or so late), the number of children they had (not wanting to have so many or wanting more), and the closeness in age of their children. Mothers discussed how their personal expectations impacted their mental health and depressive symptoms. Motherhood was described as something you’re never truly prepared for.

Pamela aged 37, a mother of two referring to motherhood believes “I don't think anything really prepares you for it until you're in it” (Pamela, Age 37)

Two mothers, Kayla, aged 19 and Kimberly, aged 37 felt they wished they had children at a different time in their life. They discussed how this personal expectation impacted their mental health, but they expressed gratitude for their children.

Kayla, a mother to a two-year old son, reflect on not wanting to have a child so ‘early’. She said,

But emotionally sometimes mi kinda seh like mi wish mi neva get pregnant suh early but then mi nuh want it be that mi a seh mi regret having mi baby [But emotionally sometimes I kind of like wish I never got pregnant so early but then I don’t want it to be said that I say I regret having my baby] (Kayla, Age 19)

While Kimberly, a mother to a one-year old daughter reflect on not wanting to have children so ‘late’. She said,
It's better to have your kid when you are younger I think so. Then you can live your life, I'm only 37 I live my life but I wish I'd had her earlier so she would have been grown now (Kimberly, Age 37)

Mothers had unique experiences being pregnant, delivering, and experiencing postpartum during the COVID-19 pandemic. Though some of the participants had their childbirth experiences prior to the pandemic; everyone in the study was able to reflect on how the pandemic impacted their lives and their maternal mental health. Mothers described their lives during the COVID-19 pandemic, especially as it related to their employment and healthcare experiences. Most participants described the negative impacts of the COVID-19 pandemic such as the fear of sickness/death for them and their children/family, job loss, and restrictive COVID-19 protocols and policies. However, some mothers describe positive impacts including financially being able to save money in transportation, clothing and other needs and the benefits of working from home. The impact of the COVID-19 pandemic on the mothers in this study varied.

One participant discussed her sentiments about the fear associated with the pandemic and the unknown impact, which we are still learning. Ann, aged 30 said,

To be honest with you, it was very scary. Knowing that it was a possibility because I was at higher risk for catching COVID. And the fact that, I did not know and still do not know what the impact on the child would have been. It was really scary (Ann, Age 30).
Stressors influenced mothers’ maternal mental health and depressive symptoms during pregnancy to postpartum. Mothers discussed the impact of internal and external stressors, including personal expectations and feelings, grief/loss, finances, employment, school, and current events such as COVID-19. Mothers’ individual experiences with stressors varied.

The ‘Maternal Lived Experience’ theme described participants lived experience in relation their physical and mental health as a mother. Individual and interpersonal factors, health and other stressors were experiences that influenced mother’s physical, mental, and emotional health after childbirth. Several mothers in the study reflected on their experiences. More importantly, they discussed how these experiences made them feel. The next theme will further discuss mother’s emotional health after childbirth. The next theme of ‘Postpartum Depression’ will include mothers experiences with postpartum depression, the identification, symptoms, knowledge, and perceptions.

Theme 2: Postpartum Depression (PPD)

“I know what it was, postpartum depression, like it's real. And, I could have identified myself going into that” (Ann, Age 30)

The ‘Postpartum Depression’ theme illuminates mothers' experiences, knowledge, and perceptions of PPD. The theme is comprised of three subthemes: ‘Experience Of’, ‘Knowledge Of’ and ‘Perceptions Of’. The ‘Experience Of’ subtheme described mother’s experiences with PPD, which included a diagnosis or lack of, how women define and identify with the term, symptoms of PPD, and timeline, including
onset and resolution. The ‘Knowledge Of’ subtheme described mothers’ education and awareness related to PPD. The ‘Perceptions Of’ subtheme described mothers’ perspectives and views related to PPD. The subthemes of ‘Experience Of’, ‘Knowledge Of’ and ‘Perceptions Of’ are summarized below.

**Subthemes:**

2.1 *Experiences Of*

Mothers in the study described various experiences of PPD. Though all mothers in the study had symptoms which would identify them as having PPD; some mothers identified with the term PPD, and others did not. None of the mothers in the study had a formal diagnosis of PPD or had been formally screened for PPD. Several mothers described their uncertainty about their experience with PPD for various reasons; including the definition of and symptoms to identify PPD, or that it even had a name.

Ann aged 30, expressed she could have identified herself going through PPD. She expressed,

*I know what it was, postpartum depression, like it's real. And, I could have identified myself going into that” (Ann, Age 30)*

Grace aged 28, described how she did not know that PPD was what she experienced. She said,
...postpartum stress depression I didn't even know that it had a name, you know being that I was a new mom...so I didn't know that the stuff that I was going through was actually because of that (Grace, Age 28)

Kim aged 28, said she heard about what PPD was, but was still unsure if that was what she experienced because she had other stressors going on in her life at the time. She said, 

So postpartum was one of them that you have to look out for, look for the symptoms. I wasn't sure if I was going through postpartum...You know, because there was a lot of things that was going through my life at that time...I'm not sure if I had that (Kim, Age 28)

Others were also unsure if they could differentiate between general depression or stress and PPD. Whether they had previous experiences or if their stressors were not solely to the baby. Mothers described various symptoms of postpartum depression including not being able to differentiate feelings of sadness and happiness, feelings of sadness, anger, generally ‘not feeling okay’, not being able to sleep or eat, crying, delayed/not producing breastmilk, anxiety, helplessness, hopelessness, worry, guilt, tired/exhausted, trouble with the infant, such as baby not sleeping or excessive crying, wanting to be away from the baby/detachment, and some even described more severe symptoms such as paranoia and thoughts of harming the baby. Some mothers recounted feeling symptoms within the first couple of months and lasting months, until about one year.
Pamela aged 37, describes her experience with PPD. She expressed uncertainty because she states her experience wasn’t extreme and she was able to overcome these feelings. She states, her depressive symptoms lasted about one year.

She explained,

Yes and no. Meaning that I know I could have diagnosed myself as to that...Is just that, it wasn't as extreme as some of the ones that I heard of. So fortunately, I was able...to rise above it...It was this sadness and anger, sadness anger. And I just using those words, because people can identify with those words, but it’s not necessarily like that...Moments of wanting to just be away from everybody and don’t want to be with anybody. That sort of thing. You know, just wants to be in my own space, don't necessarily want to be with them, the children, family, etc.

But a still, even though I don’t want that, I am still looking for opportunities to be with them. If you understand...I can go through the motions, I can do all of that.

But that's not what I'm feeling...So a lot of the feelings, I was feeling, and I think that lasted maybe for like eight, nine months for me...By about...April, May which was one year, I started to feel some sense of normalcy. Normalcy, meaning that I can now differentiate sadness from happiness (Pamela, Age 37)

Mothers described their personal experiences of postpartum depression. Mothers discussed the variety of depressive symptoms they experienced after childbirth. Some mothers describe how they overcame PPD symptoms or felt they were not experiencing PPD based on their personal understanding and perceptions. Recounting their experiences
of PPD for mothers varied, as mothers were generally unsure about PPD. Knowledge of PPD was important in determining how women defined their own personal experiences with PPD. This will be further discussed in the next section.

2.2 Knowledge Of

Mothers’ knowledge of PPD, related to education and awareness varied. Most mothers were unsure/uncertain about the definition of PPD or what it entailed. Mothers discussed learning about PPD at different times during their maternal journey and even prior to conception. They discussed learning through a variety of different outlets including clinics/hospitals/healthcare staff, family and friends, other mothers, from the internet through stories online and searches on Google or YouTube, and/or apps.

Lisa aged 19 said, she heard about PPD during her perinatal care visits but did not fully understand it. She said,

Well, we didn't get any pamphlet, but they did speak to us about the feelings we get after we have baby and they told us that however we're feeling we supposed to go to the doctor or speak with someone that's close to us about the symptoms that we're having, and just try our best not to do any harm to ourselves or the baby...I’ve heard about it, but to be honest, I don't really fully understand it that much (Lisa, Age 19)

Dolly aged 29 said, some women get knowledge from other mothers regarding PPD and that is how they know. She said,
Finding other parents, other mothers that have been through it. Listening to their stories, because there are a lot of women that have gone through postpartum depression. And sometimes it's not in the moment but after they have gone through it they will say you know that I really had a difficult time. I couldn't manage, I was so broken up, I wasn't taking care of myself, wasn't taking care of the baby. They will tell you exactly what they went through. So sometimes that is where you get your knowledge. And then that's how you can know how to handle yourself if it should happen (Dolly, Age 29)

Most women in the study stated they heard about or were somewhat aware of what PPD was, but most were not completely sure. The knowledge and information mothers had about PPD influenced their perceptions about PPD. Perceptions are further discussed in the next section.

2.3 Perceptions Of

Mothers described their perceptions of PPD. Mothers’ perspectives and views related to PPD varied, including the way women regard, understand, and interpret PPD. Women described their perceptions of stigma, judgment, labels, and views on the severity of PPD.

Kerry aged 36, describes her perception of why she believes it’s difficult for Jamaican women to admit to postpartum depression or depressive symptoms. She felt
denial but also acknowledged the experience is more common than people admit across all income levels. She said,

So, if they can find ways and means to help mothers going through depression, it’s not something that you admit to, it’s not something she know... You have some mothers who don’t want to admit the depression. There are some persons who are not accepting it yuh nuh [you know]. And they live in a denial world. You ask I’m not depressed, I’m fine. In reality they are depressed...So I was one of those persons living in denial, one of those persons that try to block it out like I’m not, that could not be me. I’m too pretty and too this and too that in society for me to be depressed...But no matter where in society you are, middle, low, medium. We all go through it. (Kerry, Age 36)

Mothers described severe cases of maternal mental illness and postpartum psychosis stories when describing what they knew or associated with postpartum depression. Mothers described severe consequences when referring to ‘extreme’ cases including killing, leaving or hurting your children, being on drugs, and even death. Mothers used labels like ‘losing your mind’ or ‘going crazy’. Mothers expressed worry and fear of judgment. Some described perceiving postpartum depression as “bad” or “dangerous” based on their experiences and what they heard regarding severe cases.

Grace aged 28, described her perceptions of PPD, based on a story with a severe case that brought PPD to her attention. She explains,
This particular group that I watch kinda, woke mi up and struck something in me, I saw that this mom she had given birth to a set of twins...then it was a week after, she literally stab both of them...because she a seh di baby did a cry too much and all a that...And I was just reading the comments and other mothers was speaking about postpartum depression and stuff and I was saying like, this is real stuff like, this thing can cause yuh to harm yuh child... I did research about this postpartum stress depression stuff and then I was like, as I said before it’s real stuff like real deep like, is like yuh a guh lose yuh mind...yuh a guh through di stress and all kind of things at the time...I neva knew that this thing was really suh dangerous, like if yuh nuh strong mentally yuh literally as a mom can just look pon yuh sweet innocent little baby and just kill it [This particular group that I watch kind of, woke me up and struck something in me, I saw that this mom she had given birth to a set of twins...then it was a week after, she literally stab both of them...because she said the baby cried too much and all a that...And I was just reading the comments and other mothers was speaking about postpartum depression and stuff and I was saying like, this is real stuff like, this thing can cause you to harm your child...I did research about this postpartum stress depression stuff and then I was like, as I said before it’s real stuff like real deep like, is like you will lose your mind...you go through the stress and all kind of things at the time...I never knew that this thing was really so dangerous, like if you’re not strong mentally you literally as a mom can just look at your sweet innocent little baby and just kill it.]

(Grace, Age 28)
Kerry aged 36, said she wouldn’t do it, but she could understand how mothers’ emotional health can lead them to hurt their child. She adds,

*It’s a rough process. You know, I understand. I don't agree with mothers who hurt their children. But when I know, because I have three of my own and how I have the last two I understand sometimes the frustration that they goes through. Why they might hurt their child. I could not do it, I could not hurt my child. I can’t hurt my child.* (Kerry, Age 36)

Mothers in the study revealed stigma, misconceptions and and/or judgments about PPD. Mothers expressed their thoughts/opinions of PPD experiences and their understanding of symptoms and consequences. Perceptions of PPD was important in understanding mother’s personal experiences with PPD.

In summary the ‘Postpartum Depression’ theme described mothers personal experiences, knowledge, and perceptions of postpartum depression. Mothers described their identification of PPD and related symptoms they experienced postpartum. These experiences varied. Mothers discussed their understanding of PPD, most felt their knowledge of PPD was limited. Perceptions of maternal mental health and PPD varied but revealed stigma in Jamaica. The next theme of ‘Support’ will describe how mothers navigated these experiences of PPD with support.

**Theme 3: Support**

“Listen, you can never do it by yourself. No matter how strong you are, you need support.

*Yuh gonna [you’re going to] need rest, yuh gonna [you’re going to] need emotional*
support because at times it will feel overwhelming and overbearing, so you need people around you to help.” (Ann, Age 30)

The ‘Support’ theme described the ways mothers felt supported during pregnancy to postpartum, which included internal and external supports. The theme is comprised of three subthemes: ‘Self- Support/Self-Care’, ‘Social Support’ and ‘Technology as Support’. The ‘Self- Support/Self-Care’ subtheme described internal support, how individuals supported themselves and personal coping strategies for their mental health and depressive symptoms. The ‘Social Support’ subtheme described external support, including how women defined their social networks of people and organizations that were a part of their maternal journey. The ‘Technology as Support’ subtheme was another external support, which described mothers use of technology and internet resources for maternal and mental health support. The subthemes are outlined below.

### Subthemes:

#### 3.1 Self- Support/Self-Care

Mothers described their personal practices of support, which highlighted how different individuals handled stress, coped with depressive symptoms, and cared for their mental well-being (self-care). Mothers described a variety of strategies, advice, and personal practices. Active coping amongst participants included listening to music, exercising, meditating/breathing, reading, practicing positive thinking, reframing and ‘self-talk’, playing games on the phone/computer, playing/activities with children, social media, cleaning/chores, cooking, working, gardening, showers/baths, sleeping/resting,
calm/soothe your mind, crying/shout, writing, recording audio journal, taking time for
yourself/break, relaxing, get a drink, shopping/window shop, talking to/visiting
family/friends and doing other activities to keep busy. Other practices included avoidant
coping such as isolating or doing nothing, going silent/internalizing, and going through
the motions/pushing past feelings.

Serene aged 35, described how she used active coping strategies to support herself. She
said,

So, I watch like movies or I listen to some music. I'll try to get some sleep...I listen
to gospel music...I would pray, read my Bible. And do chores to get my mind
active, preoccupied. I like clean environments, so I will just clean, just be a clean
mom. Just clean, non-stop until I'm done, or I'll cook, or I'll just take a walk or
visit family members (Serene, Age 35)

While Kayla aged 19, described her experiences with avoidant coping. She said that
might not be the best approach, because it can cause more issues. She stated,

Because me is a person weh nuh really like talk emotion...suh mi wi just wait until
everybody gone mi just cry and cry and cry until mi feel betta. But everybody deal
with it differently...Although I’m a person that will keep things bottled up inside.
Sometimes mi feel like if mi have somebody fi talk to and express those feelings to.
It would be better off fah mi...Yuh keep it bottled up inside, it can cause more
damage than wah it need. [Because I am a person that don’t really like to talk
about emotion...So I would just wait until everybody gone, I just cry and cry and
cry until I feel better. But everybody deal with it differently...Although I’m a person that will keep things bottled up inside. Sometimes I feel like if I have somebody to talk to and express those feelings to. It would be better off for me...You keep it bottled up inside, it can cause more damage than it would need to] (Kayla, Age 19)

Different coping strategies impacted mothers in the study differently. Participants described the impacts of both active and avoidant coping on their mental health experiences, which were both positive and negative. Mothers personal coping strategies influenced their experiences with depressive symptoms. Individual coping strategies were influenced by social support. Social support will be further described in the next section.

3.2 Social support

Social support included how mothers in the study defined their social networks, ‘their village’. Mothers described people and organizations in their lives and in their communities who are and have supported them during pregnancy through postpartum. Mothers described their experiences with support, including being supported and lack thereof.

Dolly aged 29, describes her social support and how helpful her community was during a difficult time postpartum. She said,

I can't call everyone, but I tell you. People from everywhere...when they got the news that the baby had gone through a difficult delivery and the situation that was
happening...So when it came on down to the support, I tell you all my colleagues were there. My church family was there, because everybody went straight into prayer mode. Persons, I don't even know, friends of friends, family of friends. And everybody just went into prayer mode. I got support emotionally, I got support spiritually, I got physical support, I got some amount of financial support, because as I said I had to go on no pay. So it was a lot of restructuring and everybody both familiar and unfamiliar kind of stepped in and tried to make it as easy as possible (Dolly, Age 29)

Ann aged 30, described frustration and confusion she faced with her community in caring for her child. She felt her community was not helpful at times. She said,

Because I don't know what to do, I have no help, we have this kind of people telling mi [me] this, that kinda people telling mi [me] that. Oh, give her some mint tea, don't give her no mint tea. Give her this, don't give her that, oh my God, it was, it was draining. I had to literally tell myself that I'm not going to take any phone calls from anyone. I don't waan [want] hear anything at all. Family, friends, everybody, doctors, nurses, they were just all annoying. So, what I did, I said okay I'm going to study this child and how she operates (Ann, Age 30)

Pamela aged 37, described her lack of support and the impact on her mental health. She said,

But within the moment that is something that I would have wanted because I wanted to talk and I wanted to express, but there was nobody there. And I think
that's what made it worse. Because you have the feeling but there's nobody so the only person I have to talk to is myself’ (Pamela, Age 37)

Social support was described as both a protective and risk factor in relation to maternal mental health experiences and depression symptoms. Social support came in the form of physical/tangible, emotional, and informational supports, including people, organizations, advice, recommendations, and resources. Some examples of people included spouses, child’s father, children, family, friends, church family, caregivers/childcare, employers, instructors/teachers, healthcare staff including doctors and nurses, and others. Some of the local organizations/programs that were mentioned by mothers included the University Hospital of the West Indies (UHWI), the Women’s Centre of Jamaica Foundation (WCJF), The Human Employment and Resource Training /National Service Training Agency Trust (HEART/NSTA trust), known as “HEART”, Parent Place, The Programme of Advancement Through Health and Education (PATH), churches, and health care centers/clinics.

Kayla aged 19, described the people who were her main supports. She reflects,

It was mostly my mom, and my baby father, because mi did end up live wid him cause him did step up and even when mi have di baby, my mom would come and watch fi mi...suh mi wouldn’t, like di first week mi neva duh anything because them did show up fi mi. Mi mom and mi stepdad, and mi baby father, they were my main support, up to now they are still my main support  [It was mostly my mom, and my baby father, because I ended up living him because he did step up
and even when I had the baby, my mom would come and watch him for me...So I wouldn’t, like for the first week, I never did anything because they did show up for me. My mom and my stepdad, and my baby father, they were my main support, up to now they are still my main support] (Kayla, Age 19)

Kim aged 28, expressed her support was her friends and family, who were like counselors to her postpartum. She said,

*My friends were my counsellors...my cousins...I was constantly on the phone. There was not a time that my phone wasn't ringing, yuh good. Inna di morning, inna di night, mi a guh sleep. There was somebody there to make sure that I'm okay [My friends were my counsellors...my cousins...I was constantly on the phone. There was not a time that my phone wasn't ringing, Are you good? In the morning, in the night, when I go to sleep. There was somebody there to make sure that I'm okay] (Kim, Age 28)*

Lousie aged 30, described her experience with one local organization/program, a home visitation/domiciliary service. She said,

...I got support from [state hospital] for a while they would normally come to the house once a week, and you know check her, check me you know, ask me question, how am I doing, give me information and stuff like that. That was good. It was very good because they came and they looked at...my living area...offer support and say, oh, you know, maybe you could do this, maybe you could do that move this, move that so it was good as being a new mom, per se with a newborn
at the house. You know, to give me some tips on how I can, you know, change things around to make it more conducive and safer for the baby and for myself...because they do it for like, if it’s not a month, it was a two month period after the baby born and you go home...It's something that you just sign up for, it's free (Louise, Age 30)

Mothers described how necessary and important social support was in their experiences. Social support overall was a protective factor related to postpartum depression. However, mothers also described how negative support or lack of support can pose risk or worsen symptoms for postpartum depression. Women identified social support as a preferred method of coping over ‘formal’ support such as counseling or medication. While social support was an important factor in coping, mothers also credit technology as support through their maternal journey. Technology as support will be described in the next section.

3.3 Technology as support

Mothers in this study described how they used technology and internet resources such as websites, apps, social media, and search engines such as YouTube and Google to support them through their maternal journey. Mothers used these avenues to seek information about themselves and their children during the pregnancy, childbirth, and postpartum phases including early childhood information and resources. Most mothers described using these resources, particularly YouTube and Google, to better understand what to expect in their maternal journey. Mothers used technological resources to connect
with other communities of support including other mothers through both local and global platforms. One example of a local technology resource included the Jamaica Early Childhood Commission, ‘1st 1000 days app’. Other resources included apps and websites such as the Flo App, What to Expect, BabyCenter, and Baby Sparks. Participants also discussed using Facebook and WhatsApp groups.

A first mom, Serene, aged 35 gives advice and described her experiences with using apps to guide her through her maternal experience and assisted her in delivering her child. She said,

*I would say take your time, read up, make yourself knowledgeable about motherhood and raising of children, yuh [you] have some apps that you can use, because I had some app that I had downloaded on my phone that really helps to guide me...so we can be able to take care of ourselves and our baby...proper dieting for the child and the raising of the child...If I didn't understand, if I didn't watch YouTube or get myself knowledgeable about these things...I'm not sure what would have happened on that morning when I was in labor* (Serene, Age 35)

These technology/internet resources were described by participants as supportive ‘friends’ helping women in their times of need. Information sought out by women ranged from how to make a bottle, breastfeeding, sleeping tips for baby, symptoms of labor, how to deliver a baby, and other informational topics. Overall mothers described these resources as helpful. Mothers described, how they made life easier with tips, information,
and communities to share stories and resources. Some described them as life-saving, while others enjoy the private nature of being online and having on-demand help.

One mother Kim aged 28, described the accessibility and assistance of the internet. She described a favorable experience using Google and YouTube, as a supportive ‘friend’. She said,

*Google and YouTube is my friend....Google was very good to me. YouTube has everything that you think about you know, watch the videos, it helps...to prepare to expect what is coming* (Kim, Age 28)

Another participant Lousie aged 30, stated similar sentiments of how accessible and helpful the internet is, she also adds there is a level of privacy. She said,

*If you don't personally want to call somebody the internet is there...there is nothing that you're having challenges with that you can't find...something close enough that will help to guide you suh [so], go out there and seek information, seek help* (Lousie, Age 30)

Mothers described the ease and use of technological resources throughout their maternal journey. Technology was an important area of support for mothers to seek help and information. Internet resources, apps, websites, social media, and other technological resources were used to cope with depressive symptoms.
In summary, ‘Support’ was found to be a protective factor for maternal mental health experiences and a primary source of how women cope with/managed postpartum depression symptoms. Experiences of being supported, particularly positive support made a difference in mothers health outcomes and depressive symptoms. Self, social, and technology supports were used by mothers to support themselves and their child(ren). Support is defined in context of cultural factors in Jamaica. There was a ‘Culture of Coping’, which is described in the next theme.

Theme 4: Culture as coping

“Not in Jamaica...Suh if more men could a deh inna that process then mi feel like them woulda be more stand up dads cause them woulda si wey wi guh through [Not in Jamaica...So if more men could be in that process [meaning childbirth] then I feel like there would be more stand up dads because they would see what we go through] (Kayla, Age 19).

The ‘Culture of Coping’ theme described mothers in Jamaica, shared social and cultural perspectives by describing personal and societal values, beliefs, and practices in relation to maternal mental health and postpartum depression. The theme is comprised of three subthemes: ‘Religion/Spirituality’, ‘Strength and Responsibility’, and ‘Gender Imbalances’. The ‘Religion/Spirituality’ subtheme described how religion and spirituality influenced mothers’ experiences, overall mental health, and depressive symptoms. The ‘Strength and Responsibility’ subtheme described values of strength and responsibility as mothers' motivation to cope with their mental health and depressive symptoms. The
‘Gender Imbalances’ subtheme described beliefs, practices and policies related to the roles of men and women in the childbirth, postpartum and childrearing processes in Jamaica, and the relation to mental health in mothers. The subthemes are outlined in the next sections.

Subthemes:

4.1 Religion/Spirituality

Mothers in the study describe how religion and spirituality influenced their individual experiences and mental health. Religion/spirituality was described mostly in the context of coping and social support. Mothers discussed personal beliefs, values, and practices. Some mothers used religion/spirituality to make decisions, rationalize/understand their experiences, and as a form of guidance and general support.

Serene aged 35, described how she used her knowledge and value of God to overcome negative thoughts to harm her child and depressive symptoms she faced postpartum. She said,

And she’s a God given gift...So that's what I used to overpower what was, you know, illustrated in my mind. Well, I know that thought, I know it's wrong. Whatever that was, I'm not sure...And...what will be your excuse. What if God doesn't give you another child, what if you're banned from getting pregnant...(Serene, Age 35)
The majority of mothers described their experiences in context to their religion/spiritual beliefs and values. Personal practices of prayer, going to church, praise, and worship through music, and bible reading were described as important aspects in relation to preventing and coping with depressive symptoms. Some mothers described their mental health in context to their personal identifications with specific religions and their beliefs related to their faith such as the value of blessings and punishment/consequences from God, the values of being married, having children and beliefs about abortion. Mothers described religious or spiritual communities as support, which included using pastors, or church communities/family to cope.

One participant, Kimberly aged 37, described her religious beliefs and practices. She describes her Christian family as support. She said,

"So, we are both Christians, so we have like a huge family that is Christian... We have the church support so, we prayed a lot. We had like a support group, that keep praying with us and his sisters is an apostle... So we have like that support team and his next sister is a pastor, and his nephew is a pastor. So yeah we have like a good group. So, we weren't so, we were stressed but, we know our faith in Christ (Kimberly, Age 37)."

Additionally, Kimberly age 37, discussed her preferred use of her social and religious supports opposed to “formal” supports such as counseling. Even, after experiencing loss/grief of her baby. She stated,
...They gave me...a grief counselor, but I didn't need to use her anyway, because like I said I had my support, and you know...I prayed a lot and stuff like that

(Kimberly, Age 37)

Religion/Spirituality was an integral part of mother’s experiences. Beliefs, values, and practices related to mothers’ personal experiences with religion/spirituality influenced their maternal mental health. Religion/spirituality was a protective factor in coping with depressive symptoms. While religion/spirituality was an important value for Jamaican mothers they also discussed values of strength and responsibility. These values are further described in the next section.

4.2 Strength and Responsibility

There was a culture of coping, in which cultural values of strength and responsibility motivated mothers to care for their children, despite their challenges. Strength included physical and mental components. Responsibility described mothers’ personal obligations to their children. Women expressed the need to have willpower, strength, and to ‘be strong’ to overcome mental challenges during the postpartum period. Additionally, others expressed if you’re not “strong” that is when you can fall into depression or worsen current symptoms. Mothers describe their experiences being mentally and/or physically strong. Several mothers discussed a parental responsibility to their child(ren) as a reason for their decisions and actions in relation to their mental health.
Pamela aged 37, said it was her mental strength and responsibility to her children that allowed her to overcome her depressive symptoms. She said,

*Right. And you know, I've broken many barriers. So, I have to recognize that yeah, I'm just strong like that....I’m mentally strong like that and that’s what my doctor actually said to mi [me]. Because when I explained everything, at one point, him was like, bwoy [boy], you just mentally strong to overcome all of that by yourself. And I guess yeah here I am, without tablets or anything like that...it's just because of my strong will, that never made it extreme. But I knew that there was something there. So, like there was a conscious effort to rise above it. Because to me, I never had a choice. So fortunately, I was able...to rise above it* (Pamela, aged 37)

Kerry aged 36, expressed if you aren’t mentally strong, overcoming depression will be difficult. She said, “*And if you don’t stand strong you don’t come out of the depression any at all...I ask God to help me through.*” (Kerry, Age 36)

She adds it was also her children who gave her the motivation to not give up. She felt a responsibility to them. She said,

*And having my three kids you know...I looked at all three playing together. And I say it’s amazing...I said even if I did want to give up, looking at my three boys bonding, sharing, loving it shows me that despite, what I’m going through, continue to push through* (Kerry, Age 36)
Mother’s expressed favorable experiences “being strong” mentally or physically. Particularly, experiences without the use of “formal” supports such as medication and counseling. The value of strength in Jamaican society in relation to maternal mental health and depressive symptoms was evident in mother’s experiences. One participant discussed how people will look at you differently if you don’t express/show “being strong” even physically.

Lisa aged 19 said,

...*But sometimes we just have baby our body is weak, and you can’t expect us to like move around that swiftly or, you know, get up strong, strong and just do everything same time, we have to take our time. But when they see that, they'll treat you a certain kind of way. That's not right* (Lisa, Age 19)

While Ann aged 30, was proud to show physical strength, she said,

*Yeah, it was very quick because I had her at 4:10 in the evening, I was out of there on the ward probably about after 8. And I managed to walk to the bathroom, by the next morning I was taking a shower by myself, you know, the whole works...Yeah because me tough* (Ann, Age 30)

Strength and responsibility described by mothers was an important factor in coping. Strength to care for their children was a motivation for mothers and responsibility was a priority. Some mothers described specific responsibilities as a mom, and how this influenced their mental health and coping. Mothers expressed gender imbalances related
to the responsibilities and roles of women and men, and the need for women to express strength in their role. Mothers also discussed support and coping. Gender imbalances related to roles of women and men during childbirth and through postpartum, as well as coping and support are discussed in the next section.

4.3 Gender imbalances in childbirth and postpartum

Gender imbalances reflect the practices and policies related to the roles of men and women in the childbirth, postpartum and childrearing processes. Mothers particularly discussed policies related to the allowance of men/fathers in childbirth/delivery in Jamaica. Most mothers in the study delivered without their child’s father in the room for various reasons including they weren’t allowed, an unexpected delivery, the father wasn’t present or available at the time of the birth. Some mothers described this as a typical experience in Jamaica. Some mothers in the study had the unique experience of delivering during the COVID-19 pandemic, which impacted hospital policies that may not reflect typical experiences.

Lisa aged 19, explained,

...alright in Jamaica it’s different, well depending on which hospital. If you went to the public hospital, they won’t allow anyone in the delivery room (Lisa, Age 19).
Kayla aged 19, expresses, it is not a typical practice in Jamaica for men to be included in the childbirth process. She believes that changing this policy will improve paternal involvement. She adds,

“Not in Jamaica...Suh if more men could a deh inna that process then mi feel like them woulda be more stand up dads cause them woulda si wey wi guh through
[Not in Jamaica...So if more men could be in that process (meaning childbirth) then I feel like there would be more stand up dads because they would see what we go through] (Kayla, Age 19).

Mothers express their beliefs that by allowing men to be a part of the birth/delivery process would be a positive for fathers and mothers. Fathers would get to participate and experience their child(ren)’s birth, and see what mothers go through. Mothers would be more respected and feel support during childbirth. Participants shared recommendations to change policies and practices that will help with gender equity in childbirth in the hospital setting. As well as provide support in the way that assist mothers during childbirth through postpartum.

Grace aged 28, expressed that her spouse wanted to support her during the delivery, but he was not allowed in the delivery room. She expressed her belief that changing this policy in Jamaica, would benefit mothers and fathers. She said,

My husband wanted to be there, but the thing is about giving birth in Jamaica versus overseas these public hospitals, they do not allow the men in where the delivery is taking place...So they won’t get to have that experience alongside you
giving birth, they will just be hearing you telling them, which for me personally I think that should get rid of and allow them to see. Because in my perspective I would think that allowing the men to see what the ladies would go through in giving birth to someone like them, will allow them to respect females more and understand it’s their job to help with their kids. So that’s just my take on that, but they don’t allow them there (Grace, Age 28).

Mothers discussed the influence of men, and their involvement postpartum. Some mothers described women as the primary caregiver and men as protectors and financial supports. Women discussed advocating for equitable roles amongst fathers and mothers. Mothers describe gendered expectations regarding family roles such as what mothers are expected to do in the childbirth and childrearing processes. Mothers expressed the impact of gender imbalances on their maternal mental health.

Lisa aged 19, believes mothers are typically the primary caregiver of the child, she said,

Well...I can only speak about for the moms. But what I think men should do is just always try and be there for your child because I think fathers are very important to be in a child’s life. But for the mothers now, I think mothers are the basic...mothers are...the caregivers for the kids, most of the time. Mothers are there and they're the one most of the time who always push to be in a child’s life, always push to ensure that the child have certain things in your life (Lisa, Age 19)
Ann aged 30, expresses mothers and fathers should have an equal responsibility to the care of the child, she adds,

...Because the father is not only there to protect, and the mother is not only there to love, both of them has equal responsibility to do both love and protect that child (Ann, Age 30)

Lousie aged 30, agrees that if mothers and fathers were equally responsible the child would be better off, she said,

Honestly speaking, when it comes to raising a child, I don't think anybody has a specific role because both of us made the child. Both of us have our individual experience, life experiences. So, I teach her something of value, he teaches her a value...There is nothing for you and nothing for me, all of us have our different experiences. All we have to do is just transmit those good experiences, correct the bad ones for our child to be the best version of herself. Yeah nobody has a role. It cannot be the mother's role to clean the diaper and to make sure the child is. All of us have to do the same things, so all of us have to chip in. (Lousie, Age 30).

Gender imbalances, related to the roles of men and women during childbirth through postpartum were described by mothers in the study. Mothers discussed hospital policies and practices that excluded men from the delivery process. Some mothers discussed the desire to be supported by men during childbirth and believe it would benefit mothers and fathers. Mothers discussed their roles as caregivers and the obligations of mothers. Advocating for more equitable roles and paternal involvement was important to mothers.
In summary, the ‘Culture of Coping’ theme described shared social and cultural perspectives of Jamaican mothers. Values, beliefs, and practices in relation to maternal mental health and postpartum depression was described by mothers. Religion/spirituality was an important aspect of mothers coping and support. Motivation to cope and overcome depressive symptoms was described in mothers’ values of strength and responsibility. Additionally, women describe gender imbalances for mothers compared to fathers in childbirth and caregiving postpartum. Cultural aspects related to mental health showed Jamaican women have a culture of coping.

This chapter concludes with the results showing the interconnectedness of the study themes of ‘Maternal Lived Experience’, ‘Postpartum Depression’, ‘Support’, and ‘Culture of Coping’. Mother’s lived experiences, their mental health and postpartum depression was explored. The strategies for coping and support were outlined in this study. The next section will expand the discussion of the findings within this study.
CHAPTER 5: DISCUSSION

Introduction

The purpose of this study was to explore women’s experiences in Jamaica with postpartum depression. Mothers described how they identify, cope, and manage postpartum depression experiences. Postpartum depression was defined by symptomology and literature addressing this area of research. The study explored how various factors are actualized in the maternal and mental health experiences of Jamaican women. The study identified significant risk and protective factors in Jamaican mothers’ experiences including support and the cultural impact of coping.

The primary research question of this study was “What are Jamaican women’s experiences with postpartum depression? The question examined mother’s experiences with mental health, particularly postpartum depression. Key findings from this research study suggest that Jamaican women’s experience with “postpartum depression” as a phenomenon varied. Maternal lived experiences including various stressors and personal and interpersonal health concerns influenced mother’s experiences with postpartum depression. Maternal mental health experiences including identification, symptoms, and the timeline associated with PPD, and their personal knowledge and perceptions with PPD were also explored.
The secondary research question was “How do Jamaican women manage and cope with postpartum depression? This question explored mother’s experiences with how they internally and externally cope with their mental health experiences. The results of this research study reveal that the ability to manage PPD was connected to mother’s experiences of support, including self, social, and technological support. Additionally, culture was found to influence coping which included religious/spiritual beliefs, values of strength/responsibility and beliefs and practices associated with gender imbalances experienced by mothers.

This discussion section will further describe these findings in contrast to the current literature available on this topic, and those particularly in Jamaica. The discussion section will summarize and apply the study findings using a 5-level social ecological and feminist theoretical framework. Utilizing feminist theory in conjunction with the 5 level social ecological model was purposeful for this study. Feminist theoretical frameworks centers the experiences of women and challenges systems of power that create health disparities such as postpartum depression in Jamaican women. The 5 level social ecological model describes levels of influence on Jamaican mothers’ experiences within individual, interpersonal, community/institutional, policy, and cultural levels. This framework informed the goals of the project, the results and discussion to describe Jamaican women experiences with postpartum depression, and how they managed and coped. Mothers lived experiences are valued as knowledge on this topic to inform implications for maternal mental health. How this framework connected to each theme is outlined below. Finally, this section will conclude with study limitations and strengths, and the implications of these results for practice, policy, and research.
Discussion of the findings

‘Maternal Lived Experience’ was explored at the individual and interpersonal levels of influence. Participants in the study revealed that their maternal mental health and postpartum depression symptoms, were highly defined by their maternal lived experience and related stressors through the process. The findings of the study link physical health outcomes in mothers and children to mental health experiences. Mothers recounted ‘positive’ and ‘negative’ pregnancy, labor/delivery, and postpartum experiences. Several mothers described the impact of their health outcomes during pregnancy to postpartum on how they felt mentally and emotionally.

Though both negative and positive experiences are understood within maternal mental health experiences, the results show the link between maternal health and mental health, as a key factor related to PPD. These findings are consistent with the literature that discusses significant individual factors related to PPD include pregnancy and postpartum changes such as physical changes and hormonal imbalances. (Beck, 2001; Schaffir, 2016; Soma et al., 2016; Yim et al., 2015). Additionally, research shows stress is another significant individual level factor related to PPD (Beck, 2001; Schaffir, 2016; Soma et al., 2016; Yim et al., 2015). Participants experiences of stress/stressors in this study included personal expectations and feelings, grief/loss, finances, employment, school, and current events such as COVID-19.

Financial difficulties were discussed as sources of stressors for some mothers in the study. The literature in Jamaica indicated low income, education, unemployment, and financial difficulties were associated with maternal depression (Bernard et.al, 2018;
Davidson 1972; Pottinger et al., 2009). These aspects are connected to social mobility and access to resources, which can present an added burden to mothers experiencing maternal depression in Jamaica (Bernard et.al, 2018).

Mothers in the study included a range of financial profiles and varying experiences. The study findings conclude that some women in the study identified finances including employment were sources of distress, where some faced job loss, difficulty getting a job/being unemployed, rising childcare expenses and lack of maternity leave. All of which were particularly difficult during the COVID-19 pandemic. Some mothers in the study described financial partnerships with the child’s father, being resourceful, and making sacrifices to care for their child(ren), as financial challenges.

Strengthening the financial supports for women, including maternity leave policies, financial assistance for mothers, equitable employment policies for pregnant mothers and financial partnerships with fathers were recommendations presented by mothers in the study. Additionally, prioritizing programs and policies within these areas to impact mother’s finances is critical to addressing maternal mental health. As of January 1, 2023, the Jamaican government implemented new parental and family leave policies for public sector employees. The policy provides up to three months maternity leave, as well as paternity leave for fathers of newborns, and family leave for adoptive parents with a new child (Jamaica Information Service, 2022). Evaluating the impact of this new policy in Jamaica in relation to maternal mental health will be an important area of future research.

Emerging research on the impact of COVID-19 on maternal mental health is showing that years of public health progress has been reversed by the pandemic (Ajayi,
Jamaican mothers shared their experiences and continued concerns. Mothers in the study discussed fear associated with getting COVID-19 for themselves and their child(ren), mandates related to vaccinations and testing requirements, restrictions such as visitation policies in hospitals and social distancing in schools and workplaces. The impact of working from home, school closures, and childcare and caring for newborns during the pandemic were discussed by mothers. Public health professionals should continue to explore the impact of COVID-19 on maternal mental health and postpartum depression. This is a necessary provision to achieve health equity in maternal mental health following the COVID-19 pandemic (Hessami et al., 2022; Otu & Yaya, 2022).

‘Postpartum Depression’ was another individual/interpersonal level factor related to the primary research question. The theme ‘Postpartum Depression’ describes mothers personal experiences, knowledge, and perceptions related to PPD. Some mothers in the study identified with the term PPD and others did not; self-identification using the term PPD varied. Similar findings were revealed in a documentary on postpartum depression in Jamaican mothers. They also found PPD was highly under and undiagnosed in Jamaican women, and that many women were not even aware of what postpartum depression was (Lewis, 2019). Additionally, the available quantitative data on postpartum depression in Jamaica estimates approximately 20-60% of Jamaican women experience PPD (Davidson 1972; Palmer, 1996; Wissart et al., 2005). The study results reveal a potential gap in identifying women in Jamaica who might be experiencing PPD.

Mothers in the study experienced varied symptoms related to PPD. These symptoms experienced by mothers, overlap with those reported in the literature
including, issues with sleep, mood or mood swings, crying, difficulty bonding with the baby, withdrawal from family and friends, loss of interest in activities, changes in appetite, overwhelming fatigue or loss of energy, irritability and anger, fear and feelings of inadequacy, shame, guilt, worthlessness, or hopelessness, cognitive changes such as diminished ability to think clearly, concentrate or make decisions, anxiety and panic attacks (MayoClinic, 2018; NIMH, 2021). Severity of these symptoms were subjective based on the mother’s experiences and personally measured by resources, skills and knowledge.

While most mothers in the study described their experiences with depressive symptoms within the first year of childbirth. Some women reflected on their symptoms lasting beyond a year. The findings of the study align with other researchers and organizations, who support that maternal depression usually develops within one year after childbirth (ACOG, 2015; CDC, 2020; PSI, 2021). However, those who experienced symptoms beyond a year were not atypical either, as a NIH study, supports mothers may experience depressive symptoms up to 3 years after childbirth (Putnik et al., 2020). The amount of time mothers experienced depressive symptoms varied based on a variety of different factors. This finding is consistent with the literature speaking to the complexity of identifying a timeline for postpartum depression experiences (Cooper & Murray, 1998; Vliegen, Casalin, & Luyten, 2014).

Mothers in the study were not fully aware of what PPD entailed, or what experiences were classified as PPD. While some mothers in the study recalled hearing about PPD in hospital/clinic settings, others reported never hearing about it at all. Most participants discussed learning about maternal mental health or PPD through informal
avenues such as family, friends, websites, apps etc. Perceptions from participants in the study revealed stigma associated with mental health and postpartum depression, which is consistent with the literature asserting that mental health in Jamaica is highly stigmatized (Arthur et al., 2010; Gibson et al., 2008).

Strengthening identification, education and awareness regarding PPD in Jamaica is imperative. While there are no standardized tools, screening for PPD in Jamaica is a way to identify mothers who may need assistance. Additionally, education and awareness of PPD to reduce stigma and increase support amongst Jamaican mothers.

‘Support’ was explored within the individual, interpersonal, and community levels of influence. Mothers in the study discussed coping and management of PPD symptoms in terms of support for themselves, from others, and through available resources and organizations. Management and coping with PPD symptoms varied amongst mothers based on their personal outlook on their situation, their skills, and resources. Coping strategies for women in the study were both positive and negative. Research in maternal depression suggests, positive coping serves as an important protective factor for women experiencing maternal depression (Doucet & Letourneau, 2009; Gutiérrez-Zotes et al., 2015), while negative coping can worsen symptoms of maternal depression (Azale et al., 2018).

Social support was found to be one of the most important factors in mothers experience in this study. These findings were-consistent with the literature on social support in PPD experiences, which found social support was a significant factor in maternal depression (Kim et al., 2014; O’Hara, 1994; Stewart et al., 2003). Mothers in the study discussed significant social supports from family, friends, and others within
their social networks, as well as lack of support. Consistent with the findings from Gray et al., 2018, studying PPD in Jamaica, social support or the lack thereof was indicative of depression symptoms. Social support was a protective factor, however some participants discussed how those same social supports can present risk for negative mental health experiences. This study agreed with the findings by Bernard and colleagues (2018), which describe that risk and protective factors amongst Jamaican women have to be explored in tandem, because the interconnectedness of these different factors on their experience both increase vulnerability, but also could serve to mitigate risk.

Mothers discussed organizations and institutions that offered support and resources to help them through their maternal health journey. Participants revealed the organizations and institutions in Jamaica included hospitals/clinics, social services, schools and workplaces. Past studies on PPD support that institutions and organizations are positioned to implement strategies that can both prevent and treat women experiencing postpartum depression (Stewart et al., 2003; Werner et al., 2015). The importance of social resources for mothers, such as involvement of fathers/partners, family, and friends were emphasized by mothers. Additionally, mothers provide recommendation for counseling or ‘talk therapy’.

This study also revealed that technological supports were frequently used by mothers. Favorable experiences were described by mothers using technology to support them through their maternal journey. Mothers discussed the use of apps, websites, social media, and other technological mediums to search information. As access to electronic devices and mobile phones continue to grow, studies support that technology is a promising area of support for mothers from pregnancy to postpartum, for personal and
practical information related to maternal, infant, and mental health topics, particularly PPD (Seo et al., 2022; Linardon, 2019). Additionally, the use of technology could be a cost effective tool, that can aid in self-management of symptoms, decrease stigma, and increase health benefits such as increased mood, sleep, other health promoting behaviors with the information and resources that are available (The Gleaner-Jamaica, 2020b; Linardon, 2019). This could be a promising measure in addressing mental health in Jamaica (The Gleaner-Jamaica, 2020b). None of the participants in this study discussed the drawbacks of technology, this is an area of emerging research in which both the benefits and drawbacks of technology should be considered. The area of support will be discussed within a cultural context.

‘Culture of coping’ described policy and cultural level influences of postpartum depression experiences in Jamaica. There is significant evidence to support that individual choice and behaviors result from policies, structures and systems within a society that direct behavior, knowledge and access (Golden & Wendel, 2020; Sallis et al., 2008). Mothers shared their social and cultural perspectives by describing their shared values, beliefs and practices, as well as availability of resources and coping. The study findings discuss the ways in which women in the study used cultural beliefs and values such as religion/spirituality, strength, and responsibility to cope with postpartum depression symptoms. These were found to be protective factors amongst mothers in the study. Additionally, women described their experiences with gender imbalances within Jamaican society that influenced the opportunities for coping through practice and policy.

Mothers described roles of men and women in childbirth and childrearing, the imbalances in these roles, and power dynamics. Women in the study defined “typical”
women’s roles through pregnancy to postpartum. Some women in the study regarded themselves as caregivers in child rearing, while men were regarded as protectors or financial supports. This finding aligned with The Women’s Health Survey in Jamaica, that found women’s perspectives on gender roles were varied. The survey found, most women in the survey agreed with a statement that it is natural (God-intended) that a man should be the head of his family and that a woman’s main role is to take care of the home, 77.4% and 70.2 respectively (Watson Williams, 2018).

Women in the study reflected on their caregiving experiences, and agreed they were the ones that primarily took care of the home. Cultural factors including relationships, gender roles amongst men and women, and stigma are important aspects to consider in PPD experiences (Amankwaa, 2003b; Bernard et al., 2018). Additionally, policies that center paternal involvement is important in addressing maternal mental health.

In summary these study themes provide insight into the lived experiences of PPD in Jamaican women. The discussion will extend to include limitations and strengths for this study. These should be considered for the findings of this study.

**Limitation and Strengths**

The following section discussed ways in which this study could have been improved, as well as strategies that worked really well for this study. Additionally, guidance for future research/researchers in maternal mental health is outlined. Limitations and strengths are important for the interpretation of the study results and discussion. This also increases the quality of the study.
Limitations

The first limitation is related to the nature of qualitative research. One limitation of qualitative research in general, which was also true for this study, was the potential for social desirability bias. This occurs when a participant modifies their answers to make their responses correspond to social norms (Neuman, 2003). Social desirability bias is highly connected to qualitative data because the presence of and interaction with the researcher can affect participants’ responses, this is typically unavoidable (Anderson, 2011).

Additionally, the sensitive nature and the stigma associated with mental health issues in Jamaica could have impacted the way women answered questions. They could have answered in ways they perceived to be socially desirable to themselves or to the researcher as a listener. To minimize these impacts the researcher incorporated probes within the interview guide for when participants provided generic or incomplete response. Additionally, debriefing sessions focused on developing strategies to build rapport. Finally, field note entries documented specific behaviors the primary researcher engaged in during recruitment and data collection. Future researchers should keep strategies in place to minimize the impacts of social desirability bias.

The next couple of limitations described are related to the practical aspects of the research. The second limitation was related to the time constraints which impacted the timeline, design, and execution of the study. The COVID-19 pandemic restrictions and policies altered the timeline to complete the study. The estimated timeline for the study was 9 to 10 months, including ethics review board approval, data collection, and analysis. The researcher encountered many restrictions related to the COVID-19 pandemic (e.g.,
hospital visitation restrictions) upon arrival in Jamaica that delayed the original timeline.

The university ethical review boards at both the University of the West Indies- Mona (UWI) and University of Louisville faced constraints due to the COVID-19 pandemic as well. Additionally, as a global research project there were differences between institutional policies and regulations. Therefore, this delayed approval from both university ethical review boards. As a result of this delay, the timeline for the study had to be extended, and data collection began 3-4 months after the proposed timeline.

Another limitation related to the research, included the language and cultural barriers between the researcher and the research participants. While the positionality of the researcher is described in the methods section, it is important to discuss how the researcher’s outsider position with the research could have been a potential limitation of the study. The researcher not being of Jamaican heritage could have influenced the research planning, methods, and analysis in that the researcher has biases that exist outside of the culture. Additionally certain aspects of participants narratives may or may not have been understood differently by the researcher.

To address the limitations outlined above, the researcher consulted with mental health, healthcare, and language/linguistic professionals to help inform study recruitment, data collection tools, and strategy. Additionally, a professional transcriptionist that was of Jamaican descent was contracted to transcribe interviews verbatim using local dialect. Finally, during analysis the researcher consulted with a Jamaican mental health professional and qualitative researcher to provide more context to study findings. The researcher documented and created memos to record challenges and lessons learned from the COVID-19 pandemic.
Other advice/recommendation for future research/researchers should consider allowing time for setbacks and unanticipated challenges. This is particularly true for new global partnerships. Consider that systems, ethics, research considerations and privacy laws will be different. Additionally qualitative research analysis and interpretation can be time consuming. Researchers should be prepared to navigate challenges quickly and use time wisely.

To address cultural barriers, future researchers should clearly state their position within the research. Strengths and challenges as an outsider should be clearly understood. Outside researchers could participate in community engagement activities to immerse in the culture in which the study will take place. Working closely with local and community partners is important to guide the research. Considering that perspectives differ based on epistemological, cultural, and lived experiences, especially for global health researchers. It is important to understand everyone’s position in the research and how this impacts the study execution. While these limitations outlined here could have implications for improving future research and researchers, it is important to also address the strengths of the study.

**Strengths**

One of the major strengths of this study was the global health research partnerships, which included both local and global partners. While the primary researcher of the study had cultural and language barriers, the impact of this was likely mitigated by the partnerships that supported this study. This partnership included various experts
across disciplines with interests in women’s, maternal and child, global, public, and mental health issues.

The partners in Jamaica included professors and researchers from the University of the West Indies (UWI)-Mona Campus, the Caribbean Institute of Health Research (CAIHR), and the Department of Community Health and Psychiatry, and The University Hospital of the West Indies. While global partners abroad included professors and researchers from the University of Louisville, Schools of Public Health and Information Sciences, Social Work and Family Science and Nursing. The partnership also included the Fogarty Health Equity Consortium, with researchers from the University of Arizona, and other universities affiliated with the consortium. This created a broaden view of maternal mental health issues which existed in Jamaica.

Both the insider and outsider views helped to create strategic approaches and methodology to focus on Jamaican women’s lived experiences of maternal mental health issues, depressive symptoms, and the ways in which they manage and cope. Multiple researchers were on this project from proposal, analysis, and through dissemination. This exemplifies the benefits of global health research and knowledge gained when global researchers effectively work together with a singular purpose to serve health equity.

**Implications**

The current research findings have implications for practice, policy, and future research.

**Implications for Practice**
Education continues to be an important area of practice related to addressing maternal and mental health issues. Participants expressed gaps in knowledge and education in the area of maternal mental health. Ensuring that women are knowledgeable about maternal mental health issues is important. Moreover, education helps women to identify solutions and appropriate coping strategies. Education can be included in existing prenatal and postpartum care. Additionally, as outlined by Arthur et al., 2010; Gibson et al, 2008; Hickling et al., 2011, strategic plans are necessary to create campaigns and information to educate individuals about mental health and to normalize seeking help for mental health issues including PPD.

Preferred help seeking amongst participants in the study focused on the significance and need for social support. Women in the study recommended prenatal and postpartum support groups or sessions. Women recommended these sessions or groups, potentially be offered through hospitals/clinics or other social services such as churches, non-profits or other organizations that focus on maternal health. These sessions were recommended to be offered for both mothers and fathers. Additionally, some women discussed the impact of domiciliary or home visitation services provided by the hospital/clinic. Offering these programs and interventions will be important in addressing maternal mental health in Jamaica.

**Implications for Policy**

Equitable policies in maternal mental health are essential for addressing gender equity in Jamaica. The findings of this study reveal the need to address policies related to
social factors including economic and educational policies. Participants discussed employment policies discriminating against pregnant women and maternity leave policies, these are necessary areas of continued policy evaluation. Amidst a global pandemic as we continue to rebuild economies, it’s important to do it with a gender equity lens. The Jamaican government has recently cut funding related to mental health services (PAHO, 2019; The Gleaner-Jamaica, 2020a). Additionally cost-effective strategies for addressing mental health by focusing on social factors, would be important for long term solutions. Some promising areas, which are further areas of research are described in the next section.

Implications for Research

Research addressing maternal mental health, particularly postpartum depression is limited. This study extends the research in this area, as the first qualitative study to examine PPD in this regional of Jamaica. Further research studies should address more holistic approaches to care, including both physical and mental aspects of health in Jamaica. Future research on the topic should include mixed methods studies to review the relationship between specific physical health outcomes and their relationship to mental health experiences in Jamaican women. A continued examination of personal, interpersonal, and cultural coping strategies amongst women in Jamaica is an important area of research. Research addressing the impact of mind-body-spirit practices such as meditation, yoga, and other practices with proven benefits on maternal mental health should be explored.
Maternal mental health research is imperative to addressing maternal and child health. Future research should also focus on the feasibility of screening of PPD and other maternal mental health issues in Jamaica. As well as explore the etiology and use of the term PPD in Jamaica and its appropriateness in the given context. Additionally, research is necessary considering gender diversity and sexual orientation, mothers with sickness/disabilities, mothers with sick/disabled children, those who are experiencing grief, located in rural areas or areas with limited healthcare access, and mothers with financial challenges or other life stressors. The lasting psychological and mental trauma of slavery on African diasporic populations, and its impact/influence on the ways of coping should be continually evaluated. This is essential to move forward more equitably for future generations.

Lastly, future research should focus on the use and applicability of technological supports in maternal mental health. Studies should examine the use of specific apps and websites that might be promising interventions for mothers globally. This should continue to be examined especially after the COVID-19 pandemic. The pandemic increased the use of technology, particularly health/telehealth services, use of apps and electronic devices. For Jamaica technology and globalization is a public health concern, which should be monitored to review both the benefits and drawbacks of technology, particularly for health education, and culturally sensitive materials and information.

In conclusion, postpartum depression in Jamaican mothers is an important area to address. This study was the first to qualitative examine the lived experiences of Jamaican
mothers in Kingston, Jamaica. The study findings revealed that the maternal lived experience, including personal health from pregnancy to postpartum, children’s health concerns; and stressors were important factors in maternal mental health experiences. Additionally, cultural, and social influences impact support for maternal mental health in Jamaican women. Support included self, social and technological supports. Religion/spirituality, values of strength and responsibility and gender imbalances impacted postpartum depression experiences. The study reveals the integral influences of social and cultural aspects on Jamaican mother’s experiences with maternal mental health, particularly postpartum depression. Programs and policies should address social and economic resources, such a maternity and family leave policies, involving fathers in prenatal and postpartum care, and social support groups. Research agendas should prioritize understanding PPD and coping amongst various subpopulations in Jamaica. This study confirm postpartum depression exist in Jamaica; and justifies the need to address maternal mental health more broadly in Jamaica. Additionally, a focus on support, coping and strengthening protective factors in Jamaica is imperative.
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APPENDICIES

APPENDIX A: Study Flyer

ARE YOU A MOM?
Join the Healthy Moms Project

The University of West Indies, Caribbean Institute for Health Research is inviting you to take part in the Healthy Moms Jamaica project to help us learn about women's emotional health after giving birth. Your participation in an interview will help us to design programmes for women to improve their mental and emotional health after childbirth.

YOU CAN PARTICIPATE IF YOU:
- Are 18 years old or over
- Identify as a Jamaican woman
- Have a child age 6 weeks to 3 years old
- Experienced four or more of these feelings after the birth of your baby
  - Stressed
  - Sadness
  - Loss of interest in activities
  - Nervous or worried
  - Worthless or guilty
  - Changes in appetite or your weight
  - Difficulty sleeping or concentrating

Use the QR code or link below to join

Click here to join today

CONTACT US

Instagram: @healthymomsja
Call or WhatsApp: (876) 341-5401
Email: healthymomsja@gmail.com
APPENDIX B: Prescreening Eligibility

Prescreening Eligibility

Introduction: Welcome to the Healthy Moms Jamaica study

This is a research study that is being conducted by the University of West Indies, Caribbean Institute of Health Research (CAIHR) and the University of Louisville. This study will examine women’s emotional health after giving birth, as well as experiences with depressive symptoms. Your participation in this study may benefit moms and children in Jamaica. Questions, comments, or concerns: Please call or WhatsApp 876-341-5401.

This page is to see if you are eligible to participate in this study and should take less than 5 minutes to complete. This is voluntary and confidential. Your information will not be shared, and you do not have to participate.

Prescreening Questions
1. Are you over the age of 18? YES  NO
2. Do you identify as a Jamaican woman? YES  NO
3. Have you had a child in the last 3 years? YES  NO
4. If yes, how old is your child? Less than 6wks old. 6wks-1yr. Over 1yr-2y. Over 2yr-3yr
5. Did you experience sadness or depression after the birth of your baby? YES  NO
6. For at least two weeks after the birth of your baby, daily or most days did you experience any of the following.... Check all that apply
   □ Stressed or overwhelmed
   □ Loss of enjoyment in activities
   □ Anxious or worried or scared for no good reason
   □ Difficulty sleeping
   □ Felt worthless or guilty for no good reason
   □ Difficulty concentrating or overthinking
   □ Experience weight or appetite changes (increase or decrease)
   □ Recurring thoughts of harming yourself or your baby
7. Do you currently have recurring thoughts of harming yourself or your baby? YES  NO
8. Have you ever been diagnosed with postpartum depression? YES  NO
9. Over the past two weeks, several days or more have you been bothered by: (Check all that apply)
☐ Little interest or pleasure in doing things?
☐ Feeling down, depressed, or hopeless?
☐ Thoughts that you want to kill yourself, or have you attempted suicide?
☐ None of these

**Contact Information:** First and Last Name: Phone #: Email:
APPENDIX C: Interview Guide

INTERVIEW GUIDE
POSTPARTUM DEPRESSION IN JAMAICA: EXPLORING THE LIVED EXPERIENCES

Welcome: Thank you for agreeing to take part in this interview.

Introduction: My name is Shakeyrah Elmore. I will be conducting the interview with you today.

Anonymity: Please note that although the discussion will be recorded it will be anonymous. It will not contain any personal information that could identify you. You will be assigned a participant Identification number and your name will not be used in any reports. Audio recordings will be transcribed word for word and recordings and notes will be kept in password protected files. Video recordings will be kept in password protected files. Please try to answer the questions as truthfully as possible. Please remember that you do not need to answer any questions that you are uncomfortable with.

This is a research study that is being conducted by the University of West Indies, Caribbean Institute of Health Research (CAIHR) and the University of Louisville. The study will examine Jamaican women’s emotional health and depressive symptoms experienced after childbirth. Not many people in Jamaica talk about this issue so it is important to learn about your experience as a mother. You can share with me as much about your experience as you like. The information you provide may help to improve programmes and policies for women and children in Jamaica.

Before we get started let’s review the consent form and see if you have any further questions. (See consent forms)

Do you have any questions before we begin?

Get consent to being audio and/or video recorded.

- Date/Time/Location:
- Interviewer:
- Interviewee (ID Number)/ Position of interviewee:
- Briefly chat with participant before beginning (i.e.. ask how they’re feeling, the weather, etc.)
- Briefly explain to participant what the timeline map is and what it will be used for
  - Timeline mapping: I will give you a piece of paper and a pen. This will allow you to map your journey from before you were pregnant until now as we talk. I understand a lot has happened since the birth of your child and it’s been (insert time). You can use this as an example, (Show participant multiple examples) or you may write down your journey in the way you would like.
**Experience** (What are the experiences of Jamaican women who have experienced symptoms of PPD?)

1. **Tell me about your experience as a mother**

A) **Take me back to the beginning, tell me more about your life when you were pregnant**

*PROBE:* Tell me how prepared you were once you found out, what was that like?

*PROBE:* Tell me about the things or changes that were going on before or after the birth of your child? (i.e., moving or new job, etc.)

B) **Tell me about your experience with childbirth and the time immediately after**

*PROBE:* Walk me through your labor (push or C-Section), what was this like and where?

*PROBE:* What was it like to have/raise a child(ren) during the pandemic?

C) **How did you feel after the birth of your child?**

*PROBE:* What were your thoughts and feelings after the birth of your child? (i.e., happiness, sadness, etc.)

*PROBE:* Tell me about how you were physically after the birth, how’d this make you feel

*PROBE:* Tell me about any positive feelings you had after the birth of your child

*PROBE:* Tell me about any negative feelings you had after the birth of your child

*PROBE:* Tell me about how you are feeling now compared to how you were feeling after the birth of your child

*MAP:* Map on your timeline when you first started to notice these feelings or describe any specific event you can recall?

D) **Tell me about what you know about Postpartum Depression, if anything**

*PROBE:* Tell me about your experience with postpartum depression

*PROBE:* Tell me about what kind of information was provided to you regarding PPD or your general emotional/mental health

E) **Tell me about your relationship with your baby after they were born?**

*PROBE:* If applicable, were you able to get time off, to spend time/bond with your baby once they came home? (Maternity leave)

*PROBE:* Tell me about the first couple of weeks when the baby first got home

*PROBE:* What was your experience with breastfeeding or feeding your child?

*PROBE:* What was your experience with taking care of or bonding with your child?

*MAP:* Map on your timeline this experience and explain that time to me

**Manage/Cope** (How do Jamaican women manage, and cope with symptoms of postpartum depression?)
2. **Tell me about the support you had after the birth of your child (Your support network)**

A) What kind of supports did you have after the birth of your child? (i.e., financial, personal, etc.)
   
   **PROBE:** What kind of support was offered to you after the birth of your child?
   
   **PROBE:** Tell me about how you were supported financially after the birth of your child?
   
   **MAP:** Map on your timeline when you used these supports

B) What person, place or situation if any would you identify as an important support for you with your child? (Child’s father, family, friends, religion/spirituality, work, other, etc.)
   
   **PROBE:** Tell me more about that
   
   **PROBE:** Tell me more about your experience, if any with talking to others about how you were feeling after the birth of your baby
   
   **PROBE:** Was your child’s father involved during pregnancy and after childbirth?
   
   How did this make you feel?
   
   **PROBE:** What does support look like for you now?

3. **Tell me about what you did to manage how you were feeling after the birth of your child**

A) What did you do to make you happy after the birth of your child?

B) What did you do when you felt unhappy or stressed after the birth of your child?
   
   **PROBE:** Tell me more about how you managed your feelings as a mom
   
   **PROBE:** Tell me about what impact you think this has on your child(ren)
   
   **MAP:** Map on your timeline examples/situation when you did these things after the birth of your child

C) What would you tell other women who experience different feelings and emotions, after the birth of their child?
   
   **PROBE:** Generally, what advice would you give to moms, what is something you wish you had known?

D) What do you think doctors or nurses can do to help mothers with how they feel after the birth of their child?
E) Where are the places women or mothers can go if they need help?
PROBE: What resources for women are you aware of or have utilized?

4. Interview conclusion
A) Is there anything that you want to share with me that I have not asked you about?

B) How was it for you to talk about this experience with me?

Conclusion:
Thank you for taking the time to do this interview. I really appreciate you sharing your views and experience with me.

After this you will receive a gift which I will give to you now. We are going to be interviewing other mothers, after we have completed all of the interviews we will write up a report on this issue. I ensure your name will not shared in any reports. There may be an opportunity for a 2nd interview or focus group where you talk with other mothers on this issue. You may be invited to participate, and you can accept or decline at that time.

Thank you once again! I am going to end the recording now if that is okay with you. (End recording)
**APPENDIX D : Fieldnotes Template**

Fieldnotes Template

**IDENTIFIER:** Participant code

**DATE:** Month/day/year, day of week, weather, critical current event(s).

**TIME BEGIN:** Time onset of interview.

**DURATION:** Duration of interview in minutes.

**LOCATION:** Location and setting description.

**GENERAL COMMENTS:** General impressions of setting, participant. Participant reaction to observation/observer.

**EVALUATION COMMENTS:** Analytic, theoretical notes (interpretation of activities reported, behavior observed).

**METHODOLOGICAL NOTES:** Notes regarding methods, thoughts about approach being used, the need for modification, addition or deletion of strategies in the future.

**TECHNICAL NOTES:** Suggestions for future work

**PERSONAL NOTES:** Personal notes, impressions, reactions, feelings, related to the experience, concerns about the self as researcher, reflexive thoughts, judgment, bias.

<table>
<thead>
<tr>
<th>Time</th>
<th>Descriptive Notes</th>
<th>Reflective Notes</th>
</tr>
</thead>
<tbody>
<tr>
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# APPENDIX E: Adverse Event Log

## Adverse Event Log

<table>
<thead>
<tr>
<th>Study Protocol Number:</th>
<th>IRR #:</th>
<th>Principal Investigator:</th>
<th>Subject ID:</th>
<th>Initial Consent Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Adverse event</th>
<th>Start and stop dates</th>
<th>Serious</th>
<th>Grade*</th>
<th>Relationship to study</th>
<th>Anticipated</th>
<th>Action taken with the drug/device/intervention</th>
<th>Other actions taken **</th>
<th>Was the AE reported to the sponsor?</th>
<th>Was the AE reported to the IRR? ***</th>
<th>PR initials and date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start:</td>
<td>Stop:</td>
<td>Date Site AWARE:</td>
<td>Yes</td>
<td>No</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Life Threatening</td>
<td>Death</td>
<td>Not related</td>
</tr>
<tr>
<td>Start:</td>
<td>Stop:</td>
<td>Date Site AWARE:</td>
<td>Yes</td>
<td>No</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
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<td>Death</td>
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<td>Moderate</td>
<td>Severe</td>
<td>Life Threatening</td>
<td>Death</td>
<td>Not related</td>
</tr>
</tbody>
</table>

*Revise this column to meet the grading requirements of the protocol (e.g., “Mild” vs “Mild-severe”)

**Study drug dose/jadajusted, Study drug interrupted, Study drug permanently discontinued, non-drug therapy given, hospitalized/extended hospitalization

***For further documentation your assessment of this event and determine if meets U.S. FDA’s reporting requirements, go to [https://obstetrics acesthesors/starting/clinicaltrial/eventreporting](https://obstetrics acesthesors/starting/clinicaltrial/eventreporting)

Version 3/14/2022

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CURRICULUM VITAE

Shakeyrah Elmore

EDUCATION

UNIVERSITY OF LOUISVILLE—Louisville, KY
- **PhD in Public Health Sciences** 2023
  - Specialization: Health Promotion and Behavioral Sciences
  - GPA: 4.0

UNIVERSITY OF CINCINNATI – Cincinnati, OH
- **Master of Science, Health Education – Public / Community Health** 2016
  - GPA: 3.978 / 4.0
- **Bachelor of Science, Health Education-Public/Community Health** 2014
  - GPA: 3.909 / 4.0
  - Minor: Psychology
  - Certificate: Substance Abuse Prevention and Diversity Studies

COLUMBUS STATE COMMUNITY COLLEGE – Columbus, OH
- **Associate of Arts Degree** 2011

PROFESSIONAL EXPERIENCE

**Graduate Researcher/Teaching Assistant** 2018 – Present
University of Louisville, Louisville, KY

**Substitute Teacher** 2018 – Present
Jefferson County Public Schools , Louisville, KY

**Substitute Teacher** 2017– 2018
Southwest Ohio schools, Cincinnati, OH

**Community Health Educator** 2015 – 2017
TriHealth, Healthy Women, Healthy Lives Program, Cincinnati, OH

**Community Health Educator** 2013 – 2015
The Center for Closing the Health Gap of Greater Cincinnati, Cincinnati, OH

**Tutor / Program Coordinator** 2013
Winton Place Youth Center, Cincinnati, OH
RESEARCH EXPERIENCE

Conference Presentations


- Hartson, K. R., King, K., O’Neal, C., Brown, A., **Elmore, S.,** & Perez, A. (2021, June). Farm-based education is associated with increased vegetable intake and knowledge of healthy recipes among elementary students. 2021 Association of Community Health Nurse Educators Annual Institute, Alexandria, Virginia, June 10-12, 2021


- Story, A., **Elmore, S.,** Brown, A. (2020, April). Race, Nationality & Respectful Maternity Care: The Effect on Preterm Birth. Poster presentation at the 2020 Xavier
University of Louisiana College of Pharmacy 13th Health Disparities Conference.
New Orleans, LA

- **Elmore, S.** (2020, March). Race, Gender, Stress and Meditation: The effects on black maternal and infant health. Podium presentation at the 2020 National Council of Black Studies Conference. Atlanta, GA


**Publications**


Projects

**Graduate Researcher** 2019- Present  
*University of Louisville, Louisville, KY*  
Title: Evaluation of the Play Cousins Collective Partnership with Bernheim’s Children at Play Network

**Graduate Researcher** 2019- Present  
*University of Louisville, Louisville, KY*  
Title: Food Literacy Project

**Graduate Researcher** 2019- 2020  
*University of Louisville, Louisville, KY*  
Title: Effect of Cooking Class on Cooking Behaviors and Nutrition Education amongst College Students

**Undergraduate Researcher** 2013  
*University of Cincinnati, Cincinnati, Ohio*  
Title: A Content Analysis to Compare How Obesity is Portrayed in Saturday Morning Programming Commercials between 2007 and 2012  
• Publication forthcoming

**Undergraduate Researcher** 2013  
*University of Cincinnati, Cincinnati, Ohio*  
Title: A Content Analysis to Compare How Obesity is Portrayed in Saturday Morning Programming Commercials between 2007 and 2012  
• Publication forthcoming

**Undergraduate Researcher** 2012- 2013  
*University of Cincinnati, Cincinnati, Ohio*  
Title: A Content Analysis of How Obesity is portrayed in Teen Shows and Commercials
• Poster Presentation: University of Cincinnati Annual Undergraduate Conference
  April 2013
• Publication forthcoming

TEACHING EXPERIENCE

Courses Taught:

- PHPH 401 Public Health and Health Policy, Instructor  
  Spring 2021
- PHPH 401 Public Health and Health Policy, Co-Instructor  
  Fall 2020

Teaching Courses:

- PHPB 650  
  Summer 2020
  Teaching Seminar and Lab in Health Promotion and Behavioral Sciences
- ELFH 676 Instructional Strategies in Health Promotion and Education  
  Spring 2020
- ELFH 675 Teaching/Learning in Health Promotion and Education  
  Fall 2019

STUDY ABROAD EXPERIENCE

Fulbright-Fogarty Fellowship  
Kingston, Jamaica  
October 2021

Public Health and Cultural Education Trip  
Accra, Kumasi, and Obuasi, Ghana  
May 2019

Ethiopia Service-Learning  
Addis Ababa, Ethiopia  
March 2016

Public Health in China  
Chongqing and Beijing, China  
May 2015

CERTIFICATIONS

National Commission for Health Education Credentialing Inc.,  
Certified Health Education Specialist (CHES)  
(Active)  
2015
200 Hour Yoga Teacher Training Certification (200YTT)  
(Active)

**HONORS/AWARDS**

- Southern Regional Board Education Dissertation Award 2022
- Fulbright-Fogarty Fellow, Global Health Equity Scholars (Jamaica) 2021
- University of Louisville, Outstanding Graduate Student Award 2020
- Ruth Abernathy Graduate Student Award 2020
- University of Louisville, Three-Minute Thesis Competition 2020
- University of Louisville, Women’s Center, Dr. M. Celeste Nichols Award 2019
- University of Louisville, Roberson Fund for African Studies Recipient 2019
- University of Louisville SIGS Diversity Assistantship Award 2018-2020
- University of Cincinnati (UC) Graduate Scholars Fellowship 2014-2016
- UC Graduate Incentive Award 2014-2016
- UC Undergraduate student and faculty research mentoring program grant 2013
- Martha Kidd Foundation Scholarship 2012
- Allen Endowment Scholarship 2012
- UC CECH General Scholarship 2011-2012
- Helen P. Glimpse Scholarship 2011
- Mildred Ramsey Jones Scholarship 2011

**AFFILIATIONS**

- Louisville Coalition for Black Maternal Health, Founding Member
- The Lord’s Kitchen Ministries (Food Distribution/Recovery Center), Volunteer
- University of Louisville Mindfulness Mediation Club, President
- University of Louisville Multicultural Association of Graduate Students (MAGS), Member
- Ohio Society of Public Health Educators (OSOPHE), Member
- Ronald E. McNair Scholars Program, Member