DEVELOPMENT OF STRATEGIES FOR COMMUNITY-BASED PREVENTION OF MATERNAL COMMON MENTAL DISORDERS IN URBAN OROMIA, ETHIOPIA

by

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submitted in accordance with the requirements

for the degree of

DOCTOR OF PHILOSOPHY

in the subject

PUBLIC HEALTH

at the

UNIVERSITY OF SOUTH AFRICA

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Dec 22, 2022

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DECLARATION

I declare that the work titled **DEVELOPMENT OF STRATEGIES FOR COMMUNITY-BASED PREVENTION OF MATERNAL COMMON MENTAL DISORDERS IN URBAN OROMIA, ETHIOPIA** is my work and that all the sources that I have used or quoted have been indicated and acknowledged using complete references.

I further declare that I submitted the dissertation to originality checking software. The result summary is attached.

I further declare that I have not previously submitted this work, or part thereof, for an examination at Unisa for another qualification or at any other higher education institution.

22 Dec 2022

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SIGNATURE DATE

Jalle Teferi Mekonen

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ABSTRACT

This sequential explanatory mixed-method study investigated in divided three phases: the quantitative phase, the qualitative phase, and the strategy development phase based on the findings of the first two phases. In the quantitative phase, the population entailed 228 women attending the antenatal clinic (ANC) clinic and key informants related to pregnant mothers at 5 towns administration health facilities in urban Oromia, Ethiopia. In the qualitative phase, the population comprised members of the community who had a relationship with a pregnant mother. On entry (before admission to the ANC clinic), data were collected using a standardized Likert-scale questionnaire, and in the qualitative phase, individual phenomenological interviews were done. Quantitative data analysis was done using Statistical Package for Social Sciences (SPSS) version 22, and the Colaizzi data analysis method was employed in the qualitative phase.

Findings indicate that women with common mental disorders (CMD) such as depression (10.7%) and anxiety (24.9%) prevalence is 32%. These disorders were exacerbated by having lower levels of education, perceiving their financial status as poorer, being unmarried, living alone, the CMD women also stated lower level of social support, lower relationship quality, higher scours of anxiety and depression, living urban, higher maternal age, household insecurity, and low economic status. As regards mother-to-child transmission (PMTCT), substance use were risk factors for higher prevalence compared

to the other indicators. It is also noted that very minimal mental health prevention services are available in the community for pregnant women. The psychological obstacles women face during their childbearing years may not end in just CMD. The findings were then utilized in the third phase of strategy development.

To meet the mental health needs of this group, a modified socio-ecological model was combined with a public health model for community-based prevention of maternal CMD after expert validation studies.

Key concepts

Anxiety; common mental disorders; community; depression; prevention strategy.

ACKNOWLEDGEMENTS

Above all, I am grateful to the Almighty God for providing me with the strength and fortitude to continue my studies. I am also grateful to:

- My supervisor, Professor Sheila Mokoboto-Zwane, for her constant support and encouragement throughout the research, even when I was on the verge of giving up. I appreciate her helpfulness and the time she spent guiding me in meeting deadlines. Her advice and recommendations helped me improve my critical thinking and research skills.
- The University of South Africa (UNISA), who paid for my education and provided research money through its bursary system.
- Oromia Regional Health Bureau (ORHB) and town health offices, health centres, data collectors and samples, mothers and study subjects for their permission, willingness, and cooperation.
- My Best Half, Mr Mitiku Fite SEDI, and my famous children, Abel and Nathan (14 and 8 years old), who learned discipline and appreciated their mother's education, deserve particular attention.
- My mother, Yideneku Mitiku, and my brothers and sister, who gave me the space when I needed to focus on my studies, and particularly Abraham Teferi MEKONEN, financially supported my schooling.
- My best friends, Kidist Bayissa, Adanech Dutu, Sofia Kelil, Timket Abebaw, and Addis Tilahun, to members at Betel Jalle village, for their unconditional support and encouragement, for the free Wi-Fi. Without being your support and prayer, this journey would have been challenging.
- Several people contributed to this study in various ways. Although I cannot identify everyone since the list is too long, I want to offer my heartfelt appreciation to everyone who has assisted me and my study.
- The Ethiopian Prosperity Party, for a reason that will remain in my heart.

MAY GOD BLESS YOU ALL!

Ecclesiastes 3:1 says Deuteronomy 2:9:

“God always has perfect timing, never early, never late.”

DEDICATION

I dedicate this study to:

- My family, my late father, Teferi Mekonen Minte, and the late Anti Ayelech Mitiku Engida. May their souls continue in eternal peace!
- My mother, Yideneku Mitiku Engida, my brothers, Abraham Teferi and Gemechis Teferi, and my sister Eng Lensa Teferi.
- My best half, Mitiku Fite Sadi, and my lovely children, Abel Mitiku and Nathan Mitiku, for their encouragement and unconditional support.

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LIST OF ABBREVIATIONS

ANC	Antenatal Clinic
AUDIT	Alcohol Use Disorder Identification Test
CBHIS	Community-Based Health Insurance Scheme
CMDs	Common Mental Disorders
CSRI	Client Service Receipt Inventory
FAST	Fast Alcohol Screening Test
FDREMOH	Federal Democratic Republic of Ethiopia Ministry of Health
GAD	Generalised Anxiety Disorder
LMIC	Low- and Middle-Income Countries
OCD	Obsessive-Compulsive Disorder
ORHB	Oromia Regional Health Bureau
PHCU	Primary Health Care Unit
PHC	Primary Health Care
PHQ 9	Patient Health Questionnaire 9
PMTCT	Prevention of Mother-to-Child Transmission
PTSD	Post-Traumatic Stress Disorder
RICO	Respondents, Intervention, Control, and Outcome
SEM	Social Ecological Model
SES	Socio-Economic Status
SPSS	Statistical Package for Social Sciences

UHEW	Urban Health Extension Worker
UNISA	University of South Africa
WHO	World Health Organization

CHAPTER 1: ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This introduction is the principal section of the journal, article paper, or insightful research. It sets the phase of the whole project (Slater, Hemsley & Wilkinson 1991:94).

The term common mental disorders (CMDs) was once first utilized to depict a hopeless circumstance described by utilizing diffuse physical side effects, tension, and burdensome state (Huxley 1996:12). Notwithstanding these manifestations, the idea incorporates essential medical services attributes and sociodemographic components of the area in which the disorder happens. Various researchers allude to CMD in terms of a mix of vague nervousness and sadness (Hanlon, Fekadu & Patel 2014:2). Notwithstanding these side effects, the idea incorporates essential medicinal services, area qualities and sociodemographic components of the area in which the disorder happens. It is also CMD referred by various authors to both the event of a combination of unclear nervousness and sadness (Niemi, Falkenberg, Petzold, Chuch & Patel 2013:687).

Because of its direct and likely long-term impact on their family's well-being and social and economic engagement, maternal mental health is critical to achieving worldwide health goals affecting women and children (The Partnership 2014:1). There is a developing test around self-destruction ideation among pregnant and postnatal mothers (Rochat, Bland, Tomlinson & Stein 2013:658). Mental health issues can affect the way you think, experience, and behave. Some mental health problems are described using everyday expressions.

Maternal CMD in pregnant women has been studied related to utilizing tobacco, alcohol, and other unsafe substances. It requires intervention (The Partnership 2014:3). It is a priority in terms of maternal and youth health intervention for international public health (Vythilingum, Field, Kafaar, Garman, Stein, Sanders & Honikman 2013:371-379). Pregnancy and labour are advancing as broad peril factors for improving and exacerbating emotional well-being issues (Cotter, Evans & Smokowski 2017:257).

1.2 BACKGROUND TO THE RESEARCH

Experts have become more interested in maternal mental health during pregnancy in recent years. CMDs during pregnancy have been linked to poor effects such as preterm birth and developmental delays in the unborn child. The prevalence of prenatal mental illnesses is high in low- and middle-income countries (LMIC), and untreated maternal mental illness can have negative consequences for birth outcomes, maternal health, and child health (Firoozi, Lemière, Beauchesne, Perreault, Forget & Blias 2012:202-214). Despite being a fundamental right for all women and critical for the psychosocial well-being of mothers and their children, maternal mental health has not been included in the health plans of LMICs (The Partnership 2014:2). According to a recent study, 16 per cent of Ethiopian women suffer from depression, and this includes all LMIIC women (Baron, Hanlon, Hall, Honikman, et al. 2016:2).

Maternal mental health has a huge influence on the type of care that a child might receive. Mothers, children, and families may experience genuine enthusiasm and physical and financial consequences if postpartum depression is not treated. Assistance to the maternal CMDs considerably affects the nature of care (Bindt, Guo, Te Bonle, Appiah-Poku et al. 2013:9).

In sub-Saharan Africa, utilizing balanced multivariate models, an investigation found that maternal signs and manifestations of the scholarly issues have been related to both ordinary turn of events and most improvement under scales, aside from language (Servili, Medhin, Hanlon, Tomlinsin et al. 2010:35).

The Ethiopian National Mental Health Strategy perceives the vigorous interconnections between psychological maladjustment and destitution (FDREMOH 2011:6). In the potential cohort study using patent health questionnaire (PHQ), the rate of sadness and uneasiness signs was 28.9% and 14.2% which shows that downturn and additionally nervousness in the third trimester of being pregnant are not, at this point, fair-minded indicators of horrible birth results in low obstetric hazard moms (Uriyo, Abukakar, Swai, Msuya et al. 2013:1).

CMD affects up to one in three people in the community, with a predominance in women (Steel, Marnane, Iranpour, Chey et al. 2014:482-486). A systematic review using WHO

on the prevalence of CMD during pregnancies in LAMIC revealed a range from 5.2% to 33% (Fisher, Mannava & Luchters 2012:34). In the latest one carried out in Ethiopia, it was excessively high (Baumgartner, Parcesepe, Mekuria, Abitew et al. 2014:482-486). Indicators on the neighbourhood degree of distress originating in the provincial locale showed as far as particularly over-the-top scopes of CMD, self-destructive conduct, and delighting undermining life events with regards to low phases of revealed social help.

The prevention of disorder is challenging for the whole community, not just for clinicians and their patients. To retrieve and survive the societal contexts that are often challenging, women need helpful and fair systems to assist them. Everyone understands that health improves when people follow social guidelines and feel connected to their family, friends, and community (Baker 2012:2).

Improving prevention activities for maternal CMD requires creative methodologies at the community level.

For patients with unique symptoms of situations and prenatal offers in Ethiopia, primary care remains the most time-honoured point of entry into the healthcare system. By this, Ethiopian urban and rural health extension workers were trained to focus on mental health preventive initiatives in the community, even though the carrier is not visible (FDREMOH 2011:15).

Even though the CMD issue in Ethiopia is equivalent in most developing nations, access to mental health services is constrained. Government commitment and the institution of sturdy partnerships have enabled Ethiopia to bring mental health offerings to many who earlier had not gotten admission at all (April & Bank, 2016:3).

Taking action on higher mental health is supposed to help nearby areas engage in positive and much needed activities to upgrade open psychological wellness and prevent emotional well-being troubles (Rossen, Hutchinson, Wilson, Burns, et al. 2016:12). There is a need to close the break between the epidemic growth of CMDs like depression and anxiety disorders. Prevention from the grass root huge-scale implementation of actual-world setting needs to be considered.

1.3 RESEARCH PROBLEM

Similarly, the research problem denotes a pair of challenges that the investigators' association must solve in the context of a practical or an imaginary situation and is referred to as the research problem (Debarun Chakraborty 2016:24).

Poor emotional well-being throughout pregnancy and after birth impacts a woman's support and the growth and advancement of a kid (LMIC). It has been extensively established that emotional well-being administrations have been underfunded for quite a long time. A huge number of people have had no support by any stretch of the imagination (Mental & Taskforce 2016:1). In the investigation indicated that there is an absence of financing for psychological wellness benefits in LMICs which has been attributed not exclusively to a shortage of subsidizing moreover to the nonappearance of enthusiasm about those with scholarly diseases (Armijo 2013:94). Therefore, understanding stigma both at the community and institutional decision-making degree is a quintessential step to enhancing mental health services and policies in Ethiopia. Additionally, CMD has been reported in between 10% and 50% of mothers who live in the community (De Peffer, Cabral, Torres de Mirand & Ferreira 2012:1). As in many other sub-Saharan countries, a comparable situation exists in Ethiopia. As a mental health professional, the researcher has all too regularly found that too many women in Ethiopia go through post-partum depression after having their babies. Maternal depression has numerous bad consequences for the woman herself. These include loss of functioning (inability to function in daily tasks or social roles), loss of interest in self-care and infant care, and behaviour that affects different health conditions (Lund & Town 2016:2).

Furthermore, a situational analysis carried out in Ethiopia highlighted that there is an absence of confirmation on the accessibility of socio-socially pertinent psychosocial intercessions for mental disorders (Baron et al. 2016:4). The guidelines from an integrated service of maternal CMD service and MCH in primary health care (PHC) play a key part in anticipating mental disorders (Fisher et al. 2012:2). There is additional evidence for an impartial position of socio-cultural observation in maintaining maternal mental health in Ethiopia. The substantial sociocultural elaboration of prenatal duration in non-western peoples has been hypothesized to safeguard CMD of postpartum among mothers (Hanlon, Medhin, Alem, Araya et al. 2010:5). In the study conducted in urban Oromia

Ethiopia, at Jemma town there is a high predominance of the illness among the study population (Kerebih 2016:2). There is also an increased risk in females, housewives, in the individuals who could not peruse and compose, in current Khat clients, and in respondents who revealed that they had an incessant physical disease.

WHO has proposed the improvement of system-passionate prosperity organizations through incorporating mental well-being into the present fundamental social protection structure and the getting-together of system resources.

Against this backdrop, those coherent strategies are required for community-based prevention of maternal CMDs in urban Oromia, Ethiopia. These strategies will include cost-effective psychological interventions delivered by community health workers or lay counsellors. Therefore, this study must be conducted so that the strategies emanating from it will be evidence-based. If nothing is done, the hazard factors for psychological well-being issues, for example, sexual and physical maltreatment during youth; family, school, and network savagery; destitution; social avoidance, and instructive hindrance, will endure. Creative procedures for conveying network-based emotional well-being care in Africa have come and, to a great extent, gone (Alem, Jacobsson & Hanlon 2008:54).

Pioneers of African psychiatry showed a promising drive to work with customary healers and adjust administrations to the African financial setting. It will benefit the conceptualization of network psychological well-being advancement and counteraction in this investigation.

1.4 RATIONALE OF THE STUDY

The prevalence and associated factors of maternal CMD in the general population have been discovered in much research worldwide. Hence the majority of Ethiopian research did the same. However, the community-based preventive service did not explore and describe the challenges underlying ANC CMD community-based prevention.

This study describes personal experiences and outcomes of approaches for community-based prevention of maternal CMDs in urban Oromia, Ethiopia, in addition to estimating

the prevalence, risk, and protective factors of maternal CMDs, to develop a community-based prevention strategy that will improve maternal mental health services in the area.

1.5 AIM OF THE STUDY

1.5.1 Research purpose

This research aims to develop strategies for community-based prevention of maternal CMDs in urban Oromia, Ethiopia, based on the findings of the empirical study conducted in the first two phases.

1.5.2 Research objectives

Research objectives are distinct, clear, or brief statements derived from the study topic and rationale. The study aims to give quantitative research support in defining the factors and population to be studied. The research focused on the aims that were tied together (Burns, Scholin & Zaslofsky 2011:145).

1.5.2.1 Phase 1

- To estimate the prevalence of CMDs among pregnant women in urban Oromia Ethiopia.
- To establish risk or protective factors of maternal CMDs at the community level in urban Oromia, Ethiopia.

1.5.2.2 Phase 2

- To explore and describe personal experiences and outcomes of approaches for community-based prevention of maternal CMDs in urban Oromia, Ethiopia.

1.5.2.3 Phase 3

- To develop strategies for community-based prevention of maternal CMDs in urban Oromia, Ethiopia.

1.5.3 Research questions/hypotheses

It regulates the type of information that should be collected during an examination. This was used to formulate the research questions (Bettany Saltikov 2014:6). The following research questions were used in this investigation:

1.5.3.1 Phase 1

- How prevalent are maternal CMDs in urban Oromia Ethiopia?
- What risks and protective factors are associated with maternal CMDs in urban Oromia, Ethiopia?

1.5.3.2 Phase 2

- What are the personal experiences and outcomes of approaches for community-based prevention of maternal CMDs in urban Oromia, Ethiopia?

1.5.3.3 Phase 3

- What can be done to prevent community-based maternal CMDs in Urban Oromia, Ethiopia?

1.6 SIGNIFICANCE OF THE STUDY

There are no coherent strategies to prevent CMDs among pregnant women at the community level. An ongoing report affirmed a committed maternal CMDs service, and the accessibility of mental health experts was either constrained or non-existent in PHC units (Choi, DiNitto, Maerti & Choi:359). It is imagined that the result of the investigation will fill in this gap in Ethiopia's health care system. This study helps develop and implement effective and evidence-based prevention strategies for solving the public health problem. It will also help to improve partnerships and interpectoral and interfaculty department linkages.

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

Philosophical views about characteristics, ideas, and the concept of information underpin research. Various essential rules and phrases necessitate thinking and knowledge to

accept these philosophical views. The awful reality is that current terminology might be unclear, which confounds the learner specialist's comprehension of these observations.

The historical paradigm originated from the Greek word, which was first utilized to measure the design of the study and guide the researchers (Blaschke, Hay, Kelly, Lang, et al. 2014:180-191).

A paradigm incorporates a group of major thoughts, factors, and concerns joined with concerning methodological strategies and devices. As per the researcher, the term paradigm indicates an investigation technique of life with an allowance of faith-based expectations, potentials, and suppositions that a system of analysis has concerning the nature and propensities for the investigation (Aliyu, Bello, Kasim & Martin 2014:13). Generally, it is thus the construction, and system or arrangement of logical and scholarly thoughts, qualities, and presumptions (Olsen, Lodwick & Dunlap 1993:245). Research theory is about collecting, studying, and applying the data phenomenon.

The author models a point of view about research held by utilizing a system of authorities that is situated in a lot of shared suppositions, ideas, qualities, and practices (Christensen 2011:31). Standards are additionally perceived as organizing out structures or disciplinary frameworks and continue making sense of qualities, methods, and detects that make assumptions regarding the environment and direction of research (McKerchar, Green, Myerson, Pickford, Hill & Stout 2009:18).

The utilization of this thought of ideal philosophical models is great while proposing a broad commitment to the reason for unpractised preparing for unpractised mechanical expertise (Karstensen, Peters & Andrew 2013:23).

Paradigms are prospective research conducted through community researchers predominantly grounded in shared assumptions, practices, values, and concepts. Paradigms are also recognized as organizing systems or disciplinary conditions and keep figuring out characteristics, techniques, and practices that create outlooks about the nature and behaviour of research (McKerchar et al. 2009:20). The utilization of this idea of philosophical paradigms is proposing a broad commitment to the reason for

unpractised preparing for inexperienced expertise (Lincoln, Lynham & Guba 2018:101-107).

Ideal research models characterize for the scientist what it is they are about and what falls inside and outside the constraints of authentic research (Guba & Lincoln 1994:108). Classifying ideal research models (Terre Blanche & Durrheim 1999:43), the examination strategy has three central measurements: cosmology, epistemology, and philosophy. As indicated, an examination worldview is a comprehensive device of interrelated practice along three dimensions.

(1) The ontological, for example, what is the structure and nature of the real world.

(2) The epistemological, for example, what is the fundamental conviction about information (for example, what can be known).

(3) The methodological for example in what manner can the analyst approach discovering whatever s/he accepts can be known.

1.7.1 Research paradigm

A paradigm is a collection of concepts, standards, or points of view. It is also a perspective on something. When you alter paradigms, you change your perspective on something. A paradigm is a method of looking at natural events characterized as a worldview or a universal viewpoint on the world's challenges (Mocha & Patterson 2017:39). It encompasses a set of philosophical assumptions and beliefs that guide the researcher's approach to the investigation (Creswell & Creswell 2018:15). The philosophical underpinning for this research study is *Pragmatism*.

A pragmatic researcher aims to alter a problem by delving into its intricate, interconnected components to better understand the situation as a whole. The objective is to give options and take appropriate action. Unlike positivism and interpretivism, pragmatic research philosophy allows for the integration of several research methodologies and research techniques within a single study (Creswell & Creswell 2013:45). Investigations based on the pragmatic research philosophy can employ a variety of research methods, including qualitative, quantitative, and action research.

1.7.1.1 Ontology

The discussion of what is hypothetically said to exist in some world refers to otology (Nelson, Genero, Piattini & Poels 2012:220). It is additionally referred to as metaphysics and "a part of theory worried about communicating the context and construction of the world." It manages the idea of the real world.

1.7.1.2 Epistemology

Epistemology (what is respected to be effective), instead of the human being (which is valid to be accepted), includes a scope of ways of thinking about the research procedure. Epistemology is a technique of gratefulness and describes how we know what we know (Jamshed 2014:3). Epistemology is also about giving a philosophical framework for figuring out what sorts of abilities are possible and how we can ensure that they are both sufficient and legitimate (Maynard 1994:10).

The intention of science, at that point, is the strategy of renovating things accepted into issues known: doxes to episteme. Two essential research ways of thinking have been recognized in the Western lifestyle of science, explicitly positivist (now and again known as rational) and interpretivism (Galliers 1991:51).

1.7.1.3 Methodology

The technique is "the methodology" arrangement of the activity arrangement of graph lying at the rear of the decision and utilization of exact methodologies and connecting the decision and utilization of the strategies to the preferred outcomes (Galakatos, Crotty & Kraska 2017:3).

1.7.2 Pragmatism

Practicality is depicted as a way of thinking where the world is viewed as having solitary, and numerous real factors that are available to exact requests arranged toward comprehending main problems on the planet on the other hand than on suppositions about the idea of information (Creswell & Plano 2011:20). The belief system is genuine just if it works (especially in publicizing value, opportunity, and equity) and produces

reasonable punishments for society. Subsequently, realists centre not around whether a suggestion suits an exact cosmology but on whether it suits an explanation and is effective (Ryan 2010). Confidence is genuine if that trust opens opportunities for higher methods of just, intentional living (Kelemen & Rumens 2012:56). While practical people inquire about and explore standards that can keep on being discrete, they can likewise be blended or mixed into each other's research structure. Subsequently, sober-mindedness looks at blending quantitative and subjective data (Briggs 2014:29).

1.8 CONCEPTUAL FRAMEWORK

The modified Socio-Ecological Model (SEM) will employ the theoretical framework for this study.

1.8.1 The Social-Ecological Model (SEM)

A premise-grounded layout about the multi-layered and working-together consequences of non-open and biological components oversees practices, and makes sense of conduct and basic impacting elements and authorities for wellbeing advancing inside social orders.

The brief classification of the known five nested SEM includes Individual, relational, network, hierarchical, and strategy/empowering to prevent CMDs disorder of the framework. The most prominent methodology for CMDs prevention for community mothers executives utilizes a blend of mediations at all levels of the model (Dahlberg & Krug 2002:56).

1.8.2 Individual identifiers

These are attributes of a behavioural change of an individual, together with information, mentalities, conduct, self-adequacy, influential history, sex, age, strict character, personality, sexual direction, financial status, economic assets, cultural/ethnic values, objectives, desires, proficiency, disgrace, and others.

They are relational official (and casual) interpersonal organizations and social help structures that can influence personal behaviour, comprising of private, friends, peers, colleagues, strict schemes, customs, or agreements.

1.8.3 Community factors

These are acquaintances among associations, foundations, and instructive frameworks depict inside limits, which join the assembled condition (e.g., parks), town affiliations, network pioneers, organizations, and transportation or social establishments with rules and arrangements for activities that hurt how or how well, for instance, pregnancy maternal and child health (MNCH) organizations are given to a character or integration.

1.8.4 Enabling environment

Enabling environments are nearby, local, countrywide and universal laws and strategies, comprising of protection arrangements concerning the allotment of hotspots for maternal, pregnancy, and infant wellness and getting right of passage to medical services administrations, prevention approaches, for instance, over time or duty payments for mental health workers, or absence of approaches that require for youth and adolescent.

1.9 MODIFIED SOCIAL-ECOLOGICAL MODEL USED FOR THE STUDY

According to this study, there are just three advanced steps of the SEM. To incpororapte individual, peer, family, and cultural, the SEM is adjusted as follows:

1.9.1 Individual

Mental distress results in costs in a similar way as long treatment and lost productivity. Such issues contribute significantly to destitution (Amuyunzu-nyamongo 2013:4). At the same time, shakiness, low educational levels, a lack of housing, and sickly wellbeing have all been recognized as adding to typical mental issues. There is scientific proof that the downturn is 1.5 to different occasions logically prevalent among the low-pay social occasions of a populace (Biratu & Haile 2015:5). Destitution may need to be seen as a significant supporter of mental issues, and the opposite way around (Deyessa 2014:13). The two areas are associated in a perpetual circle and impact various components of

individual and social new development. Studies have shown a significant association between the occasion of customary mental issues and low informative levels (Uriyo et al. 2013:6). A low educational degree thwarts access to most ace occupations, constructs feebleness and fragility, and adds to a resolutely low social capital. Nonappearance of training and infirmity in this way lock in poverty. CMDs are also related to substance misuse (Kroenke, Outcalt, Krebs, Bair, et al. 2013:361).

1.9.2 Relationship

Friend and family levels in part fill the gap and improve the associations that may also assemble the danger of experiencing essential mental issues or shielding from customary mental issues. Some individual neighbouring meeting of companions' allies, accomplices, and nuclear family people impacts their direct and add to their extent of experience.

1.9.3 Societal

Thisis about consolidating the person inside the social-characteristic in the community. The social condition intertwines the affiliations, subculture, and overall population. The social-ecological components influence mental wellbeing issues.

The research proposes that the social, physical, and strategy situations sway the capacity or probability of people taking part in psychological well-being. A human being is hard to change, particularly in a domain that doesn't bolster change. Additional factors impact those decisions. The Social-Ecological Model (SEM) assists with distinguishing chances to advance and anticipate psychological well-being and ailment by perceiving the numerous components that impact a person's conduct. Attempts to change conduct are bound to be productive when the various degrees of effect are tended to simultaneously.

To prevent maternal CMDs at the community level, it is important to emphasize the individual, family and societal factors that are imperative to implement prevention strategy. Family and societal variables are basic to actualize anticipation methodology that can diminish risk factors and increment protective components at each of the diverse levels within the show.

Thus, social welfare insurance, psychological well-being care in the human being framework and foundation, and an enhancement of antipsychotic and emotional wellness strategy is significant and required for the auxiliary and tertiary anticipation of maternal CMDs.

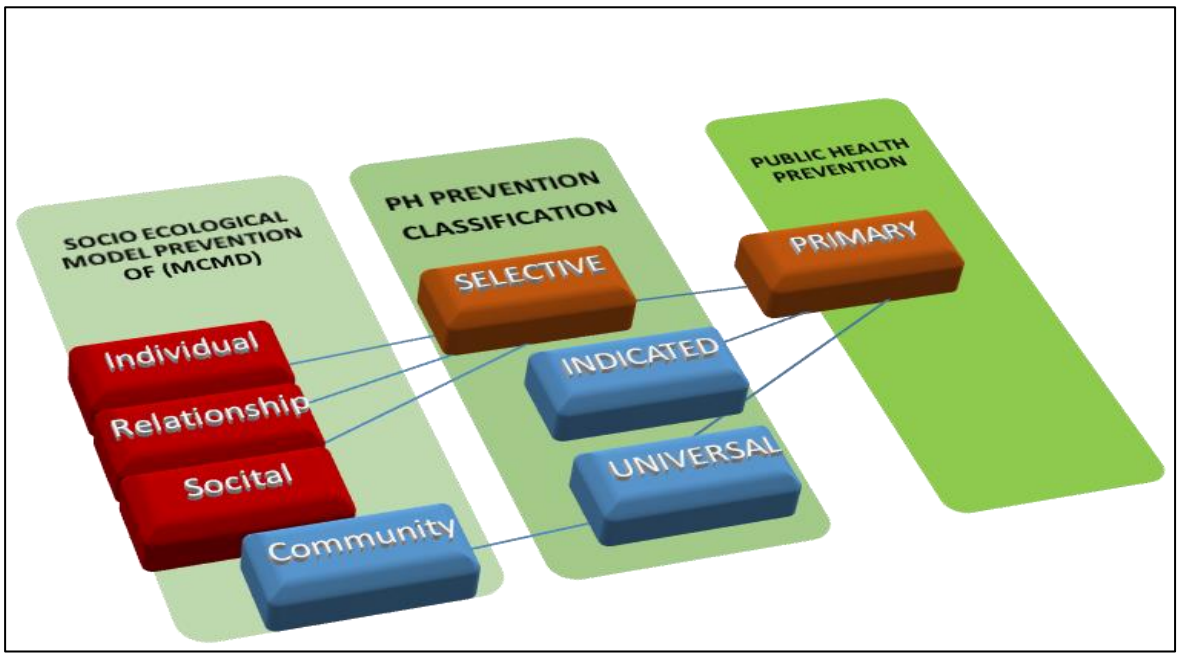

Figure 1.1: Theoretical framework for prevention of maternal CMDs Social-Ecological Model (SEM)

(Dahlberg & Krug 2002)

1.10 DEFINITION OF KEY TERMS

This includes the hypothetical implications of the ideas under our investigation (Flick, Maxwell & Chmiel 2014:59). It aids in understanding the research's major concepts. The significant meaning of ideas is differentiated against the main words of this investigation.

1.10.1 Anxiety disorder

This involves uncertainty that can make individuals feel restless more frequently than not, or just in rare instances that occur for no apparent reason. People with emotions may

have uncomfortable control assumptions, so they maintain a key good way from daily plans and activities that may trigger these feelings. A few people have had coincidental anxiety episodes that have left them terrified or powerless (Rector, Bourdeau, Kitchen & Joseph-Massiah 2008:7).

1.10.2 Common mental disorders (CMDs)

CMDs may involve a gathering of troubling states of a person showing anxiety, depressive, and unexplained somatic symptoms ordinarily experienced in the community's primary health care unit (PHCU) (Risal 2011:213).

1.10.3 Depression

A discouraging state of mind, lack of intrigue or contentment, diminished vitality, slants of fault or poor self-esteem, disturbed rest or desire, and down and out focus are all symptoms of these CMDs. Similarly, bitterness is frequently associated with feelings of unease (WHO 2014:5).

1.10.4 Harmful substance/Khat use

Khat is a bushy plant that grows and is eaten in East Africa and the Arabian Peninsula, particularly Ethiopia, where it is traditionally used for socializing and spiritual rites. In a gathering and balancing act, it is regularly consumed by chewing young leaves (Ewenat Gebrehanna 2014:45). Khat cathinone is a plant with amphetamine-like attributes.

1.10.5 Hazardous drinking

This is alcohol abuse that increases the risk of negative consequences for the client or others. Despite the absence of any current concern in the specific client, dangerous drinking patterns are of general importance (Babor, Higgins-Biddle & Saunders 2001:20).

1.10.6 Health

World Health Organization (WHO) (2011:3) defines it as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity".

1.10.7 Maternal health

Describe how women's health changes during pregnancy, labour, and postpartum (baby blues) (WHO 2014:02).

1.10.8 Mental health

Psychological well-being is defined as a state of prosperity in which each individual is aware of their latent potential to cope with everyday stresses, is connected and profitable, and can concentrate on their surroundings.

1.10.9 Mental health literacy

Knowledge and convictions about mental illness aid in their recognition, treatment, or avoidance (Reavley, Morgan & Jorm 2014:3).

1.10.10 Positive mental health

This is a dominant capability in a wide range of activities. Life's troubles never appear to spiral out of control, and others seek it out for its multiple beneficial traits (Donovan & McHenry 2017:134).

1.10.11 Prevention of mental disorders

This mostly focuses on obvious disarrays and plans to lessen the rate, prevalence, or truth of centred difficulties, such as mortality, bleakness, and hazard practices (WHO 2013a:26).

1.10.12 Protective factors

Protective factors are situations or characteristics in people, families, communities, or society as a whole that reduce or eliminate risk, therefore improving children's and families' health and well-being (Bynner 2001:6).

1.10.13 Quality of life

A person's perception of his or her circumstances in life about the way of life and value frameworks in which he or she lives, as well as his or her goals, ambitions, emotions, and concerns (Group 1995:1406).

1.10.14 Resilience

Characterizes a method having the option to skip once again from troublesome occasions and adapt well to difficulties (Werner & Stawski 2012:291).

1.10.15 Stigma

WHO (2002:16) defines stigma as a symbol of disgrace, disfavour, or disagreement that causes an individual to be discarded, mistreated, and excluded from various social settings.

1.10.16 Urban Oromia

This consists of 18 administrative towns, with a total converted working population of 1,770,274 from the Oromia regional health bureau from 1 July 2017 (Batu 2016:3).

1.10.17 Strategies for community-based maternal common mental disorders (CMDs)

This refers to a strategy that defines women's mental health and the essentials of pregnant women and their children within the national mental health system and health structure platform. Thiss strategy will be developed after the empirical result of the study.

1.11 OPERATIONAL DEFINITIONS

These establishe a procedure for estimating and characterizing research. An operational definition establishes an estimation technique (a series of tasks) for evaluating distinct, detectable conduct. Then it uses the subsequent valuations to define and estimate the theoretical construct (Gravetter 2012:99). Working definitions or operational definitions are used when a researcher characterizes concepts for an investigation. They

distinguishe the study population in a quantitative structure (Kothari, Kumar & Uusitalo 2014:66). All key concepts will be used as defined above. The study's concepts will be applied operationally as they appear below.

1.12 DEPENDENT VARIABLE

The dependent variable, also known as the outcome, is the variable being tested and measured in a research study. Its value depends on that of the independent variable (Polit & Beck 2015:726).

1.12.1 Maternal common mental disorders (CMDs)

Mental disorders include the disorder of depression and symptoms of anxiety which occur in the perinatal period and beyond. The rage of the case defines as follows:

1.12.2 Common mental disorder (CMD) case

This is defined based on the cut-off score of the patient health questionnaire (PHQ) and GAD 7 for depression and anxiety as follows:

When screening severity of depression PHQ scoring 0-9 Not depressed, 10-20 depressed, and a score of 21-27 highly depressed and advised to consult a professional.

The Depression sum of a score less than 10 is coded as 0, "NOT CMD", but if the sum of the score is 10 and above coded as 1 considered as "CMD".

CMD - Depression coded 1 and Anxiety coded 0

CMD - Depression coded 0 and Anxiety coded 1

CMD - Depression coded 1 and Anxiety coded 1

NOT CMD - Depression coded 0 and Anxiety coded 0

1.12.3 Anxiety disorder

When using GAD 7, the severity of anxiety disorders is measured by assigning scores of 0, 1, 2, and 3 to the reaction classifications of "not at all," "several days," "more than half the days," and "nearly every day," which are then added to the scores for the seven queries.

The anxiety sum of a score less than 5 is coded as 0, "NOT CMD", but if the sum of the score is 5 and above coded as 1 and considered as "CMD".

Scores of 5, 10, and 15 are individually taken as the cut of points for mild, moderate, and severe anxiety. When used as a screening tool, further assessment is suggested when the score is more noteworthy than the 10 cut point for further evaluation.

The researcher investigates the relationships between at least two factors to foresee results and draw conclusions about circumstances and logical results. In thinking about the relationship between at least two factors, the considered factors will be either predictor (independent) or outcome (dependent) variables (Kasim 2012:105).

1.12.4 Community prevention

Availability of prevention services to all community women in the reproductive age group regarding CMDs or mental disorders in general provided by WHDA or health extension workers (network level) through the government health system. In this research, the service is categorized as available or not available.

1.13 INDEPENDENT VARIABLE

The researcher modifies or changes the independent variable, which is expected to directly affect the dependent variable. In our study, the independent variables will be as follows:

1.13.1 Socio-demographic characteristics

Age of respondents, educational status, marital status, employment status, ethnicity, religion, living area urban/rural, and the number of adults and children in the household.

1.13.2 Harmful substance/Khat use

The CIDI SAM screening question for the substance “Khat" utilized included the amount and recurrence of both the heaviest use and use in the previous year, age from the start and last use, age from the outset and latest manifestations, the age that rules were first and most as of late met, and age(s) at remission(s). The CIDI SAM additionally surveys the respondent's hindrance and treatment-seeking.

In this study, the investigation will just incorporate whether the pregnant woman utilizes Khat above multiple times in the previous year or not. If yes, 1 point is categorized as "uses Khat”, and no 0 points will be scored as “not uses Khat”.

1.13.3 Hazardous alcohol use

The FAST survey has just four elements and can be completed in one moment. An all-out score of at least 3 affirms the event of hazardous alcohol use, which will have characterized perilous use in this examination. The fast alcohol screening test (FAST) was from the alcohol use disorder identification test (AUDIT) from the study conducted in Ethiopia (Medhin, Giorgis, Breuer & Hanlon 2014:5).

1.13.4 Service receipt inventory

This includes, over the past 3 months, when the participant has had a health problem, what face-to-face contact they had with the professionals, and which non-professional health service organizations the mothers went to seek help from. These could be open or private, formal or informal, herbal, traditional, cultural, religious, and other areas, and consider the correlation of administration variety with the dependent variable. In the meantime, distance from the living area, duration of time taken, and all associated costs and number of accompanied persons will be captured.

All this information is very crucial for the structure of the maternal emotional well-being anticipation system, psychological wellness mediations with an expert and normal chance, and a passage point as they are the primary entertainers of antenatal and postnatal administrations and celebratory practices.

1.13.5 Social support

We inspect social help utilizing the Oslo Social Support scale (Manual & Scale 2006) which order members as having poor (score of 3–8), moderate (9–11), or solid (12–14) social help (Manual & Scale 2006).

1.13.6 Socio-economic status

One of the most reliably reproduced discoveries in the sociologies has been the negative relationship of financial status (SES) with psychological instability. The lower the SES of an individual, the higher their danger of dysfunctional behaviour (Hudson 2005:4). Level of family unit riches are comparative with others' understanding of appetite in the former month because of the absence of cash, obligation, coming up short on the assets to get by for multi-month in case of a crisis. The expectation for everyday comforts was shown with the accompanying factors: responsibility for business, bed, and radio, accessibility of a restroom, and sterile methods for removal of refuse, including a window inside the home. Various levels of detection for everyday relief scope of these things will be ordered, lower versus greater among the 14 inquiries recorded under financial status who score 9 or more positive reaction arranges as greater and the rest as lower.

1.14 RESEARCH DESIGN AND METHOD

A three-phased study to address strategies for the community-based prevention of maternal CMDs was used. An explanatory sequential mixed methods study design was utilized. It is a kind of plan where quantitative and qualitative data sets were gathered successively in two phases, dissected independently, and then merged at the interpretation phase. The third phase was strategy development. In this investigation, quantitative and qualitative findings were utilized to test the hypothesis of realism that predicts which positively and negatively influence the prevention of CMDs at the community level for pregnant women living in urban Oromia and Ethiopia. In the first phase, the prevalence of CMDs and risk or protective factors of maternal CMDs were estimated through a quantitative method. Then, the in-depth interviews explored personal experiences, described outcomes of approaches, and identified and described risk or protective factors for maternal CMDs at the community level in urban Oromia, Ethiopia.

The nature of the variables of the research objective would not have been accessible by using one approach alone. Besides the need to introduce a deductive and inductive perspective on the independent variables, combining inductive and deductive strategies are important to fill the gap (to answer objective variables), solve the problem (to develop a strategy) and enhance the explanation.

The quantitative data was collected from the exit of the ANC clinic of the health facilities at selected administrative cities, whereas the qualitative data was collected in the working site and the natural setting of the community as per the scientific research protocol described in chapter three.

1.15 SCOPE AND LIMITATIONS

The study will take place in urban Oromia, which is a town administratively accountable to the Oromia region. This research excludes the urban districts located in zones.

Even though they may be limited due to the circumstances, the research did not go into the particular history of chronic diseases and some mental disorders that are connected to CMDs. The study includes significant expenditures related to data gathering and publishing.

1.16 STRUCTURE OF THE DISSERTATION

Under the examination destinations and research questions, the thesis is divided into coherently interconnected sections.

Table 1.1 offers a quick explanation of the thesis's structure:

Table 1.1: Summary of the content structure

Chapter	Title	Description of content
1	Orientation to the study	An overview of the study, including study aims and research questions, the centrality of the investigation, the conceptual and operational meaning of terminology, and the scope of the investigation.
2	Literature review	An analysis of the literature found on the issue under consideration provides the expert with information on what is distributed or examined in the literature. Finding relevant publications (such as

		books and journal papers), critically assessing them, and describing what you discovered was all part of the study.
3	Research design and methods	It presents precisely what will and won't be incorporated. It additionally characterizes the measures by which the researcher will assess outcomes and reach inferences. The unwavering quality and legitimacy of investigation rely upon how the researcher gathers, measures, analyses, and interprets the research data.
4	Analysis, presentation, and description of findings of quantitative findings	The overall research strategy and plan for answering the research question, setting the stage for research, investigating a worldview, challenging the approach, research technique (inspecting, gathering, and interpreting data), moral considerations, and data and structural quality (legitimacy and consistency).
5	Presentation of qualitative findings and literature control	Information investigation, introduction, and understanding of discoveries and conversation of discoveries. (To give sound contentions in an intelligent and sorted-out way following speculations and observational discoveries. Points laid out following the examination destinations and questions.)
6	Mixed method integration	The discussion will reliably interface with the introduction by the strategy for the assessment questions or theories you introduced and the thinking you investigated. Notwithstanding, the discussion does not simply repeat or re-examine the underlying sections of your paper; the discussion explains how your examination impelled. The perception of the investigation issue from where you left them close to the completion of your review of prior research.
7	Development of a strategy for prevention of community-based maternal common mental disorders, urban Oromia, Ethiopia	Portraying and proposing the promising avoidance methodology that may decrease the rate of psychological wellness issues in pregnancy.
8	Strengths, limitations, recommendations, and conclusion	The section highlighted the end feature and impediments of the investigation and closed with proposals on how the system will be used in network-based anticipation of maternal regular mental issues.

1.17 SUMMARY

The purpose of this chapter was to explain the study's purpose and offer some background information about mental health issues worldwide, as well as in Ethiopia, as background. It emphasized the necessity of mental health research. Various populations, notably prenatal mothers, suffer from prevalent common mental disorders.

At the end of the chapter, the study's objectives and research questions were developed and offered a thorough outline of the structure of the thesis that gives an overview of the whole research paper. The following chapter examines literature that relates to the study topic.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews the literature on the phenomenon under investigation in urban Oromia, Ethiopia, community-based prevention of maternal CMDs. Electronic sources, books, and journal articles were methodically searched for peer-reviewed published studies, reports, and relevant material to the research goals.

This approach involves the use of secondary or current literature, which has important findings in addition to theoretical and methodological contributions to a given topic. This methodology consequently offers reachable academic journals (Denney & Tewksbury 2013:26). A literature criticism is a systematic, explicit, and reproducible technique for identifying, evaluating, and synthesizing the existing body of carried out and recording work produced through researchers, scholars, and practitioners (Engel 2018:8).

The review defines, summarises, assesses, and explains the topic, as well as provides a theoretical foundation for the research and determines the nature of the research. These categories include the worldwide burden of maternal CMDs and health, mental health, and CMDs in the general population.

2.1.1 Importance of conducting a literature review

A literature review aims to better grasp what is known about a certain situation, topic, or problem while also identifying knowledge gaps (Kamal & Irani 2014:40).

A critical evaluation of a portion of a body of published material based on a summary, categorization, and comparison of previous research studies, literature reviews, and theoretical pieces contextualizes one's research (Cook, Marshall, Main & Deborah 2013:151). A literature review is often comprised of a summary of significant sources that consider the following factors (Boucher 2012:12; Booth, Papaioannou & Sutton 2012:03).

The review of the literature is a critical look at the existing research, which is important to the work being carried out.

- To provide background information

- To establish the importance of the research
- To demonstrate familiarity
- To “carve out a space” for further research

2.1.2 Literature review paradigms

According to the study, several methods exist for doing a literature review to further health care research. For decades, disputes have raged about whether literature review methodologies are the most or least dependable, yet, they tend to focus largely on the validity and reliability of study findings (Booth, Sutton & Papaioannou 2016:10; Polit & Beck 2013:236).

The researcher employed a variety of methodologies in this study, including argumentative, integrative, historical, methodological, systematic, and theoretical reviews. Each paradigm has its own set of advantages and disadvantages. The researcher considered all of the paradigms in this investigation. The goal of merging all paradigms is to maximize each's strengths.

The original goal of combining all of the different overview paradigms was to provide a complete picture of the sample of women with obstetric fistula, as well as excellent information on design, statistical compilation, and data analysis methods for measuring the impact of obstetric fistula care on mental health (Morris, Onwuegbuzie & Gerber 2018:24). Using certain paradigms for literature reviews can also assist the researcher in identifying ethical concerns that must be addressed throughout the research.

2.1.3 Argumentative review

The argumentative review studies information selectively to support or refute a previously established argument, firmly held assumption, or philosophical quandary in the literature (Cook & Murowchick 2014:3-11).

2.1.4 Integrative review

An integrative review is a type of study that reviews and synthesizes expert literature on a certain issue to provide new frameworks and perspectives on the subject (Onwuegbuzie & Frels 2016:30). The corpus of literature includes any research that addresses

comparable or similar theories or research challenges (Onwuegbuzie & Frels 2016:33). By evaluating relevant literature, the purpose of this literature review technique is to address or identify the research problem.

2.1.5 Historical review

The historical evaluation examines studies completed over a long period (Maynard, Bontcheva & Rout 2012:24). This type of investigation usually starts with the first mention of a topic, concept, theory, or phenomenon in the literature. Then follows the scholarship of a discipline. A historic review's purpose is to put results into a historical context to demonstrate knowledge of current events and forecast future research areas (Sarokhani, Delpisheh, Veisani, Sarokhani et al. 2013:24). A historical review was used in this study to examine the historical advancement of an obstetric fistula before and after surgical restoration to comprehend the difference or variance in the intensity of depression and anxiety.

2.1.6 Methodological review

The methodological review method focuses on the study's methods of execution. This form of evaluation does not usually focus on what a person discovers but rather on what they employed as a method of evaluation (Onwuegbuzie & Frels 2014:24). The analysis reviewing technique gives a framework for understanding how researchers draw on a diverse variety of knowledge, from conceptual to realistic fieldwork files. The review paradigm for this work focuses on the methodological issues of previous investigations, such as theories, research methodologies, and data collection and assessment techniques.

2.1.7 Systematic review

The systematic review includes a diagram of existing evidence related to a clearly defined research address. It uses pre-defined and established procedures to identify and assess critical questions, as well as collect, report, and review data from the research's investigations (Baumrind 2012:26). The systematic review concentrates on a specific experimental address that is commonly identified in a cause-and-effect framework

(Bickerdike & Booth 2017:10). “How prevalent is CMD in pregnant women, what are the factors to CMD, and how can community-level CMD be prevented?" was the question posed for this topic.

2.1.8 Theoretical review

Theoretical reviews examine the body of knowledge that has accumulated around a certain topic, concept, theory, or occurrence (Jabareen 2009:3).

Theoretical literature analysis is useful for establishing which concepts are already in use, their relationships, the amount to which current theories have been studied, and the number of new hypotheses that need to be tested. This form of research aids in the discovery of accepted concepts or holes in current theories so that new or future research problems can be better understood (Masny 2012:30). The researcher's decisions on which principles and understandings apply to the study should be driven by the investigation's objectives and questions. In contrast, modern theory and knowledge should inform the study's goals.

The study looked at what was already known about the consequences of prevalent mental illnesses on maternal mental health, as well as theoretical theories and potential future research projects. All literature overview paradigms include basic information about CMDs, mental health, especially depression and anxiety, and health services where patients can be hospitalized and treated.

To increase the audience's primary awareness, the researcher incorporated some unique data regarding Ethiopian women with common mental problems. Despite having a rickety connection to primary and secondary literature studies, the researcher claims that this third layer of information is usually referred to as “true”.

2.2 RESEARCH STRATEGY AND ORGANISING LITERATURE

To merge unique literature evaluation paradigms, the researcher used a systematic strategy (integrated literature review paradigms) to study all potential sources of literature. The researcher relied on books, peer-reviewed papers, case studies, and pertinent UNISA library archives, including the strategy for a common maternal mental problem,

prevalence, and therapy. The researcher looked through electronic databases like PubMed/Medline and the BMC/Cochrane review trial registration database, as well as hand searching the Ethiopia UNISA library's hard copies, private references, and emails to the experts' assessment list, and web resources like Google Scholar and Mendeley. As search parameters, the phrases "common mental diseases," "prevention approach," "depression," and "anxiety" were employed.

Each of the search terms used to be at the beginning used individually and then combined using the following shape to guide the literature review process:

- A summary of the subject, issue, or concept under investigation, as well as the objectives of the literature study.
- Classification of works under examination into topics or categories.
- Rationalization of how each piece is similar to and differs from the others.
- Conclusions on which pieces are quality considered in their argument as most persuasive of their ideas and offer the finest addition to the knowledge and development of maternal CMDs, as well as the relationship and prevalence, the severity of the expression and anxiety outcomes.

Before writing the literature review, the researcher clarified the following points:

- How many sources should there be?
- What sorts of sources (books, journal articles, online, scholarly vs popular sources) should be included in the review?
- Sources were summarized and analyzed by discussing a common subject or issue.
- Examine the sources of subheadings and background information.

The researcher evaluated each item of literature based on the following criteria during the literature review:

- Provenance: What are the qualifications of the researcher? Is the researcher's position backed by evidence such as historical material, case studies, narratives, statistics, and contemporary scientific findings?
- Methodology: have the procedures utilized to categorize, gather, and analyze data relating to the study topic been applied? Is the pattern's dimension appropriate? Were the effects appropriately perceived and reported?
- Objectivity: Is the author's point of view balanced or biased? Are opposing statistics evaluated, or is relevant data suppressed to demonstrate the researcher's point?

- Persuasiveness: which of the researcher's theses is the most compelling and which is the least convincing?
- Persuasiveness: Are the researcher's arguments and findings persuasive? Is it afterward useful in gaining a better understanding of the subject?

The researcher considered the following basic phases throughout the literature review procedure:

- Problem formulation: what subject matter or area is being investigated, and what are the underlying issues?
- Literature search: locating items relevant to the situation under consideration.
- Data evaluation: determining whether literature contributes significantly to the prevention of CMDs in the preventative plan.
- Analysis and interpretation: discussing the relevant literature's findings and conclusions.

Inclusion criteria for searching the literature included the following:

- Research into the magnitude of CMDs in the general population.
- Research into the prevalence of CMDs in the general population in low and middle-income countries (LMIC), Africa, and Ethiopia.
- Studies that looked at individuals, the Pear, and family, as well as society, variables that impact the development of maternal CMD.
- Research on the impact of personal experiences and the effects of initiatives for community-based prevention of maternal CMDs in low and middle-income countries (LMICs), Africa, and Ethiopia.
- Research into the role of mental illness prevention.
- The research looked at maternal help-seeking behaviour.
- Research published since 2011.
- Research that has been published in English.

2.3 MENTAL HEALTH

Mental health or psychological well-being is a significant aspect of an individual's ability to lead a fulfilling life, including building and maintaining relationships, studying, working, or pursuing leisure interests and making day-to-day decisions about education, employment, housing, or other choices.

Nonetheless, “there is no health without mental health,” as WHO warns. Mental health is defined as the ability to recognize one's abilities, interact constructively with others, deal

with life's stressors and obstacles, work successfully and fruitfully, and contribute to one's family and community. It should be noted that the definition is not exhaustive.

It is worth noting that the definition does not just refer to the absence of “mental illness” but also includes the concept of “mental wellness” (Ibrahim 2012:2). Disruptions to a person's mental health can have a detrimental influence on their decision-making abilities. Disruptions to a person's mental well-being can adversely affect this ability and the choices made, leading not only to reduced functioning at the individual level but also to wider losses of welfare for the household and society (WHO 2013a:6).

In the framework of this study, three major ways of mental health care, namely biological, psychological, and social approaches, are critically investigated and assessed. Following that, three well-known sociological ideas are addressed. Finally, one of these ideas, stress theory, is carefully investigated to determine its usefulness in the current disagreement.

Historically, there have been three major conceptions of health throughout human history. Throughout much of history, the pathogenic approach to health has been dominant (Do, McCleary, Nguyen & Winfrey 2018:34). Health is defined in this method as the absence of illness and incapacity.

Even though the alternative method, or alternative notion of health, may be traced back to Greek and Roman texts, it was not until the twentieth century that it became prominent in mainstream theoretical discourse (Antonovsky 1979:68). It is also utilized the era in the past by the author (Maslow 1966:102). Rather than using the pathogenic method, this health perspective views health as effective states of thinking, feeling, and acting capabilities and functioning (Strümpfer 1997:95). The holistic state model, which is the most current and most debated in modern literature, is the third method. This is the complete technique. According to the WHO (2014), “Health is more than the absence of sickness or disability; it is a condition of total physical, mental, and social well-being.

Mental health and mental disease are two distinct fields of research that not only provide unique problems but also have a wide range of policy implications. Similarly, these

theories use varied approaches to differentiating fitness from sickness and sanity from insanity. "Mental health," it may be argued, is a fluid concept whose meaning varies depending on the circumstances. Indeed, the WHO (2004) defines mental wellness as a country with an excessive level of psychological well-being, self-esteem, and the ability to maintain social connections, not only the absence of sickness.

The majority of people fall somewhere along the continuum of qualities that make up mental health. As a result, as opponents of CMDs, advocates of mental health promote a wide range of programs to promote mental health in the general population rather than focusing just on mental disorder patients.

These models are generally focused on the promotion of mental health and the prevention of mental disorders through education, emphasis on boosting and reinforcing healthy practices. This approach to mental health brings us closer to the "continuum model" of mental health. Continuum models of health have been a dominant perspective in research scholarship since the seventies (Scheid & Brown 2010:54). As a substitute for different identities, this paradigm considers mental health and mental disorder as two ends of a continuum. In this sense, the model implies that most people fall somewhere in the middle of the continuum. As a result, the distinction between mental health and mental disease is not absolute; rather, it reflects the extent to which a man or woman and his or her conduct are affected. There is occasionally sufficient clinical evidence to conclude that a man or woman is suffering from depressive disorders, schizophrenia, or other mental illnesses or that he or she is not. As a result, psychiatric patients are identified by establishing their indications, symptoms, and classifications within their specific illnesses (Scheid & Brown 2010:61).

The emphasis of this study is on pregnant women and the prevalence of CMDs among them. This study does not follow an experimental protocol for locating information on selected patients. Instead, it aims to investigate the pregnant mother's health status and vulnerability to prevalent mental illnesses. As a result, the study design and research aims are more strongly associated with the continuum model of mental health and disorder.

2.3.1 Approaches to mental health: An interdisciplinary theoretical debate

Aside from the continuum/dichotomous argument over mental disorders, every other approach raises questions about the nature of psychiatric symptoms. Some mental health professionals, including most psychiatrists, see psychiatric symptoms as evidence of illness, whereas others see them as signs of abnormality (Pescosolido & Boyer 1999:97). Human beings with significant symptoms that create dysfunction are the focus of the former's concern. Advocates of this perspective likely support the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) of the American Psychiatric Association as the definition of mental illness (American Psychiatric Association 2013a:6).

The DSM-IV defines a mental disorder as a clinically diagnosable behavioural or psychological condition, or pattern linked to current suffering or impairment or that may also cause decreased functioning. It is also highlighted that such a condition or pattern must be driven by more than just cultural or environmental factors.

Regardless of the cause, it should, at the very least, disclose a dysfunction that can be recognized in clinical settings. Abnormal conduct is neither a mental disorder nor is a conflict between character and society. These behaviours may only be labelled as mental disorders if they appear to be an indication of an individual's malfunction. In contrast to the DSM, mental illness can also be thought of in tertiary terms (Pescosolido & Boyer 1999:53).

As a result, many who are labelled as mentally ill are socially aberrant. While every culture has some degree of deviance, "mentally ill" individuals are those who are classified as such by mental health experts, family, peers, and other means (Pescosolido & Boyer 1999:64). The DSM does not include deviant behaviours in its description of mental diseases, but it does include actions that suggest deviance as an alternative to intrapsychic disorders in the classification of numerous concerns listed therein. These include substance abuse, antisocial personality disorder, and behaviour disorder.

Sociologists investigate the mechanisms that contribute to the classification of some behaviours as mental disorders rather than anything else. According to the researcher, perceiving "madness as a disease and linked worry of unreason" as a result of positive structural dynamics in the eighteenth century (Foucault 1965:89). These dynamics, he

argued, emerged as a result of the development of a civilization in which abstract contemplation took precedence over corporeal activity. People who had lost their cause were ostracised or expelled from society at the time. Criminal conduct has been linked to individualized insanity. According to Foucault (1965:113), psychiatry was created to segregate the sick from other dubious categories, such as the terrible and criminals.

Furthermore, has spoken out on the debate over whether mental illness is a medical ailment or a socially created label for abnormal conduct (Szasz 2012:231). Szasz (2012) mentioned that mental health is no longer an illness since it is no longer linked to identifiable physical defects but is a term applied to socially unacceptable actions. Classifying someone as "mentally ill" may limit their ability to exercise freely in their activities. Compulsory treatment of mentally ill persons is said to be a kind of punishment akin to prison (Szasz 2012:245). Furthermore, the psychiatrist's incapacity to distinguish between mentally ill persons and pseudopatients was highlighted (Rosenhan 1975:67). Those who see mental illness as a social construct that should not be treated only in professional settings applaud his work (Rosenhan 1975:79).

Given the debates and anomalies surrounding the nature of mental health and illness, developing an objective standard to assess them is a challenging task. There is a clear distinction between sociological and medical methods here as well. Sociologists are more interested in studying the sociology of the patients than in bringing them into treatment settings.

Their reluctance to research people in scientific settings originates from their opinion that these people are no longer a representative sample of all people suffering from mental illnesses. It is believed that the great majority of people suffering from mental illnesses do not seek professional help or participate in alternative activities such as spiritual settings (Dein 2013:25; Abu-Omar, Rütten & Lehtinen 2004:76).

The difficulty of researching untreated persons in public areas raises significant philosophical questions regarding how to characterize and quantify mental illness. Maternal common mental illnesses are examined objectively and subjectively in the current study and are based on literature and respondents' knowledge, i.e. pregnant moms.

This study aims to comprehend the risk and defensive variables surrounding community moms and their experiences and methods for seeking support. The study's objective was to measure the prevalence of CMDSs amongst pregnant mothers, to be aware of the threat and protective factors and experiences and strategies on how they protect and cure CMDs, and then to suggest a community-based prevention strategy. It has nothing to do with these mothers who are receiving medical care. Instead, it is more interested in comprehending such tendencies toward mental illnesses, which may lead to the termination or seeking assistance for pregnant women's lives.

Mental health encompasses our emotional, psychological, and social well-being in general. It impacts how we think, feels, and act as we deal with life. It also influences how we deal with stress, interact with people, and make decisions. Mental health is significant at all stages of life, from childhood to maturity. As a result, it is critical to research toddlers with moms who are pregnant.

2.3.2 Approaches to mental health

The approaches to mental health are generally categorized into four subsets: (i) biological, (ii) psychological, (iii) psychiatric-epidemiological, and (iv) sociological. A summary of each approach is given below:

2.3.2.1 Biological approaches

Biological methods view mental diseases as any other sickness. The place of apparent disorder is established by utilizing some anomaly in the body. The irregularity is perceived to be related to the brain in the case of psychiatric disorders. Thus, the goal of these strategies is to recognize the link between abnormalities in brain functions and psychiatric problems (Black & Andreasen 2014:74); Rice, Reich, Andreasen, Lavori et al. 1984:86). Mental disorders are said to have hereditary, neurological, or physiological origins, according to a variety of hypotheses. These ideas consider mental illness a sickness that can be treated with medication rather than psychotherapy. Recent advances in neuroscience, which seek to understand the key connections between brain anatomy and human behaviour, have confirmed biological or natural techniques.

2.3.2.2 Psychological approaches

Individuals, rather than groups, are the primary focus of psychologists. Individual stage factors of aberrant thoughts and actions are of interest to them. Traditionally, psychology has been constrained to operate within specific theoretical frameworks. Nonetheless, it has recently been proposed that the subject's scope should be broadened. Psychologists are now pursuing therapeutic approaches to alleviate distress. It is underlined that psychiatric disorders' physiological and genetic foundations must be better understood. Concurrently, societal factors impacting mental health disorders should be seen as both predictors and determinants of mental illnesses.

2.3.2.3 Psychological models

The anomalies do not rule out the biological reasons that contribute to mental disorders. From a therapeutic standpoint, psychological models place less emphasis on organic variables. Psychological theories that attempt to explain unusual behaviour can also be categorized based on their various foci. Some theories emphasize the significance of "feelings" in odd conduct, others emphasize behaviours and maladaptive patterns of behaviour, and others emphasize concept processes that may also lead to dysfunction.

2.3.2.4 Psychiatric epidemiological approaches

Mental Health epidemiology, as the name indicates, is a subset of medical epidemiology. It looks at the prevalence and trends of mental illnesses and their connections in certain areas. Psychiatric epidemiology, in particular, is concerned with the influence of social events and socio-demographic characteristics on mental health outcomes, such as age, gender, social class, and employment. This field of research is covered by both sociology and psychiatry.

Mental epidemiology frequently employs the survey research method to learn about large populations, which is also usually connected with sociology. While large samples of human beings are necessary for generalizability and policy, it is a challenging task in the case of mental illness. Non-clinicians perform epidemiological surveys regularly, inquiring about respondents' indications and symptoms. Diagnostic mistakes are more frequent in these circumstances due to a lack of protections and corrective procedures that should

only be available in medical settings. It is also no longer practical for physicians to interview a large sample of the community to make an accurate diagnosis. As a result, epidemiologists must rely on non-clinician general-purpose interviews.

2.3.2.5 Sociological approach and theories

The sociology of mental health and sickness incorporates components of both the biological and psychological approaches to mental illness. It is, nonetheless, distinct in its philosophies and methodological approach. Sociological perspectives hold that mental diseases and mental wellness are products of social life. In general, sociological threads in mental health and illness can be classified into two groups. Some methods concentrate on social conditions such as family conflicts, stressful life events, monetary strain, and social expectations, among others, which may have an impact on people's mental health.

Other approaches focus on cultural components' role in defining mental illnesses and responding to mental health difficulties. It is vital to notice the frequency of stressful occurrences in people's lives when discussing mental health and sickness (Holmes & Rahe 1967:75). Such occurrences may include traumatic childhood memories, the death of loved ones, major threats, the dissolution of intimate relationships, and the loss of work, among others. Being a victim of physical or sexual violence, witnessing a violent occurrence, or suffering from famine can all be extremely stressful events that can have long-term effects on an individual's mental health (Horwitz 2007:20). The frequency and severity of such significant episodes in one's life, regardless of biological or personality characteristics, is a major predictor of mental illness. Such conditions, it could be argued, are predictable and generally transcend the sphere of people's personality attributes, which could otherwise play a role in dealing with these stresses.

Given the preceding, sociological approaches are less interested in a limited number of persons designated as mental health patients or receiving mental health therapy. Sociologists use a variety of techniques to better understand the condition of mental health in large community samples. They may utilize statistical data to measure the prevalence of mental health issues, examine their social causes, and assess their findings in the context of a policy paradigm, such as the availability of mental health treatment in different areas As a result, sociological study on mental health and illness can help to

understand and explain societal differences in mental health. On the other hand, individual experiences of mental illness have received little attention in the sociological literature. As a result of this, the following section discusses significant sociological theories involving mental health.

2.3.2.6 Sociological theories

Three ideas may largely account for the social perspective on the origin of mental illness. These are structural strain theory (i), labelling theory (ii), and stress theory (iii). A brief review of these ideas is provided below, including their assumptions, strengths and flaws, and significance to the prevention and treatment of mental illness:

2.3.2.6.1 Labelling theory

The labelling hypothesis is based on the idea that if people characterize situations as real, then they are real in their consequences (Glassner & Corzine 1978:34). As a result, classifying and treating someone as mentally sick may contribute to mental illness. The labelling theory suggests that breaches of socially established values and standards are seen as symptoms of mental illness by the general public.

As a result, someone who is mentally ill in one group may not be recognized as such in another where moral norms differ. In an ironic twist, labeling theory claims that the ethical standards that separate what is normal from what is abnormal might be adjusted to prevent or treat mental illness. Labeling theory promotes critical approaches to social phenomena, which may be valuable in understanding the repercussions of labeling as well as the institutional definition of acceptable and unacceptable behavior.

2.3.2.6.2 Structural strain theory

The etiology of psychiatric illness, according to structural strain theory, is found in the macro-social organization. Mental problems can arise as a result of structural pressures or from a person's social integration into society. During a recession or a conflict, for example, the number of people admitted to mental health institutions may rise (Thoits 2012:8; Aneshensel, Rutter & Lachenbruch 1991:65). During periods of relative calm and

economic stability, on the other hand, there may be a decreased rate of such admission. As a consequence, structural stresses might be used to predict mental disease in people. According to the structural strain hypothesis, some persons are better suited in social hierarchies than others. These people are less prone to suffer from mental disease as a result of their resilience to specific social risks. According to this viewpoint, structural strain theory aims to improve social fairness in society by providing actions that may lessen vulnerability. One drawback of structural strain theory is that it concentrates on the behavioural outcomes of strains rather than the causes of such behaviours.

2.3.2.6.3 Stress theory

The underlining principle of stress theory is that the accumulation of social stresses can lead to psychological problems. The connection between stress exposure and the development of mental disorders is influenced by the coping methods of individuals (Folkman 1984:79). As a result, stress theory researchers prefer to focus on the relationship between stress and coping resources, as well as how stress exposure and coping alternatives differ among groups. People from low-income backgrounds are regarded to be more sensitive to mental illnesses since they are more likely to be stressed and have fewer resources.

2.4 EPIDEMIOLOGY OF MENTAL ILLNESS AND COMMON MENTAL DISORDERS (CMDs) IN THE GENERAL POPULATION

Mental illness is a broad word that refers to a variety of problems that impact one's thinking, behaviour, and emotions. A mental disorder is a more precise term for a condition characterized by clinically substantial disturbance in different elements of mental functioning (American Psychiatric Association 2013b:47).

CMDs are divided into two diagnostic groups: depressive disorders and anxiety disorders. These illnesses are quite prevalent in the community (thus the word "common") and impact the temperament or feelings of those affected; symptoms vary in terms of their intensity (from moderate to severe) and duration (from months to a long time). These disorders are recognized as health problems, and they are distinguishable from feelings of sorrow, sadness, or anxiety that everybody might experience at some point in their

existence (WHO 2017:3). The most prevalent cause of emotional problems among university students is depression (Khan, Haider & Khokhar 2015:73; Jeong, Lim, Lee & Kim 2013:41). According to thorough research published in 2013, the weighted mean prevalence of depression among university students was 30.6%, ranging from 10% to 85% (Ibrahim, Kelly & Glazebrook 2013:21). University students in both affluent and underdeveloped nations are troubled, which may seem counterintuitively distressed (Dachew, Bisetegn & Gebremariam 2015:39). Distress levels among university students were almost always greater than in the general population.

The incidence of distress among university students was virtually always higher than that of the general population (Kessler 2013:11; Stallman 2010:57). Over 300 million individuals, or 4.4 percent of the world's population, are believed to suffer from depression on a worldwide scale (WHO 2017:5).

The PHQ 9 CMD assisting instrument revealed a high incidence of depressive symptoms among patients attending general medical outpatient clinics in Nigeria. According to their score on the SRQ-20, 7 percent of Nigerian women matched the criteria for having a common mental illness, according to research performed in Africa (Ola, Crabb, Tayo, Ware, et al. 2011:7). In addition, the South Sudan study found a greater frequency of mother comments on mental illness (Uriyo et al. 2013:26).

Maternal mental health issues stem from their pre-migration experiences and post-migration situations encountered in the host nation, such as poverty, cultural adaption issues, family separation, and sexual abuse (Khanlou & Pilkington 2015:233). Furthermore, a study of violent conflict regions in South Sudan found a greater incidence (28%) (Ayazi, Lien, Eide, Ruom et al. 2012:41; Bruce, Béland & Bowen 2012:46).

Suicide rates were high in Ethiopia's rural research setting among those suffering from serious mental illnesses (Shibre, Hanlon, Medhin, Alem, et al. 2014:32). Depression can and does affect people of all ages and areas of life. Poverty, unemployment, life traumas such as the death of a loved one or the end of a relationship, physical sickness, and challenges caused by alcohol and drug use all increase the likelihood of becoming depressed (WHO 2017:5). Globally, the number of individuals suffering from CMDs is

increasing, particularly in low-income nations, as the population grows and more people reach the age when depression and anxiety are most frequent.

2.5 GLOBAL EPIDEMIOLOGY OF MATERNAL COMMON MENTAL DISORDERS (CMDs)

Maternal CMD is a significant and prevalent illness that affects the mother and may have long-term, negative effects on the child's health. Maternal depression is a key early risk factor for normal child development, the mother-infant connection, and family stability (CMCS Informational Bulletin 2016:1). Investigate the thoughts and feelings that women have throughout pregnancy and the postnatal period, their wishes for assistance from husbands and others, the challenges and difficulties they face, and the consequences these have on their mental well-being. Throughout the early phases of development, including pregnancy, the fetus forms a bond with its parent. Following birth, the child will begin to bond with a primary caregiver by copying the caregiver's facial expressions and creating eye contact with the caregiver. The caregiver-infant relationship is continuously strengthened as the kid is soothed when scared/sad, fed when hungry, and generally made to feel comfortable. This type of good and secure connection may occur only if the primary caregiver responds to the child consistently and attentively (Wimmer, Vonk & Bordnick 2009:13).

Suicide has surpassed maternal mortality as the leading cause of death in females aged 15 to 19 globally (Petroni, Patel & Patton 2015:32). Most suicides happen in the postnatal period (Gentile, Choo, Liau, Sim et al. 2011:6).

According to the WHO Mental Health Atlas, average mental health care spending in low-income nations is about $.25 per person per year, compared to about $2.00 in high-income countries (WHO 2011:25). These findings are remarkable, especially given that mental disorders have a significant negative impact on outcomes such as life expectancy and individual earnings (Esan, Van Hensbroek, Nkhoma, Musicha et al. 2012:16; Group & Lecturer 2007:13).

The number of persons who have a disease or condition at any one moment is referred to as its prevalence (WHO 2008:31). The number of persons who have a disease or

condition at any one moment is referred to as its prevalence. The variation in prevalence appears to be driven mostly by sociodemographic and health factors and the approach used. Several studies have confirmed that although the prevalence of depression has been thoroughly studied, it remains an important issue since the rates observed vary between research. The variation in prevalence appears to be mostly determined by sociodemographic and health factors (Jefferis & Hickman 2019:16). Income has been shown to influence depression prevalence rates. The World Mental Health Survey Initiative found that the average lifetime and 12-month prevalence estimates of DSM-IV MDE ranged by two to three times across wealthy and low- and middle-income countries (Bromet, Andrade, Hwang, Sampson, et al. 2011:13).

2.6 EPIDEMIOLOGY OF MATERNAL COMMON MENTAL DISORDERS IN LOW MIDDLE-INCOME COUNTRIES (LMIC), AFRICA, AND ETHIOPIA

One of the silent epidemics in most parts of African countries is mental illness. The result is a large treatment gap, with more than 75% of people in LMICs having no access to mental health services. In many LMICs, overburdened health systems are often unable to provide even the most basic mental health care, including medicines to treat mental disorders. Depression and anxiety are the two most common mental disorder conditions. Moreover, depression and anxiety are among the leading causes of functional impairment, work-related disability, and healthcare expenditures.

Furthermore, health-related quality of life can be affected by functional impairment due to the treatment of depression and anxiety, which occurs comorbid and frequently have additive and adverse effects. Depression is one of the most common mental health issues, with severe symptoms and reduced cognitive and social functioning, resulting in poor job and other performance (Kessler 2013:65; Kessler & Bromet 2013:31; Lépine & Briley 2011:4). Resources allocated to addressing mental disorders have thus far been grossly inadequate, inequitably distributed, and inefficiently used (WHO 2017:10). On average, most countries in Africa spend less than 1% of their limited health budgets on mental health care (Daar, Jacobs, Wall, Groenewald, et al. 2014:23). Measurements particular to the burden of mental illness in Africa shed assisting light on the disparities in enduring mental health care. Mental clutters account for 5% of the entire burden of illness and 19% of all incapacity in health (Amuyunzu-nyamongo 2013:59). Quantitative studies

have demonstrated that depression and anxiety in the perinatal period are common amongst women in LMIC and are associated with a range of psychosocial and health-related stressors. In the exploratory qualitative study conducted in southern Malawi (Stewart, Umar, Gleadow-Ware, Creed & Bristow 2015:11). On the Tanzanian level, the prevalence of CMD among pregnant mothers suggests that more than 1 in 4 (Bindt et al. 2013:5).

The prevalence of symptoms of anxiety 76.7% and depression 78.2% among women attending a prenatal clinic were significantly higher among younger women, with the highest prevalence found among women aged 17-29 years in the study in Tanzania (Mahenge, Stöcki, Likindikoki & Kaaya 2015:262). In the meantime, the prevalence of antenatal depression among first-trimester women was 5.1%, while it was 27.6 and 67.3 % among second and third-trimester women, respectively, conducted in the Ethiopian capital, Addis Ababa using EPDS tool (Biratu & Haile 2015:12).

The other common mental health problem category is anxiety disorders. This problem refers to a group of mental disorders characterized by feelings of anxiety and fear, including generalized anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD) (WHO 2017:7). As with depression, symptoms can range from mild to severe. The duration of symptoms typically experienced by people with anxiety disorders makes it more chronic than episodic disorders.

Given the effect of maternal depression on infant and child developmental paths, maternal depression may play a key role in maintaining inter-generational cycles of poverty. In any case, the longitudinal information to bolster this theory is not accessible in LMIC. Atif Rahman and colleagues in Pakistan are conducting long-term follow-ups of children of maternally discouraged ladies and are continuously exploring this zone (Maselko, Sikander, Bhalotra, Bangash et al. 2015:43).

As regards the Amahara locale, Ethiopia prenatal depression was detailed higher than the other comparative ponders (23%) conducted in other LMICs (Tadesse Awoke Ayele, Telake Azalea & Haregewoin Mulat 2013:4). In other studies conducted in the same region of Ethiopia, 20% to 33% of the surveyed women in the Amhara region had a

probability of CMD. Moreover, 15% of surveyed women had had suicidal thoughts (Baumgartner et al. 2014:484).

Rather than waiting for a woman to be diagnosed with CMD disorders, communities may elect to adopt a proactive approach. It is important to realize that maternal CMD is a significant health issue that must be addressed within the continuous flow health paradigm. Employers, short-term assistance for low-income families, programs, faith-based companions, neighbours, and other caregivers can all play a part in anticipating and reducing the effect of CMD.

Ethiopia is a low-income country located in the horn of Africa. It is one of the most ancient independent nations in the world and is rich in diversity and cultures. The country covers 1.1 km^2.

It has a population of 101,497,038, of which 50,524,765 (49.8%) are males, and 50,982,273 (50.2%) are females. The country has over 80 distinctive ethnic bunches and is the most crowded East African nation, following Nigeria. According to the source, the life expectancy of both sexes in Ethiopia is 56.2, male 53.6 percent, female 58.8 percent. Therefore, the total both gender and life expectancy are lower than the global life expectancy at birth, which is about 71 years (Central Statistics Authority 2016:9).

Ethiopia`s capacity-building efforts have led to major increases in human resources available to support mental health scale-up. Approximately 63 psychiatrists are practising in the public sector, with most located in the capital city of Addis Ababa. However, psychiatrist-led services have recently expanded to regional centres (FDREMOH 2011:16). Masters-level psychiatric practitioners and community mental health professionals and Bachelor's degree-level psychiatric nurses provide hospital-based emphasis on curative areas of mental health care and training institutions across the country. However, these services are limited to urban centres. As a result, the treatment gap for mental health care is exceptionally high, with an evaluated 90% of individuals with extreme mental illnesses counting schizophrenia and bipolar disorder, having never received evidence-based care and less than 1% receiving continuing care (Hanlon et al. 2009:156). Several epidemiological studies have shown that Ethiopia's burden of mental health problems is high, with untreated mental health conditions associated with

premature mortality and disability (Shibre et al. 2014:206). Most of the studies are being conducted in the locale of Ethiopia in the Butajira region. However, few studies are conducted in Amhara, and very few are conducted in the Oromia region, the foremost populated locale in Ethiopia. Recent qualitative Ethiopian studies reported that low levels of awareness and the presence of stigmatizing attitudes were common in the community and a potential barrier for people with mental illness to access mental health care. In reaction, the Federal Ministry of Health (FMOH) in Ethiopia is setting out a groundbreaking program to scale up mental health care utilizing the WHO model of integration into primary care (Hanlon, Eshetu, Alemayehu, Fekadu et al. 2017:9). As it is mentioned, Community-based health extension workers were seen as the natural gateway into the community, providing access to a network of health volunteers. However, on the assessment (Hanlon et al. 2017), none of the respondents had been involved in mental health-related activities in addition to that different topic of health service provided by the community, although not mental health.

2.7 FACTORS THAT INFLUENCE DEVELOPMENT OF MATERNAL COMMON MENTAL DISORDERS (CMDs)

Maternal CMDs are directly linked to maternal mortality and morbidity and are associated with adverse outcomes for child health and development. Studies from multilevel cross-national groups in LMIC and Colombia showed that being female is reported to be a risk factor for CMD (British, Unidad & Asistenciales 2013:3). The findings from the study conducted in Tanzania (Uriyo et al. 2013:4) mother's age, years of education, marital status, occupation, parity, having children with different partners, alcohol use, physical abuse, verbal abuse, polygamous relationship, and disclosing their HIV-positive status to the interviewer risk factors for pregnant women having CMD.

In many LMICs, the number of outpatient health care services with the ability to treat mental disorders is exceedingly low, which is a major infrastructural barrier to appropriate access to and use of medicines (WHO 2017:17). Moreover, populations in numerous African nations confront expanded vulnerability to mental illness due to many financial chance variables such as destitution, social disparity, war and struggle, disaster, urbanization, and movement the mental health care disparities (Fekadu, Medhin, Selamu, Hailemariam et al. 2014:55; WHO 2014:31). In a developing country setting where

population pressure, food insecurity, and poor public health infrastructure are more prevalent, sub-optimal maternal care provided by depressed mothers can further detriment the well-being of children (Rahman, Surkan, Cayetano, Rwagatare & Dickson 2013:6).

In a recent study conducted in five LMICs, Ethiopia, India, Nepal, South Africa, and Uganda, no district reported dedicated maternal mental health services, but referrals to specialized care in psychiatric units or general hospitals were possible. As the investigator said, no information was available on coverage for maternal mental health prevention in the study area. Challenges to the provision of maternal mental health care include; limited evidence on feasible detection and treatment strategies for maternal mental disorders, lack of mental health specialists in the public health sector, lack of prescribing guidelines for pregnant and breastfeeding women, and stigmatizing attitudes among PHC staff and the community (Baron et al. 2016:15). Sexual and physical abuse during childhood; family, school, and community violence: destitution, social prohibition, and educational drawbacks are broadly known as the risk factors of mental health. Psychiatric disorders, parent drug abuse, and conjugal violence also increase the risks for adolescents and the exposure to social alterations and psychological distress that accompany armed conflicts, natural disasters, and other humanitarian crises. The stigma driven by an adolescent with mental disorders and the human rights violations they are subjected to amplifies the adverse consequences. Mental health prevention starts with the parents and family, besides the school and community. Educating about Mental Health can help adolescents to increase their social abilities, amplify solving problems, and intensify self-confidence, which can ease mental health issues and avoid violent and risky behaviours (Cavalcante-Neto, De Paula, De Menezes Toledo Florêncio & De Miranda 2016:4).

2.7.1 Individual factors

The study reported that being female appears to be a risk factor for CMDs. Studies from India have shown that poverty and deprivation are independently associated with the risk for CMDs (Patel, Weiss, Kirkwood, Pednekar, Nevrekar, Gupte & Mabey 2006:74) in women and increase the sources of stress associated with women. According to Fisher et al's (2012:3) study, the association of prenatal CMDs was associated with, having a

partner lacking in empathy or openly antagonistic; being a victim of gender-based brutality; having hostile parents in law; being socially distraught; having no regenerative self-governance; having an unintended or undesirable pregnancy; having pregnancy-related sickness or handicap; accepting neither enthusiastic nor common sense help from one's mom, and bringing forth a female infant (Fisher et al. 2012:45). A study indicates that older age might have an effect on mental health and also findings showed that educational level plays a significant role in maternal mental health which is consistent also with the study of (Nguyes, Saha, Ali, Menon, Manohar, Mai, Rawat & Ruel 2014:36). The investigation announced that underweight moms were progressively inclined to experience the ill effects of CMD, in this way the relationship of maternal sustenance and emotional wellness endured significantly in the wake of controls for different factors in multivariate examination (Husain, Mukherjee, Notiar, Alavi et al. 2016:17). Maternal education, family income, number of children, number of people living in the household, work activity of both parents, and presence of the child's biological father in the household (Cavalcante-Neto et al. 2016:6).

The findings of the World Mental Health Survey Initiative showed the importance of income level in this context (Bromet et al. 2011:4). In high-income countries, younger age was associated with a higher 12-month prevalence of depression; in several low- and middle-income countries, by comparison, older age was associated with a greater likelihood of MD. A lower level of education is significantly associated with a higher level of depression (Ansseau, Fischler, Dierik, Albert et al. 2008:1-3; Hofmann & Smits 2008:45). There is a strong probability that the effect could be mediated by income factors associated with a lower educational level (Ladin 2008:34; Chazelle 2012:21).

Alcohol use of depressed persons hurts the prognosis (Bilszta, Ericsen & Milgrom 2010:4) and affects the treatment of depression (Namkee & Marti 2017:8; Ramsey & Veltman 2005:20). Depressed persons seeking treatment often have a history of recent alcohol and drug use or heavy episodic drinking. Alcohol use during the previous 30 days has been reported by half of the treatment seekers (Satre, Manuel, Larios, Steiger & Satterfield 2015:53). Individual protective factors include successful physical growth, academic achievement/intellectual development of high self-esteem, emotional self-regulation, strong coping skills and problem-solving skills, involvement, and interactions

in two or more of the following contexts: education, friendship, sports, work, faith, and community.

2.7.2 Pear and family factors

Pear factors found with sound evidence that protect against perinatal depression and anxiety are emotional closeness and global support. These considerations are contact, conflict, emotional and instrumental support, and relationship satisfaction (Pilkington, Milne, Cairns, Lewis & Whelan 2015:4). A systematic review suggested that lack of a partner or social support was associated with higher rates of antenatal depression and anxiety symptoms where found that low social support and poor quality relationships with close others were a predictor for postpartum depression (Husain et al. 2016:231; American Hospital Association 2012:13). They found that difficulties in the relationship between the woman and her partner were associated with CMDs (Goldie, Elliott, Regan, Bernal & Makurah 2016:4). These difficulties were varied and could include a partner who was unsupportive, uninvolved, overcritical or inflicting physical abuse (Khan & Flora 2017:22). Negative family environment (may include substance abuse in parents) child abuse/maltreatment single-parent family (for girls only) divorce marital conflict family conflict parent with anxiety parental/marital conflict.

Two or more family protective factors were mentioned: family provides structure, limits, rules, monitoring, and predictability. Supportive relationships with family members' clear expectations for behaviour and values.

2.7.3 Societal factors

Social support has been defined as “information leading the subject to believe that he or she is loved, esteemed, and belongs to a network of mutual obligations” (National Research Council and Instituut of Medicine 1976:300). However, the term may have different meanings depending on the particular study or the way of measuring it.

Many studies describe this association in specific groups, such as elderly persons. However, the term may have different meanings depending on the particular study or the way of measuring it. The effect of marital status on depressive symptoms is mediated by

family support and moderated by friend support which also stresses the importance of the functional quality of social support rather than the existence of social ties (Gatchel & Arlington 2016:569). Persons who feel socially isolated have a higher risk of depression (Chou 2012:69; Hawthorne 2008:301). In a broader sense, the alternative to functional measures of social support is loneliness, which is associated with impaired health and health-related behaviour (Christiansen, Larsen & Lasgaard 2016:87).

The study found that women with CMD were more likely to report financial problems and difficulties in meeting their daily needs (Husain et al. 2016:7). This is consistent with a review linking CMD and poverty in LAMIC (Baron et al. 2017:8). Studies conducted across the world, including studies from rural South Africa and urban Zimbabwe, have reported an association between CMD and financial problems (WHO 2007:45; Bhagwanjee, Parketh, Paruk, Petersen & Subedar 1998:23; Abas & Broadhead 1997:44). Interestingly, the study found that certain dimensions of poverty such as food insecurity, housing, social class, and financial stress tended to be more strongly associated with CMD compared with other measures such as income and employment (Lund 2014:15). This socioeconomic disadvantage was varied including low income, living in an overcrowded or inadequate home, or being unable to afford sufficient food or vital health care (Parcesepe & Cabassa 2013:26).

Urbanization in low-income countries is also associated with changes in social support and life stress, which are known to harm mental health, particularly among low-income women, Considering the detrimental effect of depression on health status and the resulting economic losses (Jefferis & Hickman 2019:38). There is a need to study the factors associated with depression prevalence and help-seeking. Besides sociodemographic and health status factors, there is a need to consider the association between alternative factors and depression.

One of the possibly modifiable or protective components, including social disparity, social systems, child abuse, and drug and alcohol abuse, plays a part in misery hazards. Preventative activities need to focus on zones of most noteworthy versatility and reach while recognizing the part of the other components. One such plastic factor is a lifestyle,

a term that encompasses diet, physical activity, and smoking (Jacka, Mykletun & Berk 2012:5). Cohabiting appeared to be protective (Uriyo et al. 2013:6).

It also comprises the presence of mentors and support for developing skills and interests and opportunities for engagement within the community with positive norms and clear expectations for behavioural, physical, and psychological safety.

2.8 HELP-SEEKING BEHAVIOUR OF MOTHERS WITH COMMON MENTAL DISORDERS (CMDS)

The *Dictionary of Epidemiology* refers to health care as “services provided to individuals or communities by agents of the health services or professions to promote, maintain, monitor, or restore health” (Miquel Porta 2014:3). Under the definition, health care is not limited to medical care. Its concept sometimes includes 'health-related self-care (O*xford English Dictionary* 2017:98). The WHO (2013b) defines health care as “the maintenance and improvement of physical and mental health, especially through the provision of medical services”. The provision of health care refers to the way resources such as money, staff, equipment, and drugs are combined to allow the delivery of health interventions.

The acceptability of mental health treatments and/or awareness of mental health problems within communities; reduced help-seeking behaviour by individuals because of stigma, discrimination, or other socio-cultural factors; poor recognition that mental disorders are responsive to effective treatment; poor treatment adherence due to several factors, including side-effects and the long-term nature of many severe mental disorders and resultant implications for duration and cost of services; and, in many areas, geographical distance from health care providers (WHO 2017:11).

Several empirical and narrative accounts look at the negative impact of stigma on help-seeking intentions, help-seeking behaviours, self-esteem, and discrimination (Monteiro 2014:81; Pheko, Chilisa, Balogun & Kgathi 2013:9). Particularly, stigma has been found to contribute to discrimination from others and internalized negative self-perceptions within the frame of self-stigma, both of which make individuals maintain a strategic distance from treatment and cover up their symptoms.

Relatedly, there are parallel health frameworks in most nations, where individuals go to traditional healers sometime recently or at the same time that they go to formal health care. Anyplace from 20% to 85% of patients in Africa who encounter indications of mental disorders look for treatment with a traditional healer at first or at the same time as formal health (Sorketti, Zuraida & Habil 2012:21; Seloilwe & Thupayagale-Tshweneagae 2007:243; Gureje, Lasebikan, Ephraim-Oluwanuga, Olley & Kola 2005:28). As a consequence, people with mental illness in Ethiopia usually rely on family support, traditional healers, and holy water sites for their need of help (Alem, Jacobsson, Araya, Kebede & Kullgren 1999:29).

However, most Ethiopian communities have rich social and community resources (Selamu, Asher, Hanlon & Medhin 2015:14), so we can anticipate that these activities are scalable at the community site. Involving the community and resources in maternal mental health problems prevents cost-effective and sustainable mechanisms.

Generally, CMD is one of the most prevalent problems for women. Over one in ten women are affected by a diagnosis of common mental health disorders during pregnancy or after the birth of their baby. It can be caused by several factors, including negative life experiences such as poverty, discrimination, violence, use of substances, unemployment, and isolation, which can also impact women's mental health and well-being. Gender roles and unequal economic and social relations between men and women in our community may also contribute to women's higher risk of depression; having no reproductive independence; having an unintended or undesirable pregnancy; having pregnancy-related sickness or inability; accepting not one or the other enthusiastic nor common-sense back from one's mother is too associated. The linkages within and between primary and secondary care to identify which women are at risk and the specialist perinatal psychiatric advice to support their care remain variable. Much work should be important at the grassroots to minimize or prevent it at the community level.

Mental health promotion aims to address the elements that impact mental health. Among these include social, environmental, behavioural, and even political challenges (Barry, Patel, Jané-Llopis, Raeburn & Mittelmark 2007:80). As previously stated, mental health is affected by macro-level realities such as poverty, unemployment, and better living

situations. Furthermore, mental health promotion is connected to behavioural issues such as smoking, substance abuse, and unlawful sexual conduct (Sebena, Ansari, Stock, Orosova, Olga & Mikolajczyk 2012:54; Tompson & Weisman 2002:139). As a result, mental health promotion has become an essential component of total health promotion. Mental health promotion encompasses a wide range of treatments that aim to improve not just mental health but also positive behaviours and conditions that are linked to physical health outcomes.

Nonetheless, the emphasis on mental health promotion in larger societal changes does not appear to be consistent with the breadth of health policies and treatments. Significant socioeconomic inequality and poverty changes, for example, are unlikely to result from initiatives to promote mental health. As a result, it is recommended that mental health promotion initiatives use an etiological approach to identify the most important determinants of mental health and demonstrate improvements in these characteristics to generate evidence for better mental health outcomes. As a result, precise markers of mental health may be developed to drive bigger policy measures and strategic adjustments.

Mental disorder avoidance has been defined as "lowering the rate, prevalence, and recurrence of mental disorders, the time spent with symptoms, or the serious condition of a depression disorder, preventing or postponing recurrences, and additionally lessening the impact of sickness on the affected individual, their families, and society." (Eddy, Barkan & Lanham 2015:96). As the description suggests, mental disorder prevention is concerned with managing and controlling mental ailments. It attempts to regulate illness aetiology to control disease prevalence and incidence. It also aims to keep sickness at bay in those with mental illnesses. The public health literature divides preventative measures into primary, secondary, and tertiary prevention (Gordon 1983:236). Primary interventions are primarily concerned with disease-preventive techniques before the onset of sickness. Secondary interventions try to reduce the prevalence of mental diseases by establishing early diagnosis and treatment facilities. Similarly, tertiary interventions provide rehabilitative therapy to mental health patients, emphasising preventing disease recurrence and aggravation.

While health promotion focuses on providing favourable conditions for health, health prevention focuses on illness causes. Mental health promotion and mental disorder prevention are intertwined, and mental disease prevention contributes to mental health promotion. This is especially true for basic preventive interventions, which aim to ameliorate situations that are harmful to mental health and increase vulnerability to disease. As a result, collective action is classified based on improving health and avoiding disease-related risk factors (Harrison, Charles & Britt 2015:41). Interventions may be universal, such as raising awareness about tobacco use to promote health and prevent disease. It is obvious that any such intervention extends beyond a given demographic and has both promotional and preventative parts. Similarly, initiatives such as teaching the young population about the dangers of substance usage may be chosen. In this situation, too, health promotion essentially corroborates with the prevention of numerous physical and mental disorders related to substance misuse. The interventions may also be indicated, for example, by counselling agencies provided to mental health patients who exhibit some signs of the disease but are not at the stage where a sophisticated diagnosis is available. Again, the effort would be geared toward preventing illness onset and promoting healthy behaviours to sustain preventive measures. As a result, health promotion and prevention are inextricably linked, and mental health is no exception.

2.9 ROLE OF PREVENTION OF MENTAL DISORDERS

Refining of public health among primary, secondary, and tertiary prevention. Under the open health classification, all-inclusive, accurate, and demonstrated preventive strategies are included under critical avoidance. Auxiliary avoidance aims to minimize the incidence of known cases of population disorder or disease (prevalence) through early identification and treatment of diagnosable diseases. Tertiary avoidance incorporates intercessions that decrease incapacity, improve restoration, and avoid backslides and repeats of the sickness (Gidey 2005:29). The approach to mental disorder prevention is based on public health principles. Mental disorder prevention aims at "reducing the incidence, prevalence, and recurrence of mental disorders'', the time spent with symptoms, or the risk of condition for mental illness, anticipating or deferring repeats, as well as lessening the impact of illness on the affected individual, their families, and society (Haggerty & Mrazek 1994:22).

Haggy and Roberts have proposed a framework of mental health intervention for mental disorders based on the classification of the prevention of physical illness and the classic public health refinements between primary, secondary, and tertiary anticipation (Gordon 1998:37). Widespread, particular, and shown preventive interventions are included inside essential anticipation within the public health classification. Primary prevention looks to lower the rate of set-up cases of disorder or illness within the populace (predominance) through early detection and treatment of diagnosable diseases. Tertiary anticipation incorporates intercessions that decrease incapacity, improve restoration, and avoid backslides and repeats of the ailment. Discrepancies between primary, secondary, and tertiary prevention in public health. General, limited, and specified preventive measures are included in the public health definition as part of primary prevention. Secondary prevention aims to reduce the incidence of identified population (prevalence) illness or disease cases through early identification and treatment of diagnosable diseases.

2.9.1 Universal prevention

Defined as interventions targeted at the general public or to a whole population group that has not been identified based on increased risk (Conley, Durlak & Kirsch 2015:34).

2.9.2 Selective prevention

This targets people or subgroups whose chance of creating a mental disorder is higher than normal, as proved by biological, mental, or social risk factors (Gladstone, Beardslee & Connor 2011:8).

2.9.3 Indicated prevention

It targets high-risk people who are identified as having minimal but detectable signs or symptoms foreshadowing mental disorder or biological markers indicating a predisposition for a mental disorder but who do not meet diagnostic criteria for the disorder at that time (Haggerty & Mrazek 1994:23).

2.10 PREVENTION OF MENTAL DISORDERS

Effective interventions and policy options focus on the primary prevention of mental disorders. Since mental health promotion and mental disorder prevention each deal primarily with the enhancement of mental health and the impact of its antecedents, they have to be understood as conceptually distinct, however interrelated, methods (WHO 2004:17).

Globally, there is growing concern about suicide ideation among pregnant and post-natal women. In the research study, rates of antenatal depression and suicide ideation were found to be high. Improvements in screening and preventative efforts for pregnant women are urgently needed (Rochat et al. 2013:658). The individual, family, and community psychosocial and spiritual aspects recommended in the integrative review should also be considered as part of integrated care for the adolescent phase to be healthy and without risks (Rochat et al. 2013:557).

The rural Vietnam study undertaken in 2014 showed that there is an indirect link in which maternal antenatal CMD is associated with an increased likelihood of postnatal CMD, which then adversely affect parenting practices that influence the social and emotional development of infants in the first 6 months of life (Tran, Biggs, Tran, Simpson, De Mello, Hanieh, Nguyen, Dwyer & Fisher 2014:110).

In the study undertaken in a predominantly rural area with high HIV prevalence in South Africa, rates of antenatal depression and suicide ideation were found to be high. Improvements in screening and preventative efforts for pregnant women are urgently needed. Primary health systems could take advantage of the increased contact with health services that result from pregnancy (Rochat, Bland, Tomlinson & Stein 2013:658).

Given the high rates of probable CMD among women in the Amhara region of Ethiopia up to 2 years postpartum, it is recommended that mental health services could potentially be integrated into MCH services offered by providers based at local health posts and/or by HEWs, such as at childhood immunization and well-being visits (Baumgartner et al. 2014:484).

More broadly, maternal depression may influence the home environment. Mothers may invest less in stimulating toys for their children. Additionally, relationships between the mother and her husband, older children, and mother-in-law may become strained. In principle, maternal depression may also affect fertility through breastfeeding, reducing the spacing between births if depressed mothers breastfeed less or reducing sex drive, which would have the opposite effect. Furthermore, maternal depression may impact contraceptive use through effort costs or time preferences (Almond & Currie 2011:213). It can also take a substantial toll on the health and well-being of both mothers and children, increasing related health costs, impeding the child's development, and creating negative social consequences (CMCS Informational Bulletin 2016:5).

Prevention, in general, and prevention of mental and psychosomatic disorders, in particular, have become a major topic in health policy to optimize provisions of health care (Bickel, Gusset-Bahrer, Stein & Schnell 2016:1). Mothers who have low incomes are more likely to experience some form of depression than the general population of mothers (CMCS Informational Bulletin 2016:1). Evidence is accumulating to guide intervention, focused on integrating mental health care into routine maternal and child health care through a task-sharing approach (Hanlon 2013:5). Some researchers have argued that the perinatal period is a time of high risk for women and their infants and that routine antenatal screening for mental health, particularly in communities where high prevalence has been reported, should be mandatory (Honikman, Van Heyningen, Field, Baron & Tomlinson 2012:2).

A community-based before and after-control study found reduced postnatal mental health problems among women with no history of psychiatric disorders (Rowe & Fisher 2010:10, 432). The proposed solutions described in these calls include: incorporating mental well-being into vital health care; developing consistent national approaches to mental well-being and concentrating on the effective implementation of those strategies; educating para-professionals in mental health; increasing community well-being; and connecting them to traditional healers, including others (Stevanovic, Atilola, Balhara, Avicenna, Kandemir, Vostanis, Knez & Petrov 2015:3; Hanlon et al. 2009:45).

Mental health security begins with the parents and family, school, and community. Educating about mental health will help adolescents improve their social skills, enhance their problem-solving ability, and improve women's self-confidence. However, people in remote areas have little or no access to that level of specialized treatment and service. The situation is similar to that of psychologists. Social workers may be more available (WHO 2011:63).

There are various models, including task-sharing or task-shifting, where non-specialists are trained to deliver mental health services (Mendenhall, De Silva, Hanlonk, Petersen et al. 2014:36); use of health surveillance assistants (HSAs) to address psychosocial distress; the apprenticeship model for training and supervising lay counsellors (Murray, Dorsey, Bolton, Jordans & Rahman 2011:8).

Research on the cost-effectiveness of interventions to prevent the development of postnatal distress, depression, and anxiety has shown mixed results. A program of structured midwife-led care was found to improve postnatal mental health without increasing costs, counselling and support for women at high risk of PND and peer support (Dukhovny, Dennis & Weston 2014:30).

The study suggested the need for sustainable, population-level prevention initiatives for the CMDs (Jacka, Mykletun & Berk 2012:8). The challenge is how to expand from the emerging epidemiological evidence to develop and evaluate a prevention system for lifestyle-related women of reproductive age living in Oromia/Ethiopia.

2.11 PUBLIC HEALTH RELEVANCE OF MENTAL HEALTH

Only lately has it been recognized that mental health and public health fundamentally intertwine. This disassociation was caused by several factors (Knifton & Quinn National Institute for Mental Health in England World Health Organization 2009:76). First, to begin with, mental health has long been considered a threat rather than a serious health problem. This misconception is mostly due to the peculiarities of mental disorders and a widespread misunderstanding about the contrast between mental health and mental disorder.

Second, it has been established that mental health is an important element of health, having a closer tie to physical health than previously thought. Third, there is an alarmingly high prevalence of mental health issues. Depression, for example, is anticipated to overtake diabetes as the most frequent illness by 2020 (WHO 2001:56).

As a result, it is possible that curative and rehabilitative therapies will not be able to keep up with the needs of mental health patients. As a corollary, mental health illnesses should be addressed through health promotion and prevention activities. Mental health issues are more common among impoverished people, according to a study (Luthar & Becker 2002:33; Patel & Kleinman 2003:75). Although therapy and rehabilitation are critical, there is growing acknowledgement that public health's role in dealing with mental disorders may entail basic structural changes such as resource allocation. The phenomena of mental health, according to this approach, may encompass both health policies as well as social and political domains.

2.12 A SOCIO-ECOLOGICAL MODEL FOR MENTAL HEALTH AND WELL-BEING

The above issues cover the full range of mental health promotion, prevention, and action that I am sure would concern you. Without clear intent, many papers in this issue denote various elements of a socio-ecological model recognizing the complex interrelationship between personal and environmental factors, including family, education, and culture. Within such a structure, while not expressly used, there is a consistent suggestion in the papers discussed here for cooperation and communication across sectors like mental health, education, and the wider community.

In the first instance, within a treatment setting, the bi-directional effect of the family and the mental health of a person is illustrated in many of the articles (Reupert, Cox, Maybery & Stokes 2015:67). As argued elsewhere, any given individual's relational recovery may include different family roles such as being a parent, spouse, or caring for older parents. Thinking these roles can promote identity as someone who is more than their illness and simultaneously provide different connections to others, both within and outside of their family. Being a parent, for example, offers an essential way to communicate with children and can also provide opportunities to interact with other parents. This issue challenges the notion of individualism inherent in many models of rehabilitation (Price-Robertson,

Obradovic & Morgan 2017:231). This they do by concentrating on social experiences and responsibilities as to how personal transformation occurs. The recovery processes in their model are disrupted within an interpersonal network rather than residing within a single individual (Awram, Hancock & Honey 2017:84) also explore notions of family recovery by investigating how mothers living with a mental illness balance the demands of mothering and mental health recovery. The intimate intersection between mothering and recovery found in this study highlights various targets of recovery for mothers with mental illness for clinicians to consider. It would be interesting to ascertain whether and how such 'balancing' might resonate for fathers with mental health (Reupert & Maybery 2016:45). The study demonstrates that treating those with mental health issues within services should not and indeed cannot exist in a vacuum. Instead, by investigating a mobile phone-optimized, SMS-based, informative, and interactive telephone-linked support system for new fathers (Fletcher 2017:51) and (Isobel & Delgado 2018:16). Additionally, a child-focused program is delivered by adult mental health services to the children of clients of the service (Isobel & Delgado 2018:32). Both studies conclude with recommendations for how services might support the various interactions between individuals (within and outside of the family) and agencies when supporting clients and their families.

Many other papers on this topic identify the various cultural and social factors influencing mental health prevention, promotion, and intervention. From the service providers' perspective, young people's obstacles and enablers when accessing mental health services have been described (Platell, Cook & Martin 2017:201), how services would listen to young people and connect with them. The programme setting and organizational structure shaped how young people could (or could not) access the support they needed. One of the many recommendations from their study was that schools should play a role in encouraging early intervention for the well-being of young people. As suggested, schools are opportunistic, non-stigmatizing places to classify and intervene with at-risk young people and promote general well-being. (Fletcher 2017:76) schools are opportunistic, non-stigmatizing places to identify and intervene with at-risk young people and promote general well-being (Costello & Costello 2017:40). The study substantiates this claim by providing preliminary support for a mindfulness program in schools in the promotion of children's well-being. An acute mental health care setting in Canada identified predictors of aggression in adults (Meehan, De Alwis & Stedman 2017:42).

They found that ratings on the brief psychiatric rating scale were the strongest predictor of aggression following admission. Their study supports the use of structured risk assessments for monitoring the risk of aggression in clients 72 hours post-admission.

The community model of mental health care in Ethiopia reserves maternal mental health services in the communities, including unequal distribution of mental health facilities, inaccessibility to administrations in remote regions, reasonableness, and social worthiness about oblivion and conviction. Families also have to pay for those services out of pocket payments for these services due to the unavailability of social support systems.

The community-based health insurance scheme (CBHIS) has limited mental health coverage. Besides, there is poor implementation of CBHIS, which leads to unnecessary expending of costs for seeking treatment. Strategies for preventing maternal and mental disorders with the aim of women of reproductive age should access mental health prevention services close to their homes by keeping families together and maintaining their daily activities. Thus, the papers in this issue draw on multiple, intersecting levels across and between individuals, families, organizations, and the community.

2.13 LIMITATIONS OF EXISTING LITERATURE

This review was not intended to be comprehensive. It is rather than address the limitation of existing literature. Our focus is on the most prevalently Maternal CMD to be associated with risk and protective factors and experiences of mothers for an existing prevention strategy to address whether insufficient evidence is available to answer critical key searches related to prevention strategy, which failed to make extensive references to sources. Peers do not review some content to ensure the reliability of methods used to the validity finding.

2.14 SUMMARY

This chapter thoroughly appraises and analyses the literature on the study's topic. The evaluation of the literature made it easy to validate the viability of investigating the identified research problem. It also aided in the development of a more in-depth grasp of

the issue under consideration. This enabled the researcher to link the study's findings to pre-existing information.

The research strategy and techniques will be detailed in the following chapter.

CHAPTER 3: RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

The preceding chapter described the literature review, which analyses, synthesizes, and critically evaluate to present a comprehensive picture of the state of knowledge on the subject. This chapter analyses and details the research strategies used to fulfil the study objectives and the questions raised during the report's writing process. It also includes details on the study's structure and data collection procedures (Rajasekar, Philominathan & Chinnathambi 2003:5). This research was conducted in three phases, namely the quantitative, qualitative, and strategy development phases. This chapter offers comprehensive details about the methodology for each phase.

3.2 PURPOSE, OBJECTIVES, AND RESEARCH QUESTIONS OF THE STUDY

3.2.1 **R**esearch purpose

This study aims to develop strategies for community-based prevention of Maternal CMDs in urban Oromia, Ethiopia, based on the findings of the empirical study conducted in the first two phases of the study.

3.2.2 Research objectives

Considers research aims to be distinct, clear, or succinct articulations drawn from the study topic and reason. The investigation seeks to provide quantitative research assistance in outlining the variables and population to be addressed. The study concentrated on the linked goals (Burns et al. 2011:145).

Phase 1

- To estimate the prevalence of CMDs among pregnant women in urban Oromia Ethiopia.
- To establish risk or protective factors of maternal CMDs at the community level in urban Oromia, Ethiopia.

Phase 2

- To explore and describe personal experiences and outcomes of approaches for community-based prevention of maternal CMDs in urban Oromia, Ethiopia.

Phase 3

- To develop strategies for community-based prevention of maternal CMDs in urban Oromia, Ethiopia.

3.2.3 Research questions/hypotheses

It controls the kind of information which ought to be gathered during an examination. This was utilized in defining the research question (Bettany-Saltikov 2014:6).

The study research questions are categorized by phases by phase as follows:

Phase 1

- How prevalent are maternal CMDs in urban Oromia Ethiopia?
- What risks and protective factors are associated with maternal CMDs in urban Oromia, Ethiopia?

Phase 2

- What are the personal experiences and outcomes of approaches for community-based prevention of maternal CMDs in urban Oromia, Ethiopia?

Phase 3

- What can be done to prevent community-based maternal CMDs in Urban Oromia, Ethiopia?

3.3 RESEARCH PARADIGM

A paradigm is a set of ideas, a norm, or a point of view; it is also a perspective on anything. When a paradigm shifts, so do one's view on something. A paradigm is a worldview, a universal view of the world's problems, and this perspective has a way of looking at natural phenomena (Moxham & Patterson 2017:39). It encompasses a set of philosophical assumptions and beliefs that guide the researcher's approach to the investigation (Creswell 2018:15). The philosophical underpinning for this research study

is *pragmatism*. Mixed method designs utilize both positivist and non-positivists ideas, known as pragmatism.

Pragmatism and the transformative perspective embrace features associated with both points of view (i.e. positivism/post-positivism and constructivism. Pragmatists believe that either method is useful, using the full array of qualitative and quantitative methods. They believe that decisions regarding the use of either (or both) method(s) depend on the current statement of the research questions and the ongoing phase of the inductive-deductive research cycle. The focus is on the consequences of research, the primary importance of the question asked rather than the methods, and the use of multiple methods of data collection to inform the problems under study. Thus, it is pluralistic and oriented toward "what works" in practice.

Creswell and Cresswell (2013) contends that:

- Pragmatism is not committed to any one system of philosophy and reality. This applies to mixed methods research in that inquirers draw liberally from both quantitative and qualitative assumptions when they engage in their research.
- Individual researchers have freedom of choice. In this way, researchers are free to choose the research methods, techniques, and procedures that best meet their needs and purposes.
- Pragmatists do not see the world as an absolute unity. Similarly, mixed methods researchers look to many approaches for collecting and analysing data rather than subscribing to only one way (e.g. quantitative or qualitative).
- Truth is what works at the time. It is not based on a duality between reality independent of the mind or within the mind. Thus, in mixed methods research, investigators use both quantitative and qualitative data because they work to provide the best understanding of a research problem.
- The pragmatist researchers look to the "what" and "how" to research based on the intended consequences – where they want to go with it. Mixed methods researchers need to establish a purpose for their mixing, a rationale for the reasons why quantitative and qualitative data need to be mixed in the first place.

A pragmatic researcher aims to alter a problem by delving into its intricate, interconnected components to better understand the situation as a whole. The objective is to give options and take appropriate action. Unlike positivism and interpretivism, pragmatic research

philosophy allows for the integration of several research methodologies and research techniques within a single study (Creswell & Creswell 2013:45). Furthermore, investigations based on the pragmatic research philosophy can employ a variety of research methods, including qualitative, quantitative, and action research.

3.4 RESEARCH DESIGN

A research design is an overall approach you choose to combine the various components of the study logically and consistently, ensuring that you can effectively solve the research problem; it is the blueprint for data collection, design, and analysis (Creswell & Creswell 2018:49).

The term "mixed methods" refers to an emerging research methodology that promotes the systematic integration or "mixing" of quantitative and qualitative data within a single investigation or long-term research program. It is also referred to as a method for gathering, evaluating, and "mixing" quantitative and qualitative data, both methods in one research (Kothari et al. 2014:4). The researcher must choose the most suitable research method to achieve the study's objectives (Clarke & Collier 2015:65).

The researcher utilized a sequential explanatory mixed-method design for this study, which includes obtaining and analysing quantitative and qualitative data in two successive phases inside one research study, with the two phases being integrated at the final interpretation stage. Determining the priority or weight should be given to quantitative research, which depends on the research problem (Creswell & Cresswell 2013:61).

The study was undertaken in three phases as follows:

3.4.1 Phase 1: Quantitative design

A quantitative design refers to descriptive [subjects are typically measured only once] or experimental [subjects are measured before and after a treatment]. A relationship between variables is established in a descriptive investigation; causation is established in an experimental investigation (Creswell & Creswell 2018:123).

To be able to generalize from the investigation to the study population, the researcher used a cross-sectional survey by administering standard questionnaires for data collection (Annexures 10 and 11).

3.4.2 Phase 2: Qualitative design

A qualitative design is a systematic subjective approach used to describe life experiences and give them meaning (Creswell 2014:87).

For this study, phenomenology was selected as a suitable approach. In a simplified way, phenomenology is a research method that aims to grasp the nature of a phenomenon by looking at it through the eyes of those who have observed it (Neubauer, Witkop & Varpio 2019:12). In this study, the women explored and described personal experiences and outcomes of approaches about CMDs regarding community-based prevention of maternal CMDs in their living area.

At the end of this second phase, the two data sets will be merged in the interpretation phase.

3.4.3 Phase 3: Strategy development

The findings of both the quantitative and qualitative phases were utilized to develop a prevention strategy, after which the strategy was evaluated by experts, contributing to the development of a final strategy.

3.5 RESEARCH METHODS

3.5.1 Phase 1:Quantitative

Research methods are systems of gathering and evaluating science-related data (Ponce & Maldonado 2015:16). The following sections include information on the study setting, population, sample, data collection, and data analysis utilized in this research project based on the descriptions of research methodologies provided above.

3.5.1.1 Study area setting

The investigation was conducted in the Oromia region. The Oromia region is one of the biggest regions in Ethiopia. The total population in 2009 EFY in Oromia was 35,875,159, more than 1/3 of Ethiopia`s population. The urban population is 5,022,522 (14%), includes female 17,794,079 (49.6%) and male 18,081,080 (50.4%). Urban females were 2,491,171 (49.6%), and urban expected pregnant women were 86,444 (3.47%). It consists of 38 zones, 20 big zones, and the other 18 administrative cities that are equally treated as zones. All 38 zones and administrative towns are directly accountable to the Regional Health Bureau. This study emphasizes urban Oromia, which are 18 administrative towns.

Figure 3.1: Administrative map of Oromia

(Shewa 2006:1)

3.5.1.2 Population

3.5.1.2.1 Study population

The study population refers to the entire set of units being studied depending on the study's goal and scope. The population could include all citizens of the country, residents of a certain geographic place, or members of a specific ethnic or economic group (Bruce, Pope & Stanistreet 2008:113).

A population is defined as the set of all collected samples that meet the criteria for the measurement of interest (Christensen 2011:5). In our study, the population of Universe is all-age prenatal women residing in Oromia, Ethiopia.

3.5.1.2.2 Target population

The target population is the indicated large group of numerous cases from which an investigator draws a sample and generalizes the sample results (Neuman 2014:252). The population is defined as the total number of units from which data could potentially be gathered (Kothari et al. 2014:29). A systematic selection of artefacts or peoples whose identification is the main purpose of the study (Christensen 2011:24). The target population for this study is all pregnant women who are living in urban Oromia Ethiopia.

3.5.1.2.3 Accessible population

An accessible population means a sample from the population or a group that a researcher can fairly access (Boswell & Cannon 2017:141). The study's accessible population included those women with confirmed pregnancies who began Anti Natal care service before the data collection date. It is chosen depending on the inclusion and exclusion criteria. Arrangements of exclusion and inclusion criteria were incorporated and provided to data collectors during the exit of the ANC clinic for the survey.

3.5.1.3 Sampling and sampling techniques

A sample is a subdivision of the chosen population and an impartial representation of the larger population. Studies using samples are easier, but it is often difficult to study the whole population (Suresh, Thomas & Suresh 2011:2).

It is also the way to choose a small number (a sample) from a bigger population (the sampling population) to shape the reason for assessing or foreseeing the predominance of an incomprehensible piece of data, condition, or result concerning a bigger population (Kothari et al. 2014:177). Sampling by the quantitative method is referred to as a procedure of selecting parts (e.g., individuals, organizations) from the general population such that by analysing the sample, we can generalize our findings equally back to the

population from which they were selected (Kasim 2012:33), in this way a wide range of categories of probability sampling techniques, including simple random sampling, systematic random sampling, stratified random sampling, and multi-stage sampling were used (Dickson & Cox 2019:65).

A two-stage sampling strategy was employed in the study; hence the first 20 percent of administrative districts (5 cities) were selected from a total of 18 administrative towns in Oromia by a simple random sampling process. The researcher chooses a random sampling method similar to tossing a coin, throwing dice, or drawing names from a hat, and it is like the lotto method. In some, it is possible to use random number tables or computerized ones (Jupp 2006:31). The sample was distributed proportionally to all Health Centres in selected districts using stratified sampling methods, using population proportion sampling.

In this study sampling method was the probability type of sampling of the stratified method to select the (PHCU). A stratified random sample describes the primary population divided into specific subgroups or strata. Then a sample is taken from each stratum (Suresh et al. 2011:5). This is especially useful when the examining units vary greatly since it indicates that those in larger purposes have the same chance of entering the sample as those in smaller areas and vice versa.

The next stage is to pick the study subjects using systematic random sampling with existing ANC clinics within the Health Institution. A systematic random sample is the selection of elements in which every Kth means every 3 respondents will be selected for interview. The number of objects in the survey frame is fragmented by the size of the sample (Suresh et al. 2011:289).

3.5.1.3.1 Sampling frame

The sampling frame denotes the eligible members of the population (Johnston 2009:27), and another author defines a complete list of elements within a population (Jupp 2006:53). The sample frame of this study will be the estimated number of pregnant women calculated from the female population in the selected administrative towns

(3.47%). The number is split over 12 months to gain the number of prenatal women who visited the ANC clinic in one month since the duration of data collection will be one month.

3.5.1.3.2 Sample size

The single proportion of population formula used for sample size estimation proportion of population formula. Add a 10 percent non-respondent rate. The sample size is proportionally applied to all selected PHCUs with a significant 0.05 level (alpha or α) and a 90% strength.

$$n=\frac{(Z\alpha/2)\ 2 \times p\ (1-p)}{d2}$$

Where n=sample size

Z α/2=Z value at (α= 0.05) =1.96

P=16%; Proportion of occurrence of the Maternal CMD of pregnant women (Baron et al. 2016).

Population - Eligible pregnant women of urban Oromia 86,444 (3.47% of urban females)

D=Margin of error (0.05).

Considering 10% of possible none response rate during the survey in adding with the correction of design effect (207+21).

=228, the final sample size will be distributed proportionally to all PHCUs found under the selected town administrative.

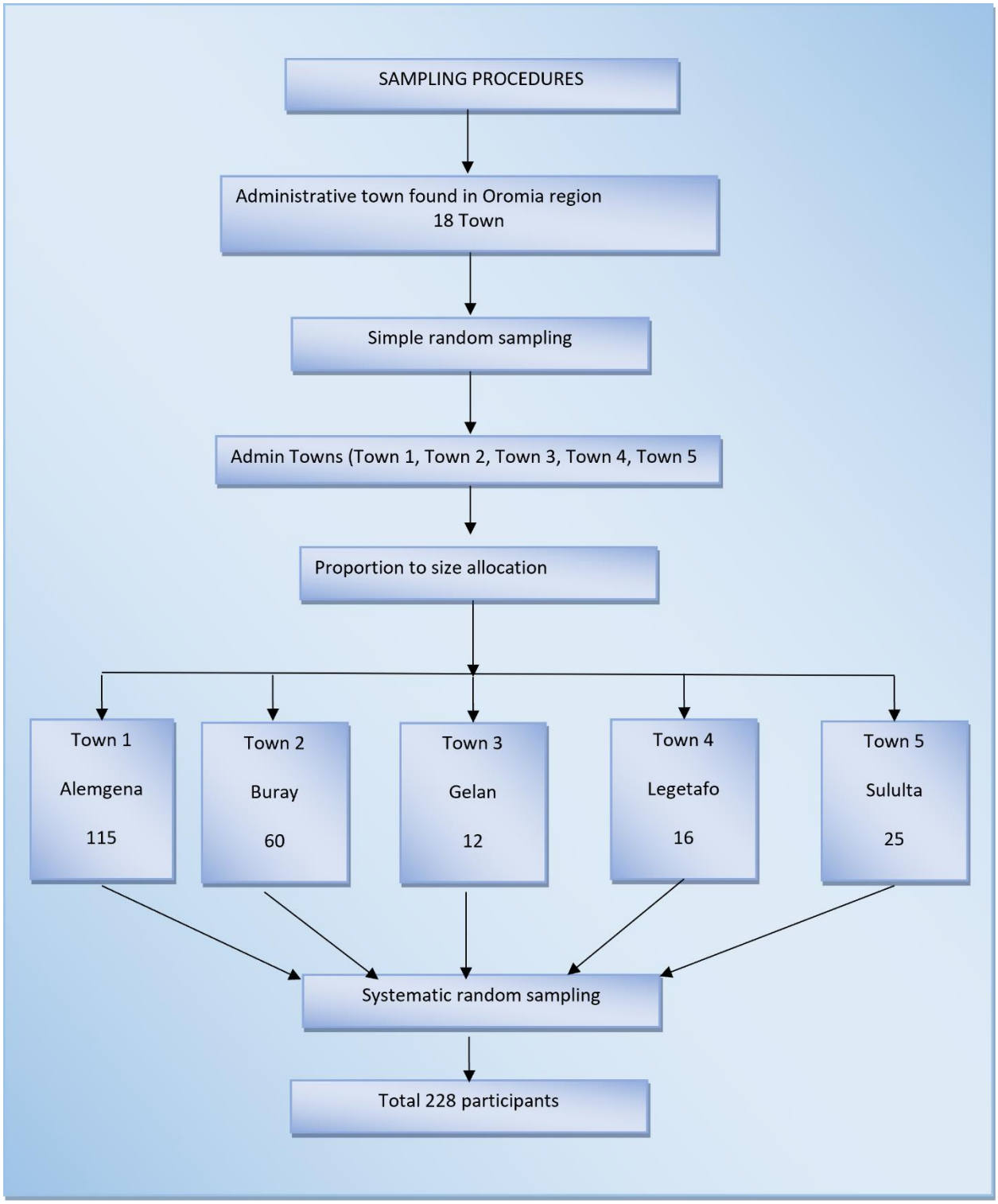

Figure 3.2: Schematic illustration of the sampling procedure for the study

3.5.1.3.3 Inclusion criteria

Requirements of the inclusion criteria that apply to the characteristics that will be essential to research participants also must be considered when selecting the research sample. It is also referred to as eligibility criteria (Boswell & Cannon 2017:149). That is as follows:

- Any reasonably healthy pregnant women at any gestational age who came to ANC during the study period at the selected health institutions.
- Women who have been residents of the administrative town of the Oromia region.

3.5.1.3.4 Exclusion criteria

Exclusion criteria apply to human characteristics that would render them ineligible for participation in the study (Rosemary 2012:39). The exclusion criteria in this study include:

- From the sample were removed pregnant women who came to treat any medical problems, including trauma-related diseases.
- Researchers believed that their mental health might be impaired by the medical condition they encountered during data collection.

3.5.1.4 Pilot study

When other issues seem inadequate, the research instruments can be revised. Therefore, they have to be correct, unambiguous, and easy to complete. A pilot study allows respondents to comment on the directions for completing the questionnaire, the importance of each question, whether they wish to delete or change an individual question, and, if so, how. A pilot study also considers the questions' consistency, duration, and sequence (Gatchel & Arlington 2016:277).

A structured non-scheduled interview helps formulate accurate and thorough questions, followed by a representative or even an exhaustive list of possible answers (Pratihari & Uzma 2019:121). Pre-testing includes assessing or piloting elements such as the sampling system, survey questions, and data collection methods.

Respondents were assisted in running a pilot survey if they had written guidance on whatever they wanted them to do. Researchers may ask participants to comment on the

directions for completing the questionnaire, the relevance of each question, and whether any questions should be removed or altered (Fishel & Bekele 2014:25).

As a result, the study simply utilized the choice with a bi-directional 5-option format without altering the original essence of the problem. Similarly, the phrasing and sequence of several questions have been altered. Furthermore, the investigator forwarded all tools to her supervisor to increase the investigation's legitimacy. Based on the feedback, the questionnaire was revised.

3.5.1.5 Data collection

3.5.1.5.1 Data collection approach and method and processes

Data collection is a description of the mechanism by which information is collected consistently and accurately (Neubauer, Witkop & Varpio 2019:67). Researchers can collect quantitative data in several ways that do not need the use of experiments. In this phase, the researcher used a quantitative survey to pose closed-ended questions with a predefined list of possible responses. Respondents appreciate this method since it requires them to select only one item from a list. The face-to-face interview, data collecting technique, and standard questionnaires were used in our study (Annexures 10, 11, 12, and 13).

3.5.1.5.2 Development and testing data collection instrument

Building a study tool is a critical part of the quantitative study since something you state by the method of discoveries or ends depends on the sort of data that the author recorded data as the researcher, and the information you gather relies totally upon the inquiries your position to your respondents (Kothari et al. 2014:147).

Pre-testing helps data collectors to assess whether there is plenty of variance in the answers; the terminology and definitions used had clarity and were well understood by the participants. All instruments must be tested and repaired. The reaction classes were proper; participants could address the inquiries effectively; the structure was anything but difficult to follow; the progression of information was legitimate, and the experiment could

be completed in a reasonable period. Making necessary modifications to the original data collection instrument based on the details learned during pre-testing leads to a more successful questionnaire. Invariably, pre-testing and subsequent revision lead to an instrument that produces fewer errors in answering the questionnaire or type.

3.5.1.5.3 Characteristics of the data collection instrument

There are already a lot of data collection instruments, and the researchers might not need to create anything new. Existing research tools, initiatives, services, and other sources of assistance.

A survey is a data collection instrument comprised of a progression of investigations and different prompts to collect data from respondents for the quantitative interview. An inside-and-out meeting is less formal and the least organized, in which the wording and questions are not foreordained. This kind of interview is progressively fitting to gather complex data with a higher extent of supposition-based data.

Pre-existing tools pointed to the survey approach for quantitative information assortment. The main questionnaires are the Patient Health Questionnaire (PHQ 9), FAST Alcohol screening test and CIDI substance use, OSLO 3 social support scale, socioeconomic status, and client service receipt inventory (CSRI) are standard and validated in Ethiopia. However, the other tool, socio-demographic details, is adopted by the researcher from other similar studies in the country. All interviews and discussions will be conducted in Oromiffa (the local language). The interview guide will be pilot-tested.

3.5.1.5.4 Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 is a known tool to assess depression and anxiety disorders. It consists of nine items, each scoring 0 to 3, which provides a 0 to 27 severity score. PHQ-9 seriousness is determined by appointing scores of 0, 1, 2, and 3 to the reaction classifications of: Not by any means, a few days, the greater part of the days, and consistently, separately. PHQ-9 complete score for the nine things went from 0 to 27.

Scores of 5, 10, 15, and 20 speak to cut focuses separately for mellow, moderate, decently extreme, and serious discouragement. Affectability to change has likewise been affirmed. The examination instruments were given to every consenting person.

Patient health questionnaire-9 (PHQ-9) study directed to assess the dependability and legitimacy as a screen for diagnosing significant burdensome issues among grown-ups in Ethiopia (Gelaye, Peterlin, Lemma, Tesfaye et al. 2013:8).

3.5.1.5.5 FAST alcohol screening test

FAST is a method for assessing the harm caused by alcohol. It comprises a subset of questions taken from the complete alcohol use disorders identification test. The Fast Alcohol Screening Test (FAST) is adapted from the AUDIT from previous comparable studies and may be completed in less than a minute (Fekadu et al. 2014:5).

3.5.1.5.6 CIDI substance use

It is an expanded and more detailed version of the substance use section of the CIDI. The interview questions serve the diagnostic criteria of DSM-III, DSM-IIR, DSM-IV, and ICD-10 psychoactive substance use disorders. There are four diagnostic sections in the SAM. Section A contains demographic questions, Section B is for tobacco, Section C is for alcohol, Section D is for drugs, and Section E covers caffeine. The substances covered in Section D include amphetamines and other stimulants, cannabinoids, cocaine, PCP and other hallucinogens, inhalants, heroin, other opiates, barbiturates, and other sedatives and tranquillizers. Substances are now included in the SAM. The SAM includes questions about the onset and recent of specific symptoms, as well as the specific withdrawal symptoms and physical, social, and psychological consequences for each category of substances used by the respondent. Also included are the quantity and frequency of both the heaviest use and use in the past 12 months, age at first and last use, age at first and most recent symptoms, the age that criteria were first and most recently met, and age(s) at remission(s). The SAM also assesses the respondent's impairment and treatment-seeking behaviour.

The SAM allows non-clinicians to administer an interview that assesses drug use, abuse, and dependence, which is a topic of increasing concern for many researchers. The SAM can quickly and accurately assess substance use disorders in a clinical setting. CIDI adopted for this study is from section D, more concentrated on Khat (amphetamines) substance use.

The SAM consists of 25 items, can be administered in 30-45 minutes, and can be scored virtually immediately.

3.5.1.5.7 OSLO 3 social support scale (OSS-3)

The OSS-3 gives a short proportion of social working, and it is viewed as perhaps the best indicator of emotional wellness. It covers various fields of social help by estimating the number of individuals the respondent feels near, the intrigue and concern appeared by others and the simplicity of acquiring down-to-earth help from others conducted in Ethiopia. The FAST questionnaire has only four items and can be completed (OECD/EUROSTAT 2018:56).

3.5.1.5.8 Socio-oeconomic status

Financial status (SES) is generally perceived as one of the significant variables influencing the well-being state of an individual or a family. The requirement for the advancement of scales using a couple of chosen measures that would best demonstrate the SES of an individual/family has been a felt requirement for a long. A few scales have been created and revealed in distributions that look to evaluate the SES of families in explicit conditions, for example, in urban populaces or country populaces.

3.5.1.5.9 Socio-demographic details factors

The TSET survey was based on her most recent publication in 2016 (Jeffreys & Smodlaka 1998:220). The researcher created the demographic data collection survey based on Jeffrey's 2016 toolkit publication.

3.5.1.5.10 Client service receipt Inventory (CSRI)

The client service receipt Inventory (CSRI) is a method used to gather information about the full range of services that study participants can use and help. This data can be used for a broad variety of uses, including calculating service receipt costs. The CSRI is a research method developed in the mid-1980s by Martin Knapp and Jennifer Beecham to collect information on service usage, sales, accommodation, and other cost-related variables. Its primary objective is to identify resource use trends and estimate the cost of supporting them using an acceptable unit cost.

The CSRI was developed grounded on the client sociodemographic and service receipt inventory used in schizophrenia research, as well as a systematic analysis of the literature and the selection of care environments, modalities, and treatments available in the participating regions (Chisholm, Knapp & Knudsen, Amaddeo, Gaite & Van Wijngaarden 2000:S28-S33).

3.5.1.5.11 The CSRI is usually divided into five sections

Information about the client's background, such as their research identification number, age, gender, and other socio-demographic information. Depending on the report and the details available, it can also include previous hospital admissions/discharges or involvement in special programs.

Data collection process

One strength of a standardized questionnaire is that the respondent is in charge of the sequence of questions and answers (Manning & Kunkel 2014:223; Daughtery 2011:221). This, in turn, aids in the evaluation of data quality. Consistency and comprehensibility are among the numerous elements of data quality evaluated in this study. The fundamental characteristics of clean data are accuracy, completeness, and correctness (Cao, Deng, Fan & Geerts 2014:36).

The data collection method used was a PHCU (institution) level questionnaire survey administered by trained field workers. All pregnant women living in the research area who came in during the study time for ANC visits were allowed to attend. Health workers at the ANC clinic helped identify eligible pregnant women in the ANC process.

The researcher asks a predetermined set of questions in the structured interview, utilizing clear wording and request for inquiries indicated in the review plan (Kothari et al. 2014:138). The assessment is a composed rundown of open-ended inquiries arranged for use by a questionnaire in an individual-to-individual interview. Quality control was intended to be an essential segment of the whole survey process, including the correct training and orientation of research assistants to ensure that they are properly qualified and acquainted with the questionnaire and the different surveys. The investigator at each phase of the review with an attention to quality data management; and standard and brief input and answer to each mindful study line director or expert in each region (PHCU) by the data collectors. To ensure reliable information, the pregnant women were interviewed in their mother tongue by field workers who were competent in both English and Amharic/Oromiffa.

3.5.1.6 Data analysis

In this study, data were cleaned for completeness and consistency during daily data collection, data entry, and before analysis. Data consistency refers to "the authenticity and integrity of real-world data,". In contrast, information completeness focuses on whether the researcher's database contains all the information needed to answer research questions (Fan, Geerts & Wijsen 2011:4). Consistency tests aid in the detection of contradictory results. Before this analysis, the data was cleaned for completeness and consistency by running frequency, crosstabs, and sorting of the variables of interest in SPSS version 21.

Finding and repairing incomplete, erroneous, or irrelevant sections of a data set or database by replacing, changing, or removing the incorrect data is known as data cleansing or data scrubbing. Cleaning data is the first stage in the data processing. It aids in creating a trustworthy database and avoiding incorrect conclusions (Tyagi, Solanki & Tyagi 2010:32).

Running variable frequencies discovered missing values, erroneous values, and outliers. When running the frequency of a variable with potential "Yes" or "No" responses and values of 1 or 2, for example, the frequency output may imply a missing category with a value of 11 or 22 owing to double tabbing, or there may be no value due to missing errors.

Invalid character values were corrected by cross-checking the values in the mother document (questionnaire) and tracking the case identification number of the related cases. If the values in the questionnaire matched those in the database, the cases were excluded from the respective analysis.

The minimum and maximum values of the numeric variable were examined to check the accuracy of the data in this study. For example, the study population includes women between the ages of 18 and 49. As a result, values less than 18 or greater than 49 would be excluded from the study.

A statistician was consulted to validate the researcher's findings (Annexure 15).

3.5.1.7 Rigour of the study

Whatever the research design or methodologies used, research instruments must have two crucial characteristics: validity and reliability (Abutabenjeh & Jaradat 2018:15). The primary predictor of data validity and reliability is the data gathering tool (Hasesk & Ilic 2019:297). The accuracy of the factors being researched is affected by the validity and reliability of measurements(Mohajan 2017:123).

Validity

Validity is an expression of the degree to which a test can measure what it is intended to measure. A study is valid if its results correspond to the truth; there should be no systematic error, and the random error should be as small as possible (Bonita & Beaglehole 2001:70). To assure validity, the researcher followed the appropriateness of the tools, processes, and data. Whether the research question is valid for the desired outcome, the choice of methodology is appropriate for answering the research question, the design is valid for the methodology, the sampling and data analysis is appropriate, and finally, the results and conclusions will be validated for the sample and context. Reliability means the replicability of the processes and the results with diverse paradigms. Hence, the essence of reliability lies in consistency.

The results are consistent over time, and an accurate representation of the total population under study followed, and the results of a study reproduced under a similar methodology, then the research instrument is considered reliable.

Reliability

The accuracy of a measurement is referred to as reliability. When completing an instrument to assess motivation, a participant should have about the same responses each time the test is taken. However, it is impossible to approximate this (Shaheen, Pradhan & Ranajee 2018:34).

Confounding factors pose significant risks in this type of research by concealing connections to avoid significant risks associated with variable associations, including false associations. Possible confounding variables were included in this study unless the confounding factors had been statistically controlled by using multivariate regression techniques to separate the effects of the different variables.

The interview was scheduled in such a way that the responder would not be missed or fatigued to get an appropriate response rate. Careful consideration was given to coding, mathematical calculation during analysis, and interpretation throughout the process.

3.5.2 Phase 2: Qualitative research method

Qualitative research includes gathering and evaluating non-numerical data (text, video, or audio) to understand ideas, thoughts, or perceptions. It can be used to gain an in-depth understanding of an issue or to generate new research ideas (Neubauer et al. 2019:31). Based on the above definition, the researcher chooses.

3.5.2.1 Study area and setting

This second phase of the study was conducted in the same setting where the first phase was carried out and has been described in detail on page 68.

3.5.2.2 Population

Qualitative research uses samples that are not likely to be used for testing to select the population. Units are intentionally selected in a non-probable sample to reflect the characteristics of the sampled population or groups (Shaheen et al. 2018:23).

3.5.2.3 Sample and sampling

It is possible to collect information from a predetermined number of people in quantitative studies, but researchers do not have a sample size in mind in qualitative research. The overall sample size could be increased depending on whether the data collection methods involve (roughly in ascending order) single interviews, paired interviews, and small or average-size group discussions (Lewi 2003:84). It is also determined by the point at which the researcher achieves data saturation.

Qualitative Sampling is aimed at saving time and energy, moreover assuring accuracy, which sounds like independent assessments of the population status as far as whatever is being investigated (Etikan 2016:34).

Several factors can affect the sample size in research design, including ease of access to potential participants; the researcher's belief that the person has detailed knowledge of an event, occurrence, or situation of interest to the researcher; and how representative the case is for the community of individuals or different from the entire population.

3.5.2.3.1 Sampling of study subjects

A sampling of study subjects included:

- Pregnant mothers
- Health extension workers
- Women health development army
- The elderly

In this phase, a purposive sampling technique was used to select the study participants who were enrolled to participate in this study.

3.5.2.3.2 Sampling size

In qualitative research, the sample size is decided by the information gathered during the data-collecting phase. The decision to cease accepting new samples into the research is based on the theoretical saturation of the data, which implies that no additional data from the study subjects are found (Flick et al. 2014:138). Further advice is that more samples be excluded from the study if a researcher finds that the data provide adequate depth and breadth of information about the phenomena under examination and that the link between variables in the study is evident (Johnson & Schoonenboom 2016:157). The data collecting for this project came to an end after the seventh interview when the field researcher reached theoretical saturation. Therefore In this study sample size was not pre-determined but was dependent on the data saturation point (Kothari et al. 2014:193).

3.5.2.4 Data collection

3.5.2.4.1 Data collection approaches, method, and process

Data collection is defined as the process of gathering information in a meaningful and reliable manner (Miquel Porta 2014:67).

Qualitative research focuses on obtaining data from a small group of people to completely understand the research topic. Participants in a qualitative study are often recruited on purpose to acquire comprehensive information about a topic under investigation. The qualitative research method does not begin with a collection of pre-designed study questions for certain variables. In contrast, qualitative researchers collect data in the form of text or images by asking a few open-ended questions that encourage participants to express their own opinions and experiences on the issue under study. As new ideas and insights emerge during data collection, questions may be posed.

Several methods can be used to collect primary data, such as. The choice of a method depends upon the purpose of the study, the resources available, and the skills of the researcher. There are times when the method most appropriate to achieve the objectives of a study cannot be used because of constraints such as a lack of resources and/or required skills (Kothari et al. 2014:133).

In this study, the in-depth interview data collection method was employed in a one-month data collection period. Since the design of the study is a sequential explanatory mixed-method, the qualitative data were collected following the initial quantitative phase.

3.5.2.4.2 Individual in-depth interview

The term “in-depth interview” conjures up one of the most famous qualitative data-gathering activities: a trained interviewer engaging in a probing conversation with a sufficiently informed respondent. To some extent, almost all qualitative researchers employ this approach, and in-depth interviews constitute the major or exclusive source of data for many projects and researchers. There is a solid reason for this method's popularity: it is adaptive to difficult field circumstances, versatile across a wide range of research topics, and effective for not merely delivering information but also creating knowledge (Lewis, Galbally, Gannon & Symeonides 2014:340).

3.5.2.4.3 Development, testing, and characteristics of the interview guide

The construction of a research instrument or tool is an extremely important aspect of a research project because anything you say by way of findings or conclusions is based upon the type of information the researcher collects, which is mentioned by the author. The data you collect depends entirely on the questions you ask of your respondents (Kothari et al. 2014:147).

The interview guide was thoroughly tested with two participants and revised before being used. Pre-testing allows data collectors to see if there is enough variation in the responses, if the language and concepts are clear, if the response categories are appropriate, if participants can easily answer the questions, if the format is easy to follow, if the information flow is logical, and if the instrument can be completed in a reasonable duration of time. Making appropriate changes to the original data collection instrument based on the information revealed during pre-testing leads to a more effective questionnaire. Pre-testing and subsequent revision invariably result in an instrument that produces fewer mistakes in answering the guide.

An in-depth interview is less formal and the least structured, in which the wording and questions are not predetermined. This type of interview is more appropriate for collecting complex information with a higher proportion of opinion-based information. Bilingual Amharic, Oromiffa, and English linguistics graduate students at Addis Ababa University translated the interview guide into Oromiffa. The accuracy, sensitivity, and validity of the translation were checked using a blind back-translation.

3.5.2.4.4 Data collection process

To collect the data, all essential preparations were made. The interview guide was developed, and those who participated in data collecting and had experience with qualitative data collecting were put to use. The research procedure was protected through ethical approval letters secured from UNISA (Annexure 1), Oromia Health Bureau Research Committee for Ethical Review, and the Town Health Offices, which also made recommendation letters to support data collection (Annexures 4 and 5).

Records were kept in locked cabinets to which access is restricted to a few members of the research team as reasonably. Similarly, data, which were stored on computerized databases, be rendered secure from access by other users of the system.

3.5.2.5 Data analysis

It primarily focuses on finding the main topic from the description's body, utilising a step-by-step technique. Data reduction or collapse, description, and/or interpretation are the key activities in qualitative data analysis. Consequently, discovering the key themes and interpreting the data may require the researchers to go back and forth from data collection to data analysis and back again. The researcher used to improve the questions they asked from the data and analysed the data concurrently with the data collecting activity.

The researcher used a methodical approach to analyse the data in many phases. Data familiarisation, identifying significant statements, formulating meanings, clustering themes, developing an exhaustive description, producing the fundamental structure, and seeking verification of the fundamental structure are the seven steps the researcher used to analyse the qualitative data.

The data is assisted by Atlas ti7 computer software developed for the analysis of qualitative data, which helps with the annotation, coding, sorting, and other required manipulation of the data and storing a record of all these activities (Flick et al. 2014:281).

The interview transcripts, field notes, and observations will be categorized into specific themes and sub-themes and coded to reduce data (keep bulk data as you may need it at some stage for further reference). Verification/interpretation was used to make meanings from the finding and link them with objectives.

Table 3.1: Steps of data analysis in a qualitative study

Step	Description
Familiarisation	The researcher became familiarised with the data by reading over all of the participant accounts numerous times. This was done after all of the interviews were completed, and all of the data was gathered.
Identifying significant statements	All statements in the accounts that were directly relevant to the phenomenon under study were identified by the researcher. This was accomplished by listening to the interviews, rereading the transcriptions, and highlighting key remarks that were relevant to the study.
Formulating meanings	The researcher identified the meanings related to the phenomenon that developed through careful analysis of the crucial remarks.
Clustering themes	The researcher organized the identified meanings into themes that appeared in all of the tales.
Developing an exhaustive description	The researcher prepared a comprehensive account of the phenomenon that included all of the themes generated during step 4. Similar data were grouped and characterized in terms of how they connected to the phenomenon.
Producing the fundamental structure	The researcher condensed the described facts into a brief, tightly packed statement containing only those characteristics critical to the phenomenon's structure.
Seeking verification of the fundamental structure	The researcher would have returned the fundamental structure statement to each participant and asked if it accurately represented their experience. This was not practicable, however, because the individuals lived in different regions, and it was unknown when they would return to the Health Facility.

(Morrow 2015:643-644)

3.5.2.6 Rigour of the study (establishment of trustworthiness)

The degree of confidence in data, interpretation, and procedures employed to assure the quality of a study is referred to as the study's trustworthiness or rigour (Polit & Beck 2014:23). The most significant factor is the study's credibility, or belief in the study's truth

and thus the findings. Credibility, reliability, conformability, transferability, and authenticity are all used in each step of this study.

Credibility: Guarantees that the study findings are believable. This was accomplished via several data collecting procedures (triangulation), such as interviews conducted with various types of participants, such as health care practitioners, traditional leaders/healers, and traditional attendants. These would guarantee that the information obtained is as diverse as possible. These (unstructured interviews) were used to assess the correctness of the findings, with a focus on verbatim quotes and outliers.

Reliability: The data collecting tools were pretested before data collection, and consistency was assessed using the tests retest approach to determine if there are any differences in data collected from the same persons several times. Data was collected in a way that increases precision, consistency, and dependability. Data was gathered, cleaned, and validated for consistency and completeness in Excel before being imported into suitable software for analysis. Data collectors were also taught how to eliminate data-collecting inconsistencies.

Conformability: When collecting and analysing the qualitative study findings, the researcher maintained a high degree of objectivity. The researcher was also examining her interests, which may impact her judgment, and they were taken into account throughout data collection and analysis.

Transferability: This frequently indicates that the study's findings might apply to a larger group or in a different context. Even though a situation is unique, the authors suggested being applied to a greater scope or a larger population. To ensure that readers are informed, sufficient detail regarding techniques, data collecting, and analytic tools was supplied. This would allow them to objectively analyse and translate the study to various contexts.

Authenticity relates to the last criterion, authenticity, which refers to how accurately and authentically researchers portray a spectrum of realities (Lopez-Morales 2008:67). The researcher's identity and integrity of the record are assessed to determine authenticity.

We can always determine what a record is, when it was made, by whom, and what activity or matter.

3.5.2.7 Mixing quantitative and qualitative analysis of data

The term "mixed methods" refers to a new research methodology that enhances data analysis through systematic examination inside a single study or across time. The underlying tenet of this strategy is that such integration allows for more effective resource utilization. Data may be used more comprehensively and synergistically when quantitative and qualitative data are combined.

The author described the advantages of using a mixed-method approach, such as how it is complementary, practicable, gradual, has higher validity and is collaborative. The phrase complementary refers to quantitative and qualitative approaches that work in tandem. Because mixed methods contain both words and numbers, the study is not limited to a single data collection methodology. The word "practicality" refers to the researcher's adoption of the methodology that best addresses the study issue while using one of the mixed-method approaches (Polit & Beck 2015:582-583).

Once the first and second phases have been completed, the two data sets must be integrated. The qualitative and quantitative components are merged at the point of integration. The following are some of the major ways in which the components might be linked to one another:

- Combining the two sets of data.
- Establishing a link between analysing one set of data and gathering the second set of data.
- The incorporation of one type of data into a broader design or method.
- Using a framework (theoretical or programmatic) to connect data sets (Creswell & Plano Clark 2011:76).

In this study, the data were merged at the end stage and used in the interpretation and strategy development stage.

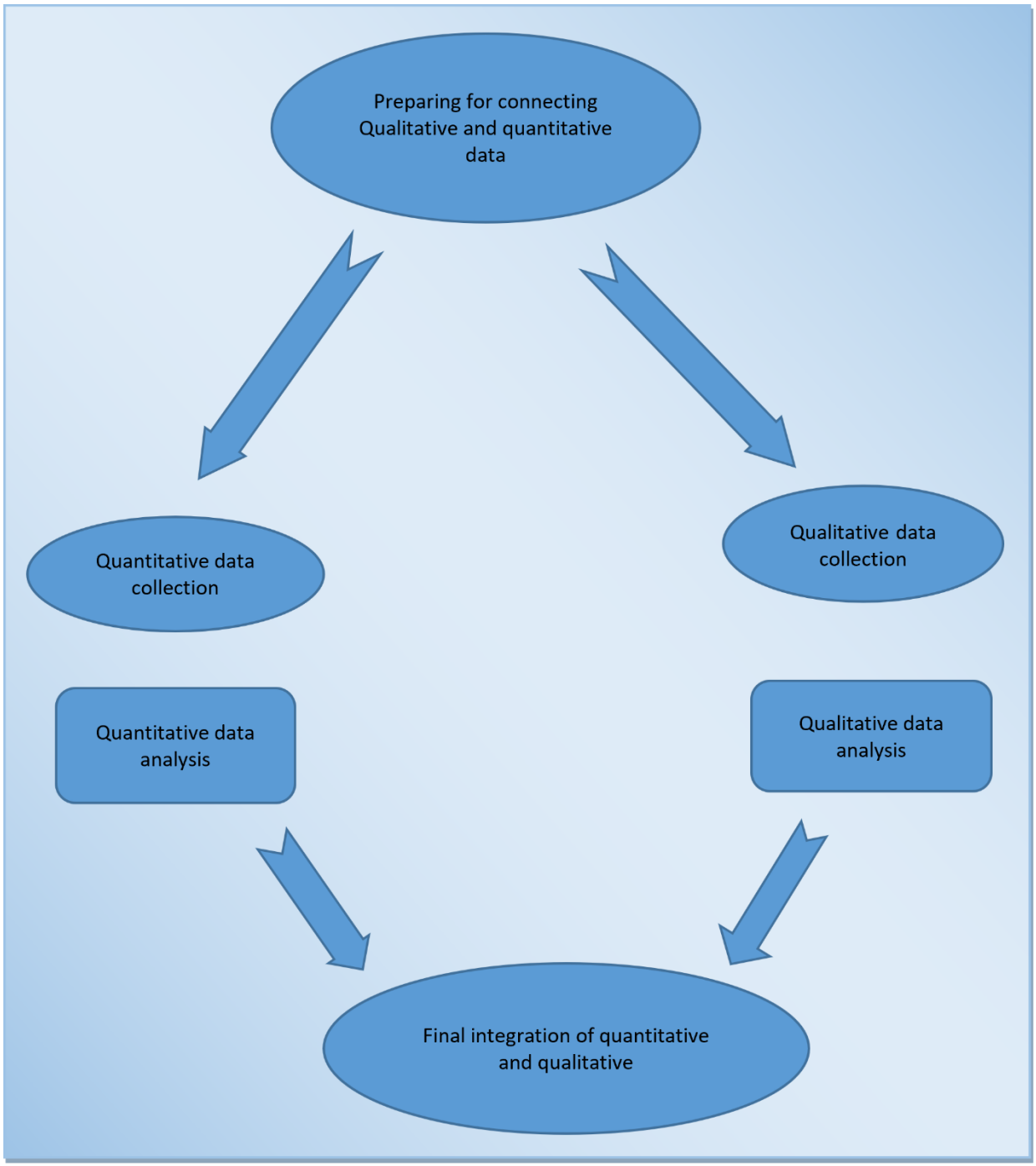

Figure 3.3: Point of interface MMD

3.5.3 Phase 3: development of strategies

The strategy development process helps prevent the document from aimlessly performing objective tasks without set priorities or a real purpose. The strategic development process is a list of steps the researcher should follow to complete and

implement a strategy within the scope. Several key components comprise the strategic planning process, including common phrases like strategic analysis, strategy formulation, and implementation and monitoring. Although the strategic development process requires great patience and can be challenging, most activities agree that the process can yield highly rewarding results.

In this study, a deductive reasoning technique was used to produce recommendations from the results of both the study's qualitative and quantitative stages, the literature review, and the mental health technical committee's (TC's) evaluation of the draft strategy document. The TCs assessed the guidelines for conciseness, transparency, comprehensiveness, effectiveness, and applicability and included their comments in the final strategy. The document has been subject to scrutiny by the EMHA's TCs.

The following steps were followed in developing strategies for community-based prevention of maternal CMDs

Step 1: Development of strategy

Step 2: Draft strategy development

Step 3: Review and consensus-building

Step 4: Finalising the strategy

These steps will be discussed in detail in Chapter 7.

3.6 ETHICAL CONSIDERATIONS

Ethical considerations are a set of values and ideas that answer the topic of what is good and wrong in human affairs. Ethics seeks grounds for doing or abstaining from acting; approving or disapproving behaviour; believing or rejecting something about virtuous or wicked behaviour, or good or bad norms (Creswell 2014:74).

To effectively handle the ethical issues component of the investigation, the researcher took all necessary steps to protect respondents and participants. Obtaining the necessary

permissions to conduct the study through the respondents' and participants' voluntary involvement in the research was critical.

The Department of Health Studies, UNISA Ethical Review Committee, provided ethical permission and authorization before data collection (Annexure 1). Oromia Regional Review Board was contacted, authorization was obtained, and a letter was sent to each of the town health offices and then to the health facility (Annexures 3, 4, and 5). Informed consent from each study participant was obtained at the time of data collection (Annexures 8 and 9). The right to refuse during data collection was respected, and information to be collected for this research project was kept confidential.

Therefore, the study participants' voluntary participation and the fact that they have the complete right to stop participating at any time without any consequences or repercussions. Furthermore, Informed consent was obtained in this study after each respondent was informed about the study's purpose, benefits, and risks. Additionally, maximum effort was employed for the protection of the privacy and confidentiality of the participants (Annexures 6, 7, 8, and 9).

3.7 SUMMARY

This chapter goes into detail on the research approach and technique used to conduct this study. This work employed Sequential Explanatory Mixed Method research, which was carried out in three stages: quantitative, qualitative, and strategy creation. During the data collection process, all components of the data collection instrument are covered, including sampling, pre-testing, and administration.

The research design and methodology utilized to perform this study are detailed in-depth in this chapter. This paper explains and discusses the sequential explanatory mixed-method study, which was conducted in three phases: quantitative, qualitative, and strategy development. The procedures used to verify the instrument's reliability and validity were addressed, and Chronbach's reliability test of this study was shown. Methods of Entry. The core principles of public health research ethics were applied and explored in various ways.

Chapter 4 deals with the analysis, interpretation, and description of quantitative findings.

CHAPTER 4: ANALYSIS, PRESENTATION, AND DESCRIPTION OF QUANTITATIVE FINDINGS

4.1 INTRODUCTION

The methodology of the research article was covered in detail in the previous chapter, and now this chapter looks at the quantitative phase's analysis and interpretation. The data was analyzed and presented using descriptive and inferential statistics. The findings were presented that addressed the study questions.

4.2 DATA MANAGEMENT AND ANALYSIS OF QUANTITATIVE STUDY

Several issues with data quality influence how survey results are interpreted. Pre-testing the questionnaire in the local Oromiffa language; interviewer preparation; rigorous monitoring of field operations; and orientation and employment of experienced data entry operators were all used in this study to safeguard data quality before, during, and after data collection. In terms of numerous characteristics, it was also required to determine if the women questioned represented the larger population of females aged 18 to 49. The response rate of the questionnaires was checked, and the age data were analyzed before further statistical analysis.

The response rate is calculated by dividing the number of participants who completed a questionnaire by the total number of individuals who were asked to participate in the survey (Polit & Beck 2015:265). Higher response rates for the questionnaires boost the validity and utility of the study's findings. Higher response rates for questionnaires were recorded in this study, reflecting the quality of training offered to interviewees, their comprehension, and the lead investigator's day-to-day supervision (Table 4.1).

Table 4.1: Response rate

Districts' name	Questionnaires administered	Response rate	Per cent	Reason
Bureau Town	60	60	100	
Almena Town	115	115	100	
Glean Town	12	12	100	
Suluta Town	25	25	100	
Legetafo Town	16	16	100	
Total	228	228	100	

4.3 DESCRIPTIVE RESULTS

4.3.1 Socio-demographic characteristics participants

Demographics is the study of a population based on factors such as age, race, and sex. Demographic data refers to statistical socio-economic information, including employment, education, income, marriage rates, birth and death rates, and more factors. Governments, businesses, and non-government organisations use surveys to learn more about a population's characteristics for many purposes, hence socio-demographics relating to or involving a combination of social and demographic factors (Blumstein 2015:45).

4.3.1.1 Age of respondents

The mothers' ages ranged from 18 to 42 years, with a mean of 26.57 ± 4.79 years. The non-respondent rate was 0. More than half of them were young women aged between 24 and 30. The respondents' mean age was 26.23 years, with a median of 25 and a standard deviation of roughly 4.7 years.

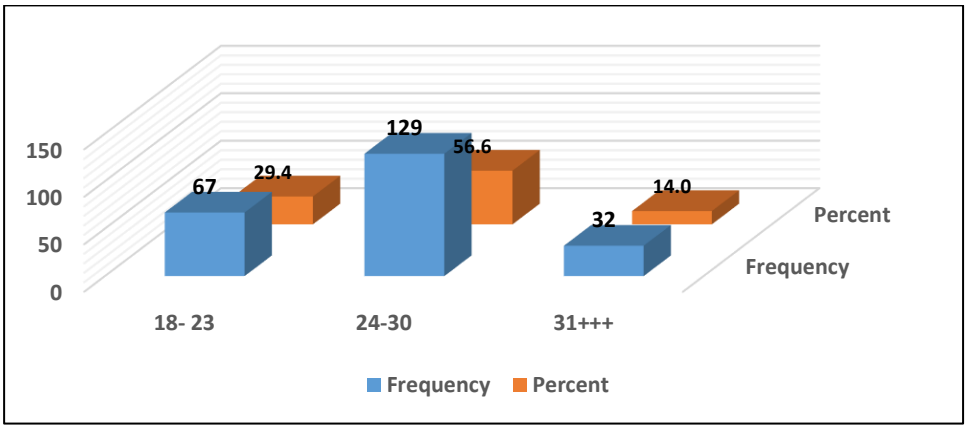

Figure 4.1: Age group

4.3.1.2 Educational status of women

The educational status of the women studied is presented. The literacy rate among women exceeds 88.5 per cent, with the majority of moms (33.3 per cent) merely having an elementary education and only 2.3 per cent having tertiary education.

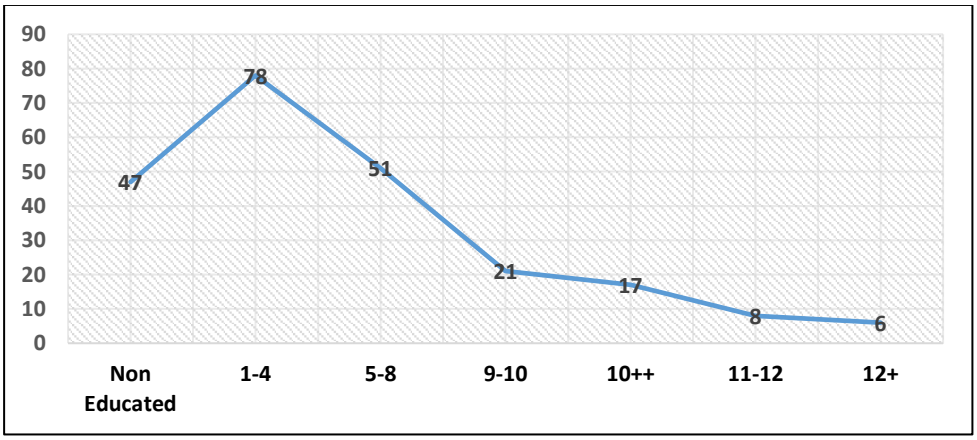

Figure 4.2: Educational status

4.3.1.3 Marital status

In the poll directed at pre-natal women, around 63.3 per cent (146) of 228 respondents came for a prenatal check-up, as would be expected. However, just around 4% of the

participants were cohabiting with their spouses; the remaining women had never been married, divorced, widowed, or separated.

4.3.1.4 Employment status of the women

Most of the mothers (58.3%) were housewives. The rest were working mothers. More than three-fourths of the fathers (68%) rested in the group of employed and the rest proportion were in the unemployed group.

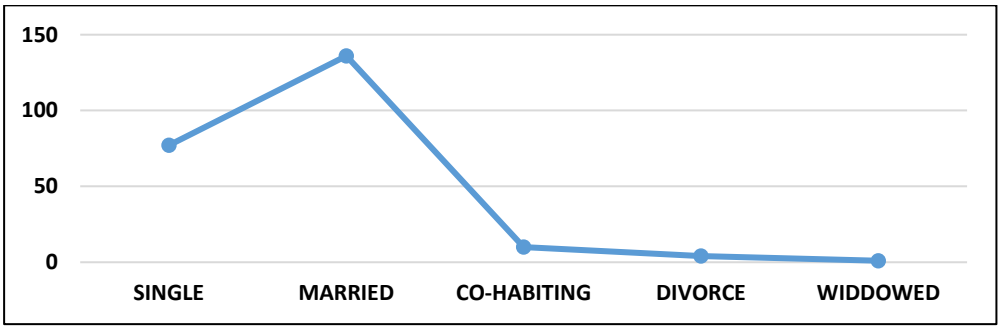

Figure 4.3: Marital status

4.3.1.5 Ethnicity of women

This section presents the ethnicity of the women studied. The Oromo ethnic group is dominant among the women studied. It was represented by 61.6% of the respondents, and the second majority (22%) were South Nation Nationalities and Peoples Region SNNPR, followed by the Amahara and Tigray ethnic groups, which were few.

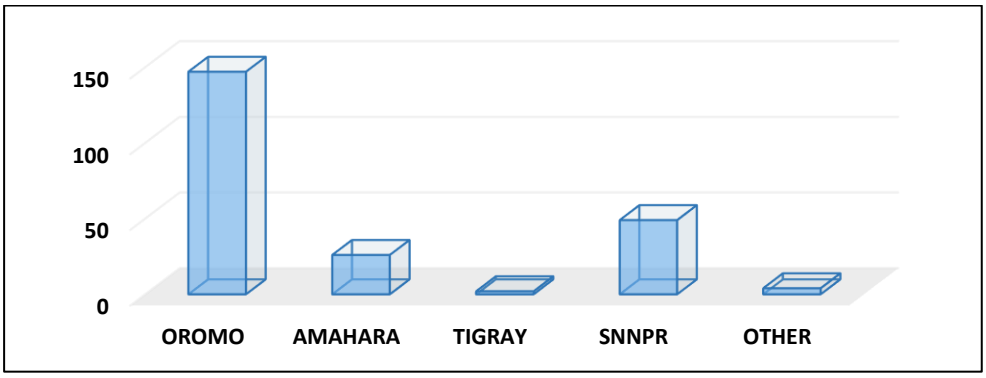

Figure 4.4: Ethnicity

4.3.1.6 Proportion of religion among pregnant women

The majority of the women's religion was Orthodox Christianity, Muslim and Protestant Cristian were the following majority of their religion.

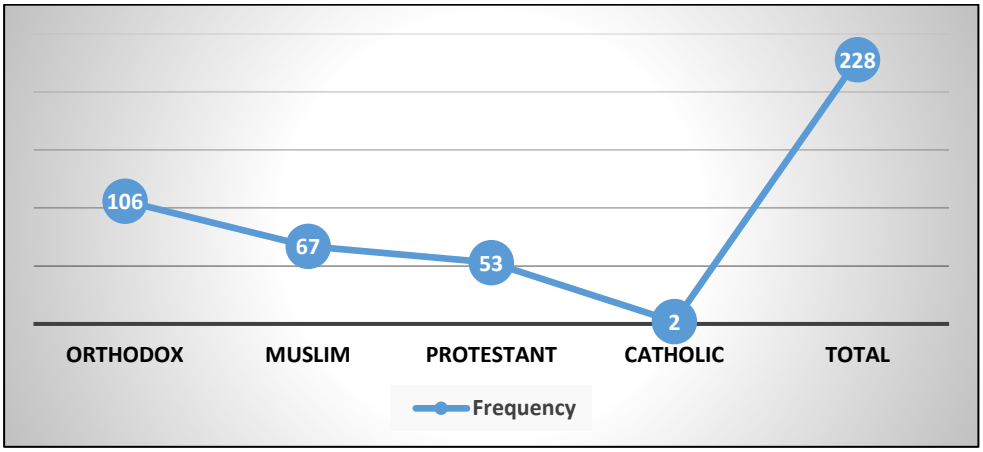

Figure 4.5: Religion

4.3.1.7 Number of pregnant mothers living in urban and rural areas

In the course of this study, 228 pregnant women, 24.6% rural and 75.4% urban were surveyed (Figure 4.6). The participant's occupational status concerning the settlement of their living place was urban and rural. Thirty-two unemployed participants were found from rural places; among the urban, 69 were unemployed. Nearly half of the urban women (60) were employed.

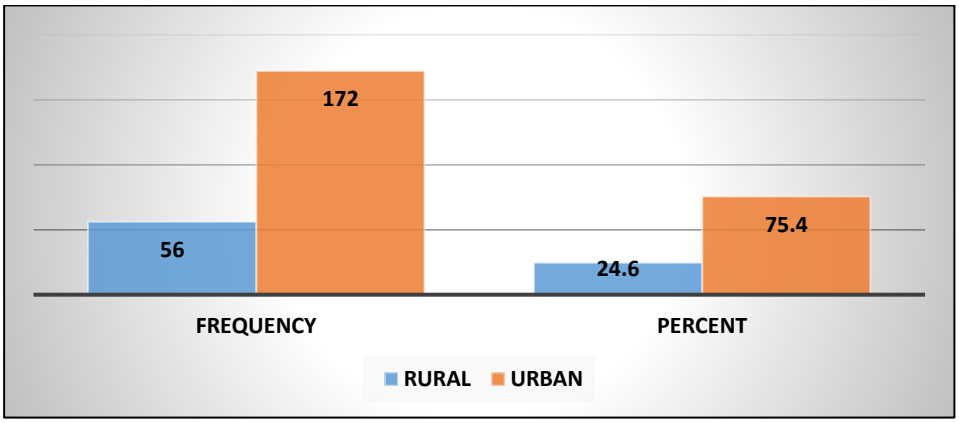

Figure 4.6: Living place

4.3.1.8 Number of adults and children living in the household

Figure 4.7 depicts the children and adults living in the study population's household. Almost all of the women had at least one child in their family. The number of children in each woman's household ranged from 0 to 6. Slightly more than 83.8 per cent of the participants had 1-2 children living in the house, and the average number of children in a woman's household was two. Similarly, 84.6 per cent of households have at least 1-2 adults living in them.

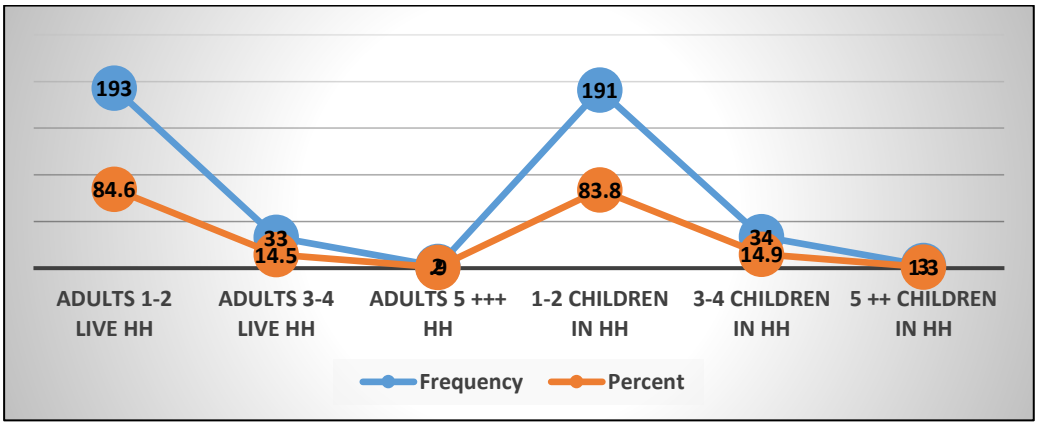

Figure 4.6: Number of adults and children

4.3.2 Social support of the respondents

Social support is often described as a key component of stable relationships and good psychological well-being, but what exactly does it mean? Social support means providing a network of family and friends you can turn to in times of need. Whether you are facing a personal crisis and need immediate assistance, or you just want to spend time with people who care about you, these relationships play a critical role in how you function in your day-to-day life. Social support builds people up during times of stress and gives them the strength to carry on and even succeed. But social help is not a one-way path (Baqutayan 2011:145).

The average OSS-3 score was 10.30 (SD=2.65), with scores ranging from 3 to 14. The Oslo 3-items is a quick measure of the prenatal mother's social functioning that is employed. It is considered of the Majority (53%) of the respondents were found in low

social support status. Less than half (47%) of the respondents were fallen into the category of good social support.

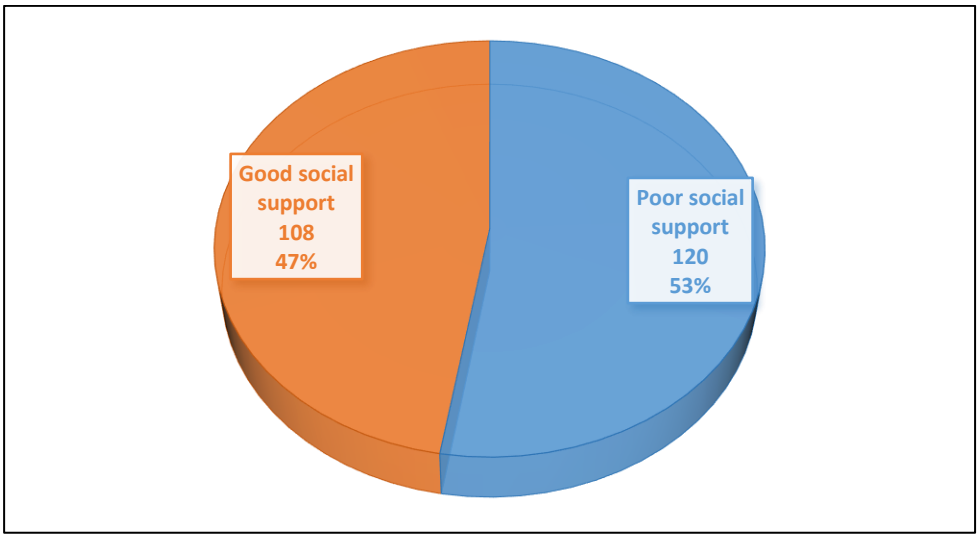

Figure 4.7: Social support

Detailed results of social support variables will be presented in the table.

4.3.3 Hierarchical living standard

A hierarchal living standard is the level of wealth, comfort, material goods, and necessities available to a particular socio-economic class or geographic area. The standard of living includes important material factors such as employment, GDP, life expectancy, and economic opportunity. Living standards are closely linked to the quality of life and may also include factors such as economic and political stability, political and religious freedom, quality of the environment, climate, and health (Isaac 1966:256).

As a result of our study, about two-tenths (56%) of the respondents had a lower hierarchal living standard, and the rest (43.9%) were in the category of greater hierarchal living standard.

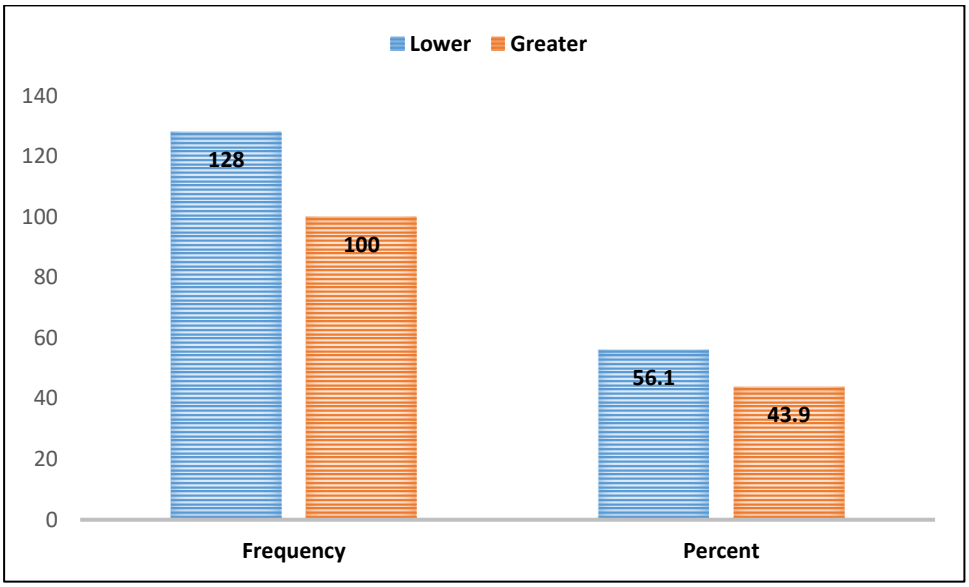

Figure 4.8: Hierarchical living standard

4.3.4 Use of ART for prevention of mother-to-child transmission

Antiretroviral therapy is used by 93 out of the 228 pregnant women polled. They were between the ages of 24 and 30. Regarding substance use by PMTCT mothers, 43.3 per cent of them fall into the category of hazardous alcohol use, whereas 42.1 per cent of the PMTCT women use Khat.

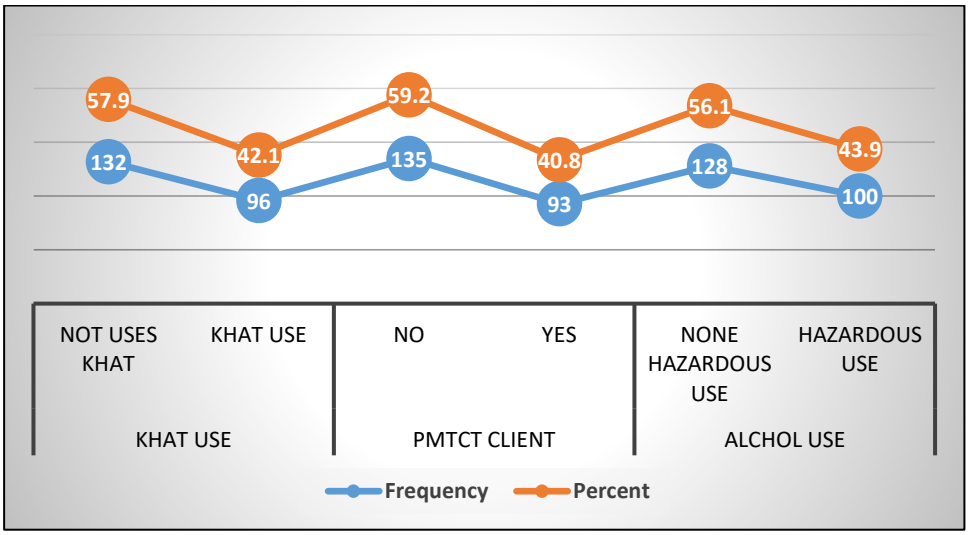

Figure 4.9: PMTCT and substance use

4.4 PREVALENCE OF COMMON MENTAL DISORDERS AMONG PREGNANT WOMEN IN URBAN OROMIA ETHIOPIA

Prevalence is a statistical concept referring to the number of cases of a disease that occur in a specific population at a given time, whereas incidence refers to the number of new cases that occur within a given period (Wyndaele & Wyndaele 2006:345).

In the study, participants were recruited while attending a health facility for antenatal care. Results show that high prevalence of the common mental disorder among pregnant women in urban Oromia. Out of the 228 mothers, 125 (54.8%) were found to have CMD. Of the pregnant women who participated, about 103 (45.2%) had anxiety, and 63 (27.6%) had a positive score for depression.

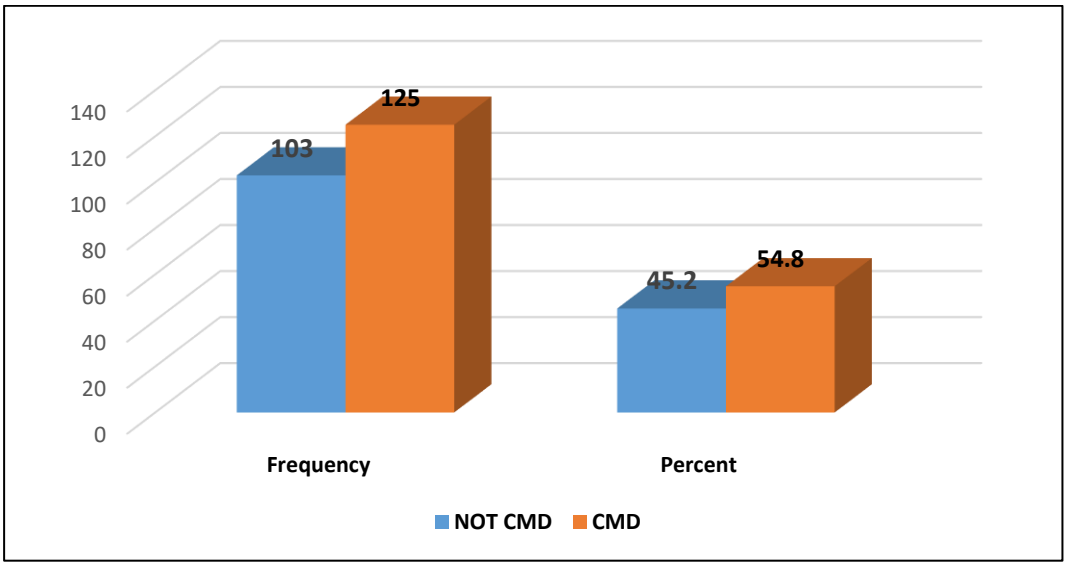

Figure 4.10: Prevalence of common mental disorders

Figure 4.11: Number of the prevalence of anxiety

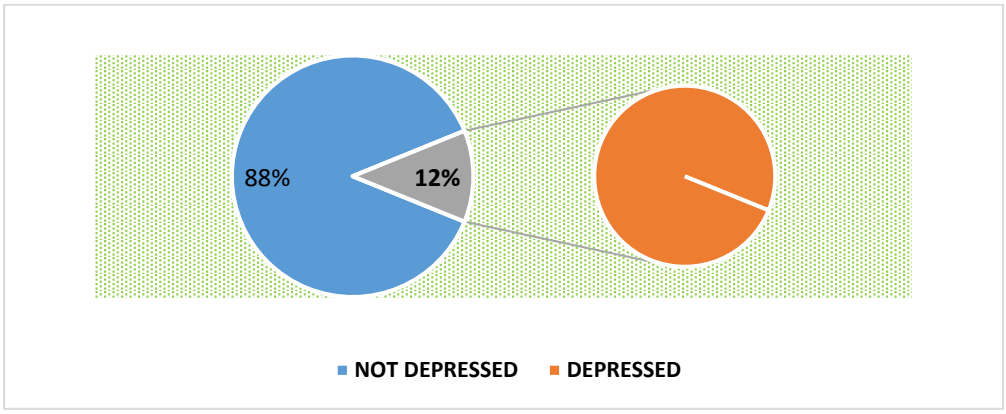

Figure 4.12: Prevalence of depression

4.4.1 Severity of anxiety and depression

According to the frequency distribution of the respondents screened for anxiety, the majority (78.5%) fell into the minimal or no category, (17.1%) into the mild category, (and 4.4%) into the moderate category, but no respondents fell into the severe category of anxiety disorders.

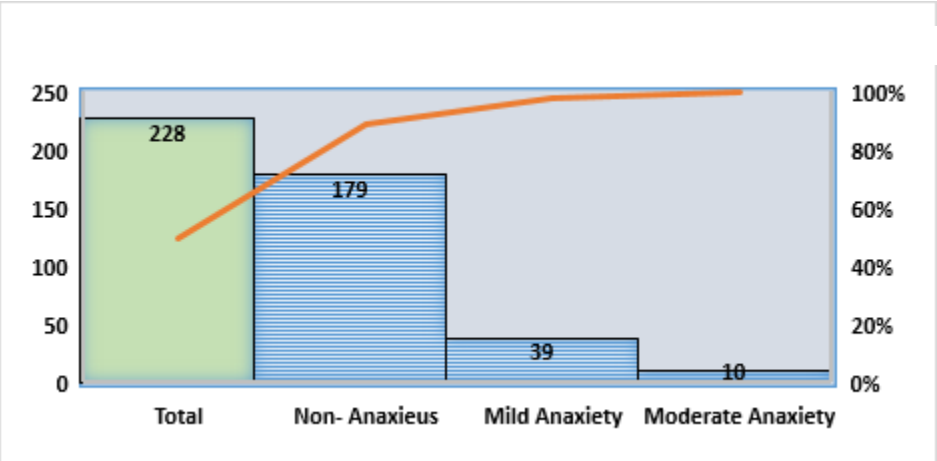

Figure 4.13: Severity of anxiety

When we look further into the severity of depression, moderate type of depression is more frequent on PHQ-9 scores seen in pregnant women to depression severity breakdown of this group that screened for mild to severe depression; as represented in Figure 4.15; it is evident that less prevalent of depression among pregnant women than the prevalence of anxiety disorder. In the analysis, positive for mild 28 (12.3%) and no moderate depression were seen. In the study, no pregnant women are categorised under the severe and suicide depression range. These findings indicate that the cases seen could be managed and prevented in the surveyed community.

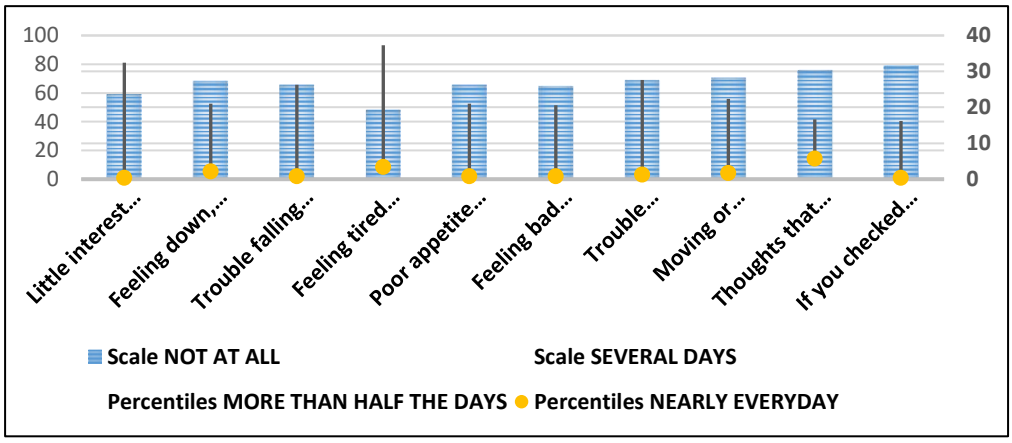

Figure 4.14: Percentage of PHQ 9 symptoms of depression

Table 4.2: GAD 7 vs prevalence of anxiety disorder of respondents

Prevalence of anxiety Vs GAD 7	Not at all	Several days	More than half the day	Nearly every day	
	Feeling nervous, anxious or on edge				Total
No anxiety	137	24	4	0	165
Anxiety	12	37	9	5	63
	Not being able to stop or control worrying				Total
No anxiety	157	7	1	0	165
Anxiety	16	42	4	1	63
	Worrying too much about different things				Total
No anxiety	137	27	1	0	165
Anxiety	10	39	11	3	63
	Trouble relaxing				Total
No anxiety	150	14	1	0	165
Anxiety	13	35	13	2	63
	Being so restless that it is hard to sit still				Total
No anxiety	155	9	1	0	165
Anxiety	17	31	7	8	63
	Becoming easily annoyed or irritable				Total
No anxiety	121	39	5	0	165
Anxiety	6	38	15	4	63
	Feeling afraid, as if something awful might happen				Total
No anxiety	132	27	5	1	165
Anxiety	17	27	10	9	63

4.4.2 Community prevention service received by pregnant mothers for maternal common mental disorders (CMDs)

Overall, the quality of evidence for existing prevention programmes in the preconception, pregnancy and overall population is limited, and this study found that nearly 5.3% of the study population reported the availability of community maternal mental disorder prevention services provided during perception, prenatal and postnatal period in the surveyed community. Only 1.7% know where to go if they are concerned about mental health problems or feel distressed.

The general practice of affected mothers was getting treatment from community healers, like religious leaders and traditional healers. Few of them visited health posts or health centres. If the case is severe, they will go to Hospitals. Affected mothers do not seek treatment by themselves unless their cases worsen; their relatives would accompany them.

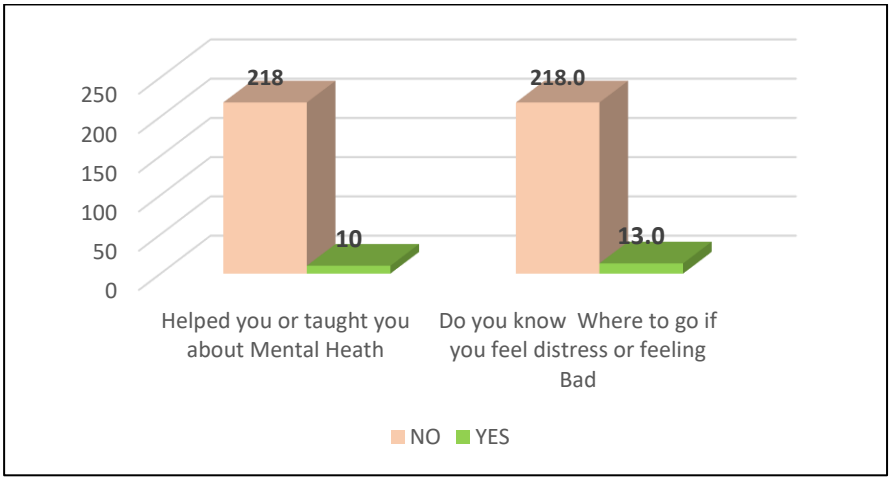

Figure 4.15: Mental health service

4.5 ANALYTICAL EPIDEMIOLOGY

Analytical epidemiology attempts to identify factors in a disease-bearing population that differs from a non-diseased population; AE is divided into cross-sectional, prospective, and retrospective forms (Borrell & Papapanou 2005:65).

The descriptive findings of the study were described in the previous section. This part has based on the findings of inferential statistics that were used to answer the study questions. Simple and binary logistic regression models were employed to investigate risk or protective factors for maternal common mental disorders. The associations of predetermined risk or protective factors for maternal CMDs are summarized in table 4.6 using these associates ($p<0.05$).

4.5.1 Bivariate associations of predetermined risk or protective factors for maternal common mental disorders at the community level in urban Oromia, Ethiopia

Univariate analysis showed that adjusting separately for maternal factors, socio-economic/living situation, social support, maternal functioning, and health affect our finding of significant associations between maternal CMD. The fully adjusted HRs will be seen in Table 4.6.

Table 4.3: Bivariate analysis of potential risk and protective factors associated with maternal CMD in Oromia region, Ethiopia

Potential risk factors	Value	Age category		Total	P-value	Crude OR (95% CI)
		Younger	Older			
Age category	NOT CMD	87	16	103	0.000	8.937 (4.453 17.939)
	CMD	36	89	125		
Total		123	105	228		
Living status	Value	Living status		Total		Crude OR (95%CI)
		Living alone	Living together			
	NOT CMD	13	90	103	0.000	9.483 (4.364 - 20.606)
	CMD	77	48	125		
Total		90	138	228		
Living place	Value	Living place		Total		Crude OR (95%CI)
		RURAL	URBAN			
Living Status	NOT CMD	5	98	103		
	CMD	51	74	125	0.000	16.799 (4.938 -57.152)
Total		56	172	228		
PMTCT	Value	PMTCT client		Total	P-value	Crude OR (95%CI)
		NO	YES			
PMTCT use	NOT CMD	85	18	103		
	CMD	50	75	125	0	7.002 (3.493 -14.034)
Total		135	93	228		
Alcohol use	Value	Alcohol use		Total	P-value	Crude OR (95%CI)
		None hazardous use	Hazardous use			
Alcohol use	NOT CMD	69	34	103		
	CMD	59	66	125	0.001	2.757 (1.483 - 5.125)
Total		128	100	228		
Social support	Value	Social support status		Total	P-value	Crude OR (95%CI)
		Poor social support	Good social support			
Social support	NOT CMD	31	72	103		
	CMD	89	36	125	0.000	4.902 (2.590 – 9.277)
Total		120	108	228		
	Value	Hierarchical living standard		Total	P-value	Crude OR (95%CI)
		Lower	Greater			
Hierarchical living standard	NOT CMD	34	69	103		
	CMD	94	31	125	0.001	5.705 (2.978 -10.929)
Total		128	100	228		

Multivariate analysis of predetermined risk or protective factors for maternal CMDs at the community level in urban Oromia, Ethiopia

Multivariate analysis is traditionally conceptualised as the statistical study of experiments in which multiple measurements are carried out on each experimental unit and for which the relationship between multivariate measurements and their structure is important to the understanding of the experiment (Härdle & Simar 2013:14). Our finding showed the following significant association by Multivariate analysis, those Potential Risk factors on CMD Age Category with [(OR: 7.704 (2.187-27.131)], PMTCT [(OR: 5.240 (2.028-13.542)] and Alcohol use [OR: 14.006 (4.105-47.781)] have a statically significant association as a risk factor and Social Sports Status [OR: 0.315 (0.122-0.817)], and Hierarchical living standard scale [OR: 0.253 (0.096-0.668)] were statistically significant as a protective factor for developing CMD.

Table 4.4: Bivariate analysis vs multivariable analysis of CMD in the Oromia region, Ethiopia

Potential risk factors	Value	Not CMD	CMD	P-value	Crude OR (95%CI)	P-value	Adjusted OR (95%CI)
Age category	Younger	87	36	0.000	8.937 (4.453-17.939)	0.000	7.704 (2.187-27.131)
	Older	16	89				
PMTCT	Yes	18	75	0.000	7.002 (3.493-14.034)	0.000	5.240 (2.028-13.542)
	No	85	50				
Alcohol use	Hazardous	34	66	0.001	2.757 (1.483-5.125)	0.000	14.006 (4.105-47.781)
	Non-hazardous	69	59				
Social sport status	Poor social support	31	89	0.000	4.902 (2.590-9.277)	0.014	0.315 (0.122-0.817)
	Good social support	72	36				
The hierarchical living standard scale	Lower	34	94	0.000	5.705 (2.978-10.929)	0.007	0.253 (0.096-0.668)
	Greater	69	34				

4.5.2 Interpretation of AOR (adjusted odds ratio)

Odds ratio or crude odds ratio is obtained when one is considering the effect of only one predictor variable, i.e. the equation consists of only one independent variable. However, when one includes more variables in the analysis (confounder variables for the said relationship), one gets what is called an ADJUSTED ODDS RATIO, which takes into account the effect due to all the additional variables included in the analysis.

The main difference between a crude odds ratio and an adjusted odds ratio is that the adjusted odds ratio is adjusted within a formula according to the other variables. Then you get the adjusted odds ratio for the variable of interest (whatever that may be) by keeping all other independent variables within a model constant (Hosmer & Lemeshow 2000:342). Note that "modified odds ratios are obtained by comparing individuals that vary only in the interesting characters and have constant values for all other variables." For example, we can use logistic regression to estimate the risk of substance abuse relapse after individuals receive treatment at a drug rehabilitation centre.

The study's key findings reveal that older women are 7 times more likely to have CMD than younger women or that younger women are 7 times more protected from CMD than older women. Furthermore, women with HIV/AIDS are 5 times more likely to develop CMD than women without HIV/AIDS, and women without HIV/AIDS are 5 times more protected from CMD than women with HIV/AIDS. Women who are classified as having hazardous alcohol consumption are 14 times more likely to get CMD than women who are not classified as having hazardous alcohol use. It was also discovered that persons with high social support have a 69 per cent lower risk of developing CMD than those with inadequate social support. Those who fall into this category have a 75% lower risk of developing CMD.

Table 4.5: Summary of frequency and percentage distribution of variables

Value	Category	Frequency	Per cent
OCCUPATIONAL STATUS	EMPLOYED/SELF EMPLOYED	59	25.9
	FARMER	5	2.2
	HOUSEWIFE	73	32.0
	STUDENT	5	2.2
	UNEMPLOYED	85	37.3
	OTHER	1	0.4
	TOTAL	228	100.0
OCCUPATION STATUS OF THE MAIN BREADWINNER	EMPLOYED/SELF EMPLOYED	133	58.3
	FARMER	15	6.6
	HOUSEWIFE	66	28.9
	STUDENT	3	1.3
	UNEMPLOYED	8	3.5
	OTHER	3	1.3
	TOTAL	228	100.0
MAIN SOURCE OF DRINKING WATER FOR MEMBERS OF YOUR HOUSEHOLD	RIVER	3	1.3
	PROTECTED WELL	7	3.1
	UNPROTECTED WELL	4	1.8
	LAKE OR POND	3	1.3
	PIPE	207	90.8
	PROTECTED SPRING	4	1.8
	TOTAL	228	100.0
TOILET FACILITY	FLASH LATRIN (FUNCTIONAL)	36	15.8
	FLASH LATRINE (NON-FUNCTIONAL)	27	11.8
	PIT LATRINE FUNCTIONAL	149	65.4
	PIT LATRINE (NON-FUNCTIONAL)	10	4.4
	FIELD	6	2.6
	TOTAL	228	100.0
OCCUPATION OF THE MOTHER	NOT EMPLOYED	22	9.6
	EMPLOYED	206	90.4
	TOTAL	228	100.0
OCCUPATION OF THE MAIN BREADWINNER	NOT EMPLOYED	11	4.8
	EMPLOYED	217	95.2
	TOTAL	228	100.0
SOURCE OF WATER	ANOTHER SOURCE	21	9.2
	PIPE WATER	207	90.8
	TOTAL	228	100.0
TOILET FACILITY	OPEN FIELD	6	2.6
	TOILET USE	222	97.4
	TOTAL	228	100.0

Value	Category	Frequency	Per cent
SHARE THE TOILET	YES	138	60.5
	NO	90	39.5
	TOTAL	228	100.0
HOUSEHOLD HAVE ELECTRICITY	NO	13	5.7
	YES	215	94.3
	TOTAL	228	100.0
HOUSEHOLD HAVE A RADIO	NO	27	11.8
	YES	201	88.2
	TOTAL	228	100.0
AT LEAST ONE MOBILE TELEPHONE IN HH	NO	17	7.5
	YES	211	92.5
	TOTAL	228	100.0
HAVE SEPARATE ROOM	NO	68	29.8
	YES	160	70.2
	TOTAL	228	100.0
MAIN MATERIAL OF THE ROOF	CORRUGATED IRON SHEET	12	5.3
	TRADITIONAL STYLE	216	94.7
	TOTAL	228	100.0
HUNGRY IN THE LAST MONTH DUE TO LACK OF RESOURCES/FOOD	YES	23	10.1
	NO	205	89.9
	TOTAL	228	100.0
AMOUNT OF MONEY	ONE	120	52.6
	MORE THAN ONE	108	47.4
	TOTAL	228	100.0
FAMILY HAVE ANY DEBTS THAT YOU CAN1 PAY	YES	29	12.7
	NO	199	87.3
	TOTAL	228	100.0
WOULD RAISE ENOUGH MONEY TO HOUSEHOLDS AND FEED YOUR FAMILY FOR 4 WEEKS	NO	98	43.0
	YES	130	57.0
	TOTAL	228	100.0
PEOPLE ARE SO CLOSE TO YOU THAT YOU COUNT ON THEM IF YOU HAVE A PROBLEM	NONE	18	7.9
	1 OR 2	101	44.3
	3-5	77	33.8
	6 OR MORE	32	14.0
	TOTAL	228	100.0
CONCERN OF PEOPLE SHOW IN WHAT YOU ARE DOING	NO CONCERN OR INTEREST	17	7.5
	LITTLE CONCERN OR INTEREST	27	11.8
	UNCERTAIN	55	24.1
	SOME CONCERN OR INTEREST	49	21.5
	A LOT OF CONCERN OR INTEREST	80	35.1
	TOTAL	228	100.0

Value	Category	Frequency	Per cent
EASE OF PRACTICAL HELP FROM NEIGHBOURS	VERY DIFFICULT	11	4.8
	DIFFICULT	34	14.9
	POSSIBLE	51	22.4
	EASY	82	36.0
	VERY EASY	50	21.9
	TOTAL	228	100.0
YEARS OF EDUCATION	NON-EDUCATED	47	20.6
	1-4	78	34.2
	5-8	51	22.4
	9-10	21	9.2
	10++	17	7.5
	11-12	8	3.5
	12+	6	2.6
	TOTAL	228	100.0
MARITAL STATUS	SINGLE	77	33.8
	MARRIED	136	59.6
	CO-HABITING	10	4.4
	DIVORCE	4	1.8
	WIDOWED	1	0.4
	TOTAL	228	100.0
ETHNICITY	OROMO	147	64.5
	AMARA	26	11.4
	TIGRAY	2	0.9
	SNNPR	49	21.5
	OTHER	4	1.8
	TOTAL	228	100.0
RELIGION	ORTHODOX	106	46.5
	MUSLIM	67	29.4
	PROTESTANT	53	23.2
	CATHOLIC	2	0.9
	TOTAL	228	100.0
AGE GROUP	18- 23	67	29.4
	24-30	129	56.6
	31+++	32	14.0
	TOTAL	228	100.0
NUMBER OF ADULTS IN HH	ADULTS 1-2 LIVE HH	193	84.6
	ADULTS 3-4 LIVE HH	33	14.5
	ADULTS 5 +++ HH	2	.9
	TOTAL	228	100.0
NUMBER OF CHILDREN IN HH	1-2 CHILDREN IN HH	191	83.8
	3-4 CHILDREN IN HH	34	14.9

Value	Category	Frequency	Per cent
	5 ++ CHILDREN IN HH	3	1.3
	TOTAL	228	100.0
EMPLOYMENT STATUS OF THE BREADWINNER	UN EMPLOYED	74	32.5
	EMPLOYED	154	67.5
	TOTAL	228	100.0
HELPED YOU OR TAUGHT YOU ABOUT MENTAL HEALTH	NO	218	95.6
	YES	10	4.4
	TOTAL	228	100.0
WHERE TO GO IF YOU FEEL DISTRESSED OR FEELING BAD	NO	218	95.6
	YES	10	4.4
	TOTAL	228	100.0
WHERE ARE YOU PREFERRING TO GO GET RID OF MENTAL PROBLEM	DON`T KNOW	218	95.6
	RELIGIOUS LEADER/ MUSLIM/CHRISTIAN	1	0.4
	HEALTH CENTRE/ HOSPITAL/PHARMACY	9	3.9
	TOTAL	228	100.0
SEVERITY OF ANXIETY	NOT- ANXIOUS	179	78.5
	MILD ANXIETY	39	17.1
	MODERATE ANXIETY	10	4.4
	TOTAL	228	100.0
SEVERITY OF DEPRESSION	NOT DEPRESSED	200	87.7
	DEPRESSED	28	12.3
	TOTAL	228	100.0
PREVALENCE OF DEPRESSION	NOT DEPRESSED	200	87.7
	DEPRESSED	28	12.3
	TOTAL	228	100.0
PREVALENCE OF ANXIETY	NOT ANXIETY	165	72.4
	ANXIETY	63	27.6
	TOTAL	228	100.0
EMPLOYMENT STATUS OF THE MOTHER	UN EMPLOYED	139	61.0
	EMPLOYED	89	39.0
	TOTAL	228	100.0
AGE CATEGORY	YOUNGER	123	53.9
	OLDER	105	46.1
	TOTAL	228	100.0
LIVING STATUS	LIVING ALONE	90	39.5
	LIVING TOGETHER	138	60.5
	TOTAL	228	100.0
ABLE TO READ AND WRITE	NO	136	59.6
	YES	92	40.4
	TOTAL	228	100.0
LIVING PLACE	RURAL	56	24.6

Value	Category	Frequency	Per cent
	URBAN	172	75.4
	TOTAL	228	100.0
PMTCT CLIENT	NO	135	59.2
	YES	93	40.8
	TOTAL	228	100.0
ALCOHOL USE	NONE HAZARDOUS USE	128	56.1
	HAZARDOUS USE	100	43.9
	TOTAL	228	100.0
KHAT USE	NOT USES KHAT	132	57.9
	KHAT USE	96	42.1
	TOTAL	228	100.0
SOCIAL SUPPORT STATUS	POOR SOCIAL SUPPORT	120	52.6
	GOOD SOCIAL SUPPORT	108	47.4
	TOTAL	228	100.0
HIERARCHICAL LIVING STANDARD SCALE	LOWER	128	56.1
	GREATER	100	43.9
	TOTAL	228	100.0
PREVALENCE OF COMMON MENTAL DISORDER	NOT CMD	103	45.2
	CMD	125	54.8
	TOTAL	228	100.0

4.6 SUMMARY

CHAPTER 5: PRESENTATION OF QUALITATIVE FINDINGS AND LITERATURE CONTROL

5.1 INTRODUCTION

The preceding chapter provided the quantitative research findings in a logical sequence based on the methodology of the investigation. The researcher describes the key findings of the qualitative investigation and the literature control in Chapter 3 and also on page 128 in the summary of this chapter. A review of the literature was done to validate or refute the conclusions of this study. The findings will be presented in line with the study's goal. To support the finding, the researcher included extracts from the participant descriptions.

The participants are said to have used identical wording and phrases, although minor grammatical changes were made to retain the logic and clarity of the words.

5.2 SUMMARY OF DATA COLLECTION AND ANALYSIS METHODS

5.2.1 Sampling

Phenomenological researchers seek to examine a wide range of human experiences and, as a result, look for persons who have a similar experience despite demographic or other differences (Etikan 2016:73). The researcher employed purposive sampling to choose individuals in this study.

5.2.2 Data collection

The researcher used phenomenological research interviews to acquire as accurate a description of the interactions encountered by the participants as feasible. The researcher did not direct the interviewees to say anything specific to prevent biasing the results. Instead, the researcher asked them to describe their daily lives (Bevan 2014:46).

Data collection was done in the community's natural setting, while others were in their various workplaces. Data was collected there, whilst confidentiality and privacy were maintained at all times. All participants obtained a summary of what the study entails and

signed an informed consent document before the data was collected. Data was collected for 2 weeks in June 2019. The duration of interviews was 30-40 minutes using semi-structured individual interviews, and data were collected until it reached saturation.

The researcher adhered to the procedures described in the research proposal on conducting individual semi-structured and in-depth interviews. The researcher kept in mind the following principles for individual interviews:

- Start with broad questions to specific ones.
- Not to ask double-barrelled questions.
- Refrain from asking leading questions but probe participants where necessary.
- Listen attentively to clarify concepts and ask follow-up questions.

5.2.3 Data analysis

After permission was granted in writing by the participants, all interviews were audiotaped. Verbatim transcriptions were done, and phenomenological data analysis was conducted using Colaizzi's steps (Wirihana, Welch, & Mental 2018:643-644). This method has been discussed in detail in Chapter 3 and summarised on the 7th page of this chapter. The data was also independently analysed by an independent coder, after which the researcher and the independent coder agreed on the themes and sub-themes discussed in this chapter.

The qualitative data analysis process has been ongoing since the time of data collection. Transcribed records of interviews and field notes were utilized for interpretation. The transcripts were kept in a specific place inaccessible text format, before the data was explored inductively using content analysis to create categories and explanations. Atlas ti7 software packaging assisted the researcher with coding and systematic analysis. ''A good thematic code captures the qualitative richness of the phenomenon. It is usable in the analysis, the interpretation, and the presentation of research" (Boyatzis 1998:97).

The coding scheme was well-refined to fit the design. The researcher completed all of the steps required for effective qualitative data analysis, including identifying biases/noting overall impressions, reducing and coding data themes into themes, finding patterns and

interconnections, mapping and building themes, developing and testing theories, and concluding.

5.3 RESEARCH FINDINGS

The research results will be presented in two sections as follows:

- Section 1: Characteristics of participants will be discussed as 5.4 bellows)
- Section 2: Thematic findings (will be discussed as 5.5 below)

5.4 CHARACTERISTICS OF PARTICIPANTS

The participants were described according to the following variables: age, marital status, the highest level of education, employment status, pregnancy status, and role description in the community participation.

A total of seven (7) Individual semi-structured interviews were conducted. Among them, four (4) pregnant mothers, one (1) Health extension worker, one (1) women health development army, and one (1) elderly were enrolled to participate in this study. As indicated in Table 5.1, married 3 and 3 were single and 1 divorced; All 7 were able to read and write 6 are employed or self-employed. Their age ranged from 21 to 63. They lived and worked for more than 5 years in the study area.

Table 5.1: Participants' demographic profile

Participant codes	Gender	Age	Marital status	Living in the area	Educational status
ID1/2019	Female	43	Divorced	6	Secondary
ID2/2019	Female	29	Married	8	Tertiary
ID3/2019	Female	23	Married	5	Secondary
ID4/2019	Female	20	Single	23	Primary
ID5/2019	Female	31	Single	11	Primary
ID6/2019	Female	41	Married	16	Secondary

5.5 THEMATIC FINDINGS

5.5.1 Data analysis steps

Data were analysed using Colaizzi's steps as indicated below:

Table 5.2: Collaizzi's steps of data analysis

Step	Description
Familiarisation	The researcher familiarised herself with the data by reading all the participant accounts several times. This was done after all the interviews had been conducted and all the data had been collected.
Identifying significant statements	The researcher identified all statements in the accounts that were of direct relevance to the phenomenon under investigation. This was done by listening to the interviews, re-reading the transcriptions, and picking up important statements which related most to the study.
Formulating meanings	The researcher identified meanings relevant to the phenomenon that arose from a careful consideration of the significant statements.
Clustering themes	The researcher grouped the identified meanings into themes that were common across all accounts.
Developing an exhaustive description	The researcher wrote a full and inclusive description of the phenomenon, incorporating all the themes produced during step 4. Similar information was grouped as described concerning how it related to the phenomenon.
Producing the fundamental structure	The researcher cut down the described data to a short, closely compacted statement that captured just those aspects which were essential to the structure of the phenomenon.
Seeking verification of the fundamental structure	The researcher would have returned the fundamental structure statement to all participants to ask whether it captured their experience. However, this was not possible because the participants resided in different locations, and it was not known when they would come back to the hospital again.

(Adapted from Morrow 2015:643-644)

5.5.2 Themes and sub-themes

The identified themes and sub-themes are summarised in the table below:

Table 5.3: Themes and sub-themes

Themes	Sub-themes
Experience of symptoms associated with a state of unhappiness (CMD)	• Feeling sadness and irritability • Excessive worriedness • Attempting suicide • Poor impulse control • Feeling guilty because of unintended pregnancy • Predisposition to substance misuse • Historical trauma
Individual risk factors	• Negative self-image; self-regulation and control; social competence • Prenatal exposure to alcohol • Preferred other healers than going to the health facility • Perceive that if their friends, neighbours, siblings, and other families know their status, they'll be discriminated against, creating discomfort in being seen at a psychiatric hospital • Low awareness about maternal common mental disorders • Occurrence of maternal common mental disorders
Family-related risk factors	• Parental permissiveness • Peer acceptance of heavy drinking • No supportive relatives and experiencing an unintended pregnancy • Inadequate attention • Experiencing the loss of a trusted provider • Poor parental involvement
Social-related risk factors	• Availability of substances • Law enforcement permissive of underage substance use • Empathy discomfort in health institutions • Empathy is seen in other healers • Poor parental involvement • Poor neighbourhood safety • Laws are favourable to substance use • A low number of health professionals at HP, HC to mental health care • No service provision for common mental disorders • Observe that clients prefer not to be referred to other departments for mental health care; use the service hiding their status at the same department/ANC
Protective factors	• Positive self-image; self-regulation and control; social competence • Awareness about maternal common mental disorders • Early identification and referral of mothers suspected of CMD • Peer disapproval of substance use • Low peer substance use • Positive parental involvement

5.5.3 Synthesis and summary of themes

The altered meaning units were then analysed for themes and key aspects before being combined into a narrative experience framework. Essence was born through an examination of the topic content of the participants' testimonials. Table 5.3 summarises

the essence and associated themes that were determined following consensus discussions with an independent coder who is an expert in qualitative methods.

Themes

Finally, five themes were identified, namely symptoms associated with a state of unhappiness (CMD); individual risk and protective factors; relationship-related risk and protective factors; social-related factors risk and protective factors.

Theme 1: Experience of symptoms associated with a state of unhappiness (CMD)

A feeling of sadness and irritability

As indicated in Table 5.3, the first theme: Sadness and irritability, of the common depressive and excessive anxiety symptoms, were identified and categorized under the main category experience of symptoms associated with a state of unhappiness (CMD).

The majority of the remarks made by some of the participants and based on their personal experiences showed symptoms linked with a state of sadness (CMD) before birth. However, not everyone identified it as an illness or believed they needed medical attention. These were women's remarks that attained a good degree of inside data saturation since they appeared quickly from the initial individual interview and were repeated in subsequent interviews, as indicated later. The remarks are examined in terms of the women's first-hand experiences to synthesize them.

ID2 “I didn’t get any bad feeling related to unhappiness. The topic is generally about a healthy person and; specifically, it refers to a healthy mind. A person who is mentally ill becomes mad and will leave the house and live in the street.”

This finding is supported by Tefera:

“… one of my friend's pregnant mother who commuted suicide and she has been in marital dispute and has low-income, her husband was not properly managed what she and her kid required for daily life, besides, her pregnancy was unintended … ehee.”

The participant has sadly continued her idea,

ID1 “… she was sleeping all day, crying, complaining, she is not going to neighbours while she called for coffee, which is our culture, everybody, doing even though, she did so before she changed her behavior.”

ID2 “… thank God am happy with my life.”

As the participants started powerfully, rendering it invisible,

ID3 “it is something that you have to get on with ... I can’t fall to sleep after midnight, I can’t eat food properly, I am crying alone, wishing to die, feeling ashamed, and unconsented to do things at home. I became irritable and couldn’t control my anger when I learned that I am infected with HIV, how can I disclose my problem to somebody?”

ID4 “I didn’t have any fillings during my previous and current pregnancy, … We are observed about only on friend among 10 about mothers. If you’re among the 1 in 10 or even more pregnant women who struggle with the symptoms of unhappiness, then you might not be feeling overjoyed at all. While you may be happy to be pregnant, this may be overshadowed by cloudy feelings.”

Interestingly, she welcomed the idea of, an individual interview that allowed her, to express her internal emotional struggles and feelings with concern about mental health.

ID5 “Unfortunately I am pregnant women and HEW, working in another next village, while I am pregnant for the first time, I got miscarriage on 21st week ok gestation. It was unexpected, it can happen to me. I couldn’t manage my sadness at that time. When I learned that my current pregnancy, about 13th week I started feeling Sadness and irritability, failed to pleasure and has no satisfaction on my job, easily tired, I hate mixing with friends and hesitated to communicate with clients and supervisor, become careless and preferred staying at home, worrying like something bad happen on my pregnancy and me."

On a work-related activity, we encounter several mothers who are unhappy, and we try to connect them with a primary health unit, but there is no one available.

ID6 "Pointed that many … Most women are wary of the stigma involved in admitting they have a problem. furthermore, they are also fearful of what admitting to a mental disorder

will mean for their children. For example, I also fear that if I am not seen as a good mother, the husband`s parents will take my children away."

ID7 "I didn't know how common this symptom is and when coming to us."

As indicated, essences one: excessive worry, predisposition to substance misuse, prenatal exposure to alcohol, historical trauma, and poor impulse control of the common anxiety symptom was identified and categorized under the main category experience of symptoms associated with a state of unhappiness (CMD).

However, their narratives showed features such as distressed states manifested by sadness, irritability, anger, and unhappiness, all of which characterize the medical concept of antenatal depression and anxiety (CMD). So, certainly, the narrative of those states was comparable to the criteria for a diagnosis of per-natal common mental disorder, but, as seen, these become invisible because they are not identified as mental disorders as such (Mucci, Galderisi, Green, Nuechterlein, Rucci, et al. 2018:13).

Theme 2: Individual risk factors

Even though maternal CMDs are widespread in the population, PHC does not provide services such as early detection and referral of women who are suspected of having CMD. As previously said, a lack of knowledge about maternal CMDs can make it difficult for families to recognise the signs and symptoms of the disease. This can make them unsure about when and how to seek help.

IDI1 "My Husband who was abusive to me and my children, we couldn`t live together and ended up in divorces. I was about to go mad at that time I was living with him. The he showed me was intolerable. He abusing substances, he should have to diagnosis mentally ill."

IDI2 “Everybody thought that she got evil sprite but as I am now understanding.”

ID3 “Actually, I used to drink locally made alcohol before I get into pregnancy, then I started feeling guilty by my unintended pregnancy horribly, after that I was consuming increasingly day by day because I want to hide the bad fillings backfire I had been challenged, that was, I abused and get pregnant unwantedly.”

ID5 “I couldn’t believe mental disorder close to us such, and pretending that … because I am health professional, how I simply get into this illness ... Preferred other healers than to go health facility … I stated follow up then getting back to my previous mined slowly and I started work.”

Theme 3: Relationship-related risk factors

The participants share their experiences related to risk factors, their preference, their experience in case of mental health problems, and the outcome of treatment approaches. Includes family members, friends, teachers, and other close relationships in an individual's closest social circle, which adds to their breadth of experience and may influence their behaviour. This may explain why pregnant women may have mental health problems due to perceived support from their families (husband and mother-in-law, friends, sisters and brothers, community and health services (lack of knowledge and health visitors).

ID4 "… I will be a new mother. My intimate friends, my husband, my mother, and my neighbours supporting me in any way that I asked."

ID5 “My husband was so stressed, consulted with my supervisors and they advised him to assist me to go Addis and see psychiatrist … assigned the health post nearest village to my home.”

ID6 "Participants "my first conception was one year after I married. I feel so happy become I became pregnant. However, my happiness went away, by the arrival of my mother-in-law, who did not help me at all but rather caused them distress. The absence of babies causes unfulfilled expectations in both families, the woman is seen as unfamiliar, and the longer she remains without a child the more sadness she experiences. She receives unfriendly comments from her mother-in-law and other members of her husband's family, and not even the husband will intervene in this matter."

ID7 “… mother-in-law as one of the sources of unhappiness in the dynamics of the household once the baby has arrived. Once a woman gets married, it is expected that, in the next few months, she will become pregnant.”

Family members include spouses or partners of either gender, grandparents, and other extended family members. Husbands or spouses may or may not be the biological fathers of children in the family, they may stay with mothers or not, and they may engage in childcare to varying degrees. One divorced mother reported having legal custody of her children from their former husbands. Men may become involved as stepparents in families. Women may depend on their partners for day-to-day resources and support in maintaining relationships with children, such as transportation to visits when children are living with foster parents or other family members.

The study included parental tolerance, peer acceptance of heavy drinking, poor neighbourhood safety, divorce, no supportive relatives, and experiencing an unintended pregnancy. Adequate attention to experiencing the loss of a trusted provider is the risk for relationship-related factors. Limited availability of substances, positive parental involvement, peer disapproval of substance use, low peer substance use, and law enforcement permissive of underage substance use were protective factors. The study understands the complexity of family relationships and support for mothers. Findings may be useful for services when considering family involvement, for how to better meet the needs of mothers in preventing CMDs, or for the curative contribution of relationship to mothers who suffer from CMD and support their recovery.

Theme 4: Social related risks factors

Participants were asked in the research setting to describe personal experiences of mental health care or mental disorder prevention service they received at the community level.

ID1 “… the month earlier she passed away, she has been followed at holly water …”

“Head women health development army get awareness in all health service activities once or twice annually or biannually which mental health part overlooked but we are evidence most of the mothers experienced depression.”

ID2 “… but I didn’t hear that she went to the doctor.”

P6 stated that "... stigma prevent me from acknowledging and talking about what I was experiencing. It also prevented me from asking for help … I am poor if my friends ignored and isolated me how can I leave …"

ID7 "Nobody discussed it with me about it. So that I have no information about the real symptoms and where to get help when I feel."

"I and most of my friends who suffer from mental distress, we preferred to be healed through pray, holly water, exorcism. What we are doing is, we convey ourselves to God and we did what our religion allows, most of the time we become successful but not always. The religious fathers will pray to God to help them to differentiate the problem, whether it comes from bad spirits or natural illness-related problems. If they believe the problem is biological, they advised us to go to doctors, but the religious organization has no relation with doctors and they are not followed don t know our status, whether we consulted health professionals or not.

The idea revealed by the women health development army (WHAD) mentioned,

ID1 “some pregnant women are reluctant to take medications because they fear that the side effects will impair their parenting and become dependent on medication for life. So that they are not willing to go to health institutions. Rather they went to church to prayers, holy water, and Muslim healers according to their religious status …”

She continued,

ID1 "We have a conference for pregnant women" but the schedule is not always respected. At that conference, health professionals supporting health posts and health centers will come to give awareness to the community related to pregnancy and childbirth. Nevertheless, maternal CMDs topic was included.:

Another participant mentioned that,

ID5 “lack of access to treatment in women living with maternal CMDs is a significant barrier to seeking help and may hinge, cost and affordability of treatment, lack of health insurance or inadequate coverage for mental health services, availability of transportation, availability of appropriate treatment, including culturally and linguistically

competent treatment for diverse families and availability of community-level quality treatment and follow up.”

ID5 “It is, of course, our work is very hard, we are walking on foot more than 12 km per day, village to village, house to house, up and down on hilling all summer and winter time in our catchment. Ideally, we expected 500 per household per catchment but we working more than 700 households per 2 HEW, surprisingly while we walking on foot, we carry vaccine carriers, registration books, cards, some medical equipment’s helped us to check ANC at home, nutrition-related materials …, so that I could have to expect my abortion. we might also didn’t give more attention and time to mothers because of the challenges of workload.”

"... when I was distressed and unhappy while I was pregnant the first time, I went to the traditional healer found in our community. The main reason I went to him was, he approaches me and know our cultural ethics, which is dropped by the health professionals found in the health facility. The health professional concentrated only on my biological illness and medication, but the traditional healer was feeling sad for my suffering. He understands my situation; he respects me because I am a pregnant woman. I didn't have money when I went to him but he told me that I can bring it whenever I got it. The money he asked me for was also very cheap. He advises me to drink holy water every morning, to pray, to get rest on regular basis, and to make busy myself with household chores in the daytime. I got the holy water from church and he visited me at home after one week. Then, after two weeks followed his advice I got relief and become happy. I paid his money and even I presented him with an additional gift."

Further descriptions of the women's experiences related to their emotional feelings when facing a lack of social support. They perceived themselves as drained, which made them feel emotionally down. Additional units of meaning here included,

“caring for my baby alone, cooking for the family, worrying about my finances, and looking after the house.”

Lack of awareness in community members, such as family, friends, neighbours, we (health care providers), social services agencies, schoolteachers, or childcare providers,

can also play a role in whether or not a family gets help. The major task of us as urban health extension workers (UHEWs) is preventing illness but mental health prevention services got low attention that's why we are not doing activities in this issue.

As the participant mentioned, barriers to treatment include lack of awareness, inaccessible treatment, and stigma are the main cases in that women did not come to health posts. These barriers can be overwhelming and make seeking help difficult or impossible for families living with maternal mental disorders.

In the study reported here, this fact was revalidated by the women who reported that there is no prevention service for mental illness around their village. Even though effective treatments for maternal CMDs exist at the health centre, mothers and their families are not getting the help they need. It is estimated that up to 42% percent of mothers that are from 7 mothers than 3 agreed most pregnant mothers with a common mental disorder are not receiving treatment.

Unlikely, as most of the participants narrated, counting on their own mothers' support seems to have helped most participants cope with the distress they faced during this perinatal period, although not in all cases, as a few never had the opportunity for their mothers to be present. Thus, they visited churches and mosques and discussed their filling with their friends to get rid of maternal mental disorders during pregnancy.

Theme 5: Protecting factors

The presence or absence of protective and risk factors influences pregnant women's mental health. Identifying protective and risk factors in early female adolescents can aid in the development of preventative and intervention strategies. Protective and risk factors may influence the course they choose if mental health concerns are present.

ID4 "… my parents were following us, they were very strict and religious. When I was young, we were not allowed to drink alcohol and any other substances, and they were even not willing to have a boyfriend before marriage. They want their children to stick to our religious organization. So … I am proud of what I am now and have the happiest life because I am expecting a child."

The presence or absence of protective factors has an impact on mental health. It was found that protective factors (such as support from parents, strict parents, or parents who had strong religious beliefs) the participants were likely to be protected from CMDs when they fell pregnant later in life.

Positive self-image, self-regulation and control, social competence, awareness about maternal CMDs, early identification and referral of mothers suspected of CMD, peer disapproval of substance use, low peer substance use, positive parental involvement, and social support and inclusion, strong cultural identity, and pride, personal attributes, including the ability to cope with stress, face adversity, and problem-solving skills were found to be the most protective factors against maternal CMDs.

Field notes

Field notes are a type of qualitative research method that is commonly employed in ethnography. Field notes are written observations made during or shortly after participant observations in the field, and they are important for comprehending phenomena experienced in the field. Scratch notes, diaries, and notebooks are all popular examples of field notes. They are a type of data collection that may be used in conjunction with interviews and focus groups, or they can be used on their own as a text for analysis. A collection of papers reflecting a researcher's observed experience in a given place or area is known as field notes (Phillippi & Lauderdale 2018:67). Written notes, reports, and environmental resources, such as photos, films, and brochures, can all be utilized to assist the researcher to immerse themselves in the environment under observation. The manner the researcher takes notes during observational research is mostly a personal choice that develops over time as the researcher gets more fieldwork experience. Field notes, on the other hand, are usually divided into two sections. Descriptive data, in which the researcher strives to correctly capture factual facts [e.g., date and time] as well as the surroundings, activities, behaviours, and conversations you witness; during the reflective information, the researcher should keep a diary of your thoughts, ideas, questions, and worries.

Observational notes

The method of observing or taking notes is usually done by descriptive writing, although it may also include sketching and diagramming. The trick to taking observational notes is for the researcher to remain invisible, unseen by the group being observed. If the researcher remains unnoticed, then it is much more probable that the group being observed would act in a normal manner (Katz 2015:76).

Theoretical notes

Theoretical notes (or analytical notes) document a researcher's thoughts about how to make sense of what is going on (Polit & Beck 2017:522). These notes serve as a starting point for subsequent analysis.

Agreed that all available information mostly on the subject in question, should be needed for analysis of the experimental results; a priori likelihood is a kind of summary statement of much of this knowledge (Hainsworth & Wolf 1975:45).

Methodological notes

Methodological notes are reflections on observational strategies. These can provide instructions or reminders about how subsequent observations will be made (Nelson et al. 2020:234).

These notes detail the researcher's study techniques, as well as any new research methods presented and how to track their development. Methodological notes were kept with field notes in this investigation and finally made their way into the final report.

Personal notes

Personal notes are comments about the researcher's feelings in the field. Field experiences give rise to personal emotions and challenge researchers' assumptions. Personal notes can also contain reflections relating to ethical dilemmas (Vaughn 2015:543).

The interviews that were conducted in the PHC setting had time restrictions. Interviews were conducted between 08:00 am to 5:00 pm, but some mothers need to interview in the natural setting of their village.

Pregnancy and delivery are typically followed by grief, worry, anxiety, and trouble-making decisions for many moms. Many women struggle to find the energy to look after themselves, their children, and their families. Some people even consider hurting themselves or their children. These might be signs of depression.

The prenatal mother was interviewed by the researcher at the exit of the ANC clinic; thus, the health professionals providing ANC did not ask or recognize the mother had a problem with CMD or any mental health problem, but the researcher recognized one ANC mother had some symptoms of CMD and advised her to seek mental health care. Because of the overlap of the sickness of thoughts with perinatal depression, cultural adaptation of existing screening measures for major depressive episodes seems a feasible next step. During normal prenatal care, healthcare providers were not considered to address these risk factors. Additionally, including early screening, diagnosis, and treatment of prenatal depression into regular antenatal care is necessary to enhance pregnant women's quality of life and pregnancy outcomes.

5.6 SUMMARY

This chapter gave a detailed summary of the occurrence of depression and anxiety in pregnant women. The chapter also discusses community-level risk or protective factors for maternal CMDs, as well as the findings, personal experiences, and outcomes of community-based approaches for the prevention of maternal CMDs.

The findings also revealed that pre-natal women had reported substantially older women, HIV-positive pregnant women, and women who drink alcohol are at risk of CMDs, whereas excellent social support has been safeguarded.

The next chapter will discuss the integration of the first two phases.

CHAPTER 6: MIXED METHOD INTEGRATION

6.1 INTRODUCTION

The study's qualitative findings were explored, evaluated, and reported in the preceding chapter following the design and methodology.

In this chapter, the integration of phase 1 and phase 2 of the study is articulated before strategies for community-based prevention of maternal CMDs in urban Oromia are proposed.

Mixed methods originated in the social sciences and have lately expanded to nursing, family medicine, social work, mental health, pharmacy, allied health, and other fields. Over the previous decade, these techniques have been created and enhanced to address a wide range of research questions (Creswell & Plano-Clark 2011:127).

This methodology's core concept is that such integration allows data to be used more completely and synergistically than separate quantitative and qualitative data gathering and analysis do. Evaluation of maternal CMD is a good opportunity for mixed-method research to contribute to learning about the best experience of risk and protective factors for CMD, as well as mothers' experiences of how to approach to get rid of CMD. There are different levels of integration in a mixed-method study.

Advantages of a mixed-method study

Using the analysis of mixed methods has many benefits, which we will discuss below.

Compares both quantitative and qualitative figures

Mixed approaches are especially useful for explaining the inconsistencies between quantitative and qualitative results.

Reflects the experiences of the participants

Mixed approaches give the participants a voice to research and ensure that the study results are focused on participants' experiences.

Fosters student contact

Such studies add breadth to multidisciplinary team research by promoting interaction between quantitative, qualitative, and mixed methods scholars.

Provides versatility in methods

Mixed approaches are extremely versatile and can be adapted to multiple designs of the study, such as observational experiments and randomised trials, to elucidate more knowledge than can be gathered through quantitative research alone.

Gathers detailed, rich information

Mixed approaches often reflect how individuals naturally collect information by combining quantitative and qualitative data. Sports stories, for example, also combine quantitative data (scores or number of errors) with qualitative data (descriptions and highlight images) to provide a more complete story than either approach alone would (Hanson, Plano Clark, Petska, Cresswell & Creswell 2005:105).

6.2 LEVEL OF INTEGRATION IN MIXED-METHOD STUDY

6.2.1 Integrating at the design level

Mixed methods may be an appropriate technique for evaluating complex interventions such as modified SEM of Prevention of maternal CMDs. Researchers choose from five primary mixed-method designs based on the research questions they want to address and available resources for assessment (Ramlo 2016:618; Creswell & Plano-Clark 2011:134).

In this study, no integration took place at the design level.

6.2.2 Integration at the methods level

At the methodological level, four techniques are used. When linking, one database joins to another by sampling. When it comes to constructing, one database informs the approach to data collecting of the other. When two databases are merged, they are

brought together for analysis. Data gathering and analysis can be linked at numerous places via embedding (Mertens 2013:49).

On the methodological level, no integration occurred in this study.

6.2.3 Integration at the interpretation and reporting level

At the interpretation and reporting level, there are three ways to combine qualitative and quantitative data: (1) narrative integration, (2) data transformation integration, and (3) joint display integration. Several publishing techniques that utilise these ideas have been proposed (Fetters, Curry & Creswell 2013:2149).

The degree to which the qualitative and quantitative findings are in sync is referred to as the fit of integration. Understanding the concepts and practices of integration can assist healthcare researchers in using mixed-methods research's advantages.

Even though the stages of this study were carried out sequentially, data in phase one was gathered and evaluated statistically, while data in phase two was collected and examined qualitatively. The two data sets were then combined at the level of interpretation. This is seen in the figure below.

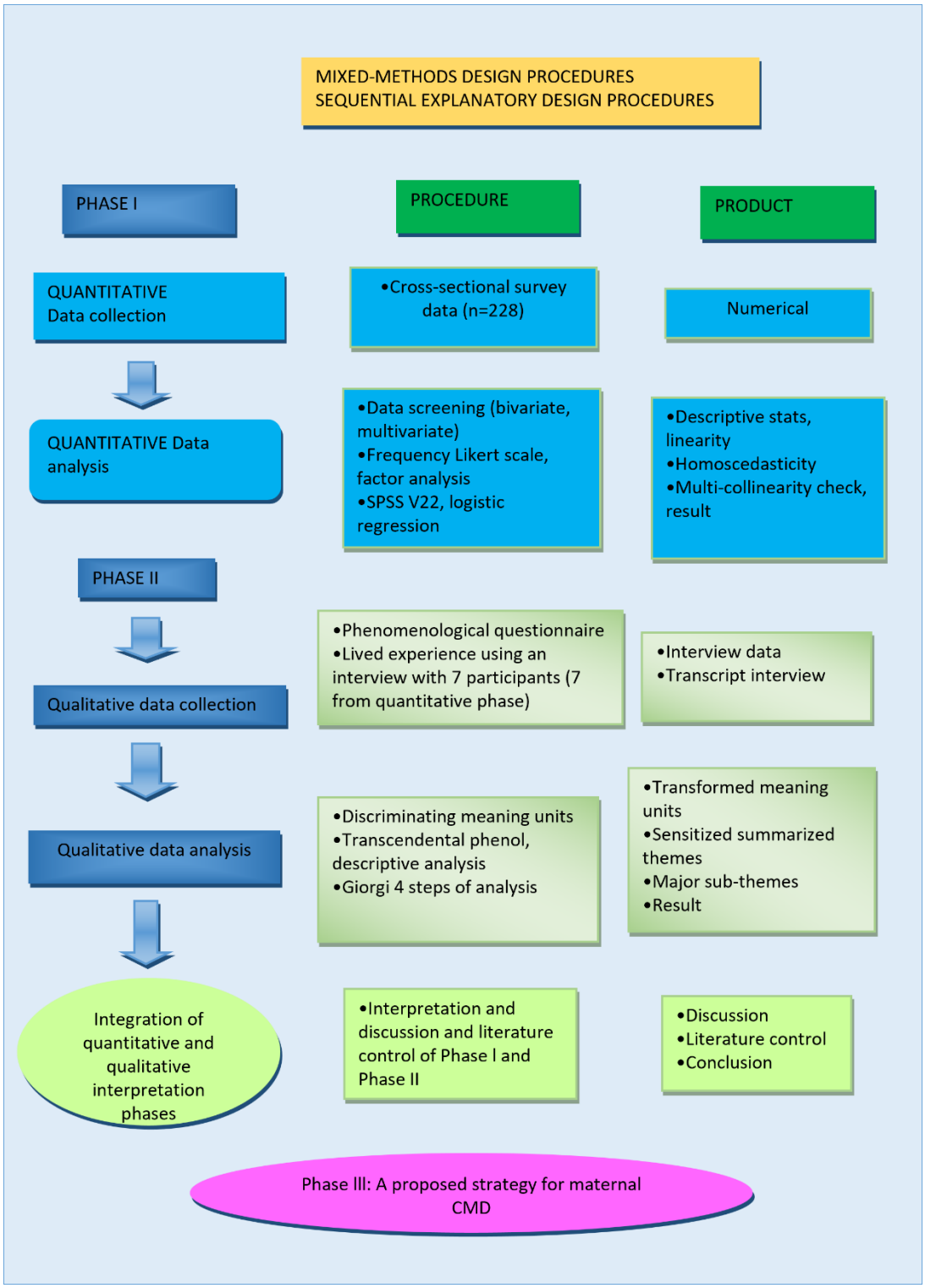

Figure 6.1: Visual model of mixed-methods design procedures

(Adapted from Creswell & Stick 2006:18)

6.3 DISCUSSION

6.3.1 Prevalence of depression

The patient health questionnaire-9 depression module (PHQ-9) is a widely used tool for screening depression in no psychiatric environments. The PHQ-9 can be graded using various methods, including an algorithm based on the Mental Disorders Diagnostic and Statistical Manual, Fourth Edition criteria, and a summed-item-based cut-off. The algorithm was the scoring tool originally proposed to test for depression. We summarised PHQ-9's diagnostic test accuracy using the algorithm scoring method through several validation studies, compared the PHQ-9 's diagnostic properties using the algorithm, and summed the scoring method at the suggested cut-off point of 10 (Rutter & Brown 2017:65).

Those anxiety symptoms assessed from the study were feeling uneasy, apprehensive, or on edge; not being able to stop or control worrying; worrying excessively about many things; being so restless that it is difficult to sit down; quickly getting angered or angry; feeling fearful that something terrible would happen.

Aside from measuring anxiety, it also measures the following symptoms: little interest or pleasure in doing things; feeling down, depressed, or hopeless; difficulty falling or staying asleep, or sleeping too much, feeling tired or having little energy; poor appetite or overeating, feeling bad about yourself or that you are a failure or have let yourself or your family down; difficulty concentrating on things, such as reading the newspaper or watching television; moving or speaking so slowly that the or the reverse, being so fidgety or restless that you have been moving about a lot more than usual, and; thoughts that you would be better off dead or hurting yourself in some manner, as detailed on our phase one results (Manea, Gilbody & McMillan 2015:264).

We used the quantitative finding to measure the prevalence of CMDs with screening tools PHQ 9 and GAD7 during the prenatal period. Our results demonstrated that the prevalence of CMD was 54.8%, our finding higher than most study results (Jenkins 2012; Uriyo et al. 2013:4; Usuda, Nishi, Makino, Tachimori, Matsuoka 2016:18) whereas compared with the study Khan were beyond comparable (Khan & Flora 2017:47). It is

important to note, that the present evidence relies on the difference of measuring tools, and depending on the study design, it might increase or decrease the prevalence. However, even better results are achieved when we see the components of CMD that anxiety and depression see separately account for 12.3% and anxiety 27.6 respectively.

A strong emerging theme was the image of a "state of unhappiness "where there might be elements of depression and anxiety. The category had a large number of sub-categories that together give a fuller picture of a depressed prenatal mother who can be categorised under CMDs.

Two more participants gave a colourful explanation of the maternal common mental disorder,

ID1 “She was sleeping all day, crying, complaining, she is not going to neighbours while she called for coffee, which is our culture, everybody, doing even though, she did so before she changed her behaviour.”

ID3 “I can’t fall to sleep after midnight, I can’t eat food properly, I am crying alone, wishing to die, feeling ashamed, and unconsented to do things at home. I became irritable and could not control my anger. Several studies in recent years have shown that people with depressive symptoms have similar symptoms.” (Donohue & Luby 2016:34; Wallace & Milev 2017:48; Otte 2016:23).

The result now provides evidence that CMDs often suffer from significant impairment of social and interpersonal functioning, including the capacity to work, relate to friends and family and even enjoy leisure time which is a DSM-5 criterion to make a diagnosis of depression (American Psychiatric Association 2013:5).

Both the quantitative and qualitative findings of this research suggest that CMDs are seen in pre-natal mothers. The present study also confirmed the findings of the prevalence of CMD. These results go beyond previous reports, showing between 12.8% (Fiala, Svancara, Klanova & Kasparek 2017:5; Women's and Health 2015:58).

This is not causal research since women who had little prenatal care were not investigated. There has been little study on the relationship between CMD, the desire for

prenatal care, and other healthy behaviours to date. Furthermore, other research has found that mild anxiety accounts for 17.1% per cent of the population, moderate anxiety accounts for 4.4 per cent, and the severity of depression accounts for 12.3 per cent of the population. Hence women, in particular, suffer from even higher rates of depression (on average) as well as suffer from greater impairment (Usuda et al. 2016:453).

6.3.2 Socio-ecological factors of maternal common mental disorders (CMDs)

Despite evidence of associations between our findings on socio-ecological risk and protective factors at least hint that risk increased with advanced age: low family income, living alone, hazardous use of alcohol, Khat use, older age, unemployed, being PMTCT mother, poor social support, lower hierarchical living standard scale, less number of children and adults living in the household.

Participants spoke of the importance of social matters such as financial support for families. One practitioner spoke of comparisons with the capital city, while others talked of matters related to local council social activities. Mothers spoke of the importance of financial help as a way of decreasing pre-natal CMD. This was also seen in our study's quantitative phase as more CMD women placed on the lower hierarchal living standard scale. The result of this analysis is then compared with the (Silva, Cerqueira & Lima 2014:45).

Our results demonstrated that some older women have a 7-fold greater chance of CMD than younger women, or those younger women are 7-fold safer from CMD than older women, achieving statistical significance. Our findings from previous age studies were inconsistent with older ages and were protected from CMD (Usuda et al. 2016:134; Bruce et al. 2012:47).

A similar pattern of results was obtained in phase one and two studies those women who have HIV/AIDS were 5 times risk of getting CMD than women who have no HIV/ADIS or those women who have no HIV/ ADIS 5 times more protected from CMD than those who have HIV/ ADIS. This does seem to depend on (Villar-Loubet, Illa, Echenique, Cook, Messick et al. 2014:345; Baral, Logie, Grosso, Wirtz & Beyrer 2013:68).

Those women who drink alcohol in a hazardous way have a 14 times risk of getting CMD than those who do not drink alcohol in a hazardous way, or those who do not drink alcohol in a hazardous way are 14 times more protected from CMD than those who drink alcohol in a hazardous way. The implications of these findings are discussed in phase two, where one participant reported that when a pregnant woman is depressed, the more alcohol she consumes and the more she drinks, the worse her CMD becomes. In this regard, the parents' role was very important to raise kids in an alcohol-free environment and to link children with phase organisation, and strong relation led the young women protected to be addicted to alcohol was reported in the qualitative finding of our study. It is worth discussing these interesting facts revealed by the results of (Carod-Artal 2017:145; Fekadu et al. 2014:19). Substance use disorder in DSM-5 combines the DSM-IV categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Each specific substance (other than caffeine, which cannot be diagnosed as a substance use disorder) is addressed as a separate use disorder (alcohol use disorder, stimulant use disorder), but nearly all substances are diagnosed based on the same overarching criteria.

In this study, overarching disorder criteria were measured by the fast alcohol screening test (FAST) for alcohol and CIDI SAM screening questions for the substance "Khat". In the study, Khat was one of the risk factors affecting the general population by CMDs (Mekuriaw, Segeye, Molla & Kabthymer 2020:5).

In contrast to Khat's findings, we did not detect a significant relationship between "usage of khat" and our multivariate analysis. However, it was subjectively responded in the qualitative phase that Khat use might influence maternal CMDs or that they use it to relieve distress. It is a possible danger for pregnancy, according to the research. Nevertheless, in the study area, the role of socio-demographic and cultural factors on Khat use during pregnancy is discouraged. However, other studies have a similarly low number of Khat users of pregnant mothers found in our study (Nakajima, Jebena, Taha, Tesfaye, Gudina, Lemieux, Hoffman & Al'Absi 2017:134).

The mothers were clear that income support, community-based safety net programmes for pregnant mothers, the ANC care supported with a home visit, HEW phone calls, and

mothers' groups all contributed to supporting them when they needed any support. Women reported no evidence that any pregnant women were supported at PHCW related to mental health or CMD, while some women were found to suffer from CMD. This analysis found evidence that the odds of contracting CMD are 69 per cent less among those with Good Social support than those with poor social support. The phase two study drew a link with a lack of social cohesion and noted that some local government councils were investing in community work while others were not. The findings are directly in line with previous studies (Laland & Rendell 2019:68; Das-Munsh, Lund, Mathews, Clark, Rothon & Stansfeld 2016:93; Santos, Amorim, Santos & Barreto 2015:8).

This was surprising considering that mothers-in-law is both supportive of CMD mothers. On the other hand, more prone study participants reported that their mother-in-law is the source of unhappiness for pregnant mothers. These results show that husbands, intimate friends, HDA, and HEWs supported the phase two study. This highlights the important role that social policy plays in influencing the situation of mothers vulnerable to CMD.

We discovered that people with higher socioeconomic status have a 75 percent reduced risk of getting CMD than those with a lower socioeconomic position. A related concept was suggested on the qualitative finding that the community health insurance system (CHIS) was accessible to help mothers with various medical issues. Concerns were raised about the lack of mental health experts and mental health-related medicines in the PHC environment and the necessity for additional testing. One mother who works as a HEW in the village highlighted that there is a lack of government financial support to fulfil the requirement.

6.3.3 Availability of prevention strategy

In both processes, mothers reported that very limited invisible help women got mental health and psychosocial prevention activities in their locality. A further novel finding is that the pregnant mother chose to go to other healers than the health facility because empathy is used in other healers. Our findings showed that mothers do not know where to go while feeling depressed and are not aware of the mental health service given close to them. Some others indicated on the individual interview that they felt as if mental health services would only be offered in the capital Addis Ababa Amanuel Psychiatric Specialized

Hospital, while curative treatment would also be given in the health centre but on a scaled-up basis (FDREMOH 2011:57).

This indicates that mothers did not use the term "entry", which professionals commonly used. However, mothers often spoke of transport problems regarding isolation comments or not going to seek medical help early when filling up unhappiness and somewhere thought the filling was normal (Maritz 2010:56-68). Transport shortages are due to inadequate access to infrastructure and facilities. We identified service access as a significant emerging theme.

6.4 SUMMARY

The findings indicated that CMD components of maternal anxiety and depression and related socio-ecological risk factors in pre-natal periods were addressed. Maternal views were also explored, including the implications of community-based approaches to preventing certain maternal mental disorders. These findings led to the development of techniques for establishing viable community-level interventions to prevent maternal CMDS.

This chapter discussed the integration of phases one and two. The following chapter will begin with phase three, which offers proposed strategies for community-based prevention of maternal CMDs in urban Oromia, Ethiopia.

CHAPTER 7: DEVELOPMENT OF STRATEGY FOR PREVENTION OF COMMUNITY-BASED MATERNAL COMMON MENTAL DISORDERS, URBAN OROMIA, ETHIOPIA

7.1 INTRODUCTION

The study's first phase revealed the prevalence and severity of CMD among women throughout the perinatal period. It also describes the associations of predetermined risk or protective factors for maternal CMDs at the community level; in addition to the findings, personal experiences are explored, and the outcomes of approaches for community-based prevention of maternal CMDs are described in phase two.

The research included the first and second stages outlined in the prior chapter; data also demonstrated that pregnant women reported much reduced social support. This deficit significantly affects the intensity of depression and anxiety symptoms. The study also discussed and supported the need for a prevention strategy that might reduce the prevalence of mental health disorders during pregnancy.

The proposed strategies will be detailed in this chapter based on the findings of the first two empirical phases of the study. They also guide various levels and stages of targeted treatments to reduce risk or improve protective factors and resilience, particularly during critical developmental phases of pregnancy.

Developing prevention strategies in accessible community-based sites is a potentially important public health intervention. Therefore, the researcher used deductive reasoning to generate the proposed strategies based on the following:

- Findings of the study
- Literature reviewed
- Ethiopian Mental Health Association technical committee (EMHA) recommendations

7.2 DEVELOPMENT OF STRATEGIES

The following guiding concepts and core values were utilised to modify and execute the suggestions to offer a community-based preventive approach for maternal CMDs:

Guiding principles

- Cultural and linguistic competency
- Developmentally appropriate
- Evidence-based intervention
- Equitable and cost-effective care
- Quality
- Sustainability
- Serving vulnerable and at-risk populations
- Youth-guided and family-driven

Core values

- Altruism
- Empathy
- Integrity
- Honesty
- Truth-telling
- Transparency
- Showing respect for patients and families

The following efforts were done to develop community-based prevention strategies for maternal CMDs.

- Step 1: Strategy development process
- Step 2: Draft strategy development
- Step 3: Review and consensus-building
- Step 4: Finalising the strategy

7.3 STEP 1: STRATEGY DEVELOPMENT PROCESS

Concerns about the significant unmet demand for community-based prevention strategies for maternal CMDs prompted the development of the proposed strategy.

A deductive reasoning technique was used to produce recommendations for the results of the study's qualitative and quantitative phases, the literature review, and the mental health technical committee's (TC) recommendation for the draft strategy. The TCs assessed the strategy for conciseness, transparency, comprehensiveness, effectiveness, and applicability and included their comments in the final strategy.

7.4 STEP 2: DRAFT STRATEGY DEVELOPMENT

The draft strategy was based on the themes and categories indicated in step 1 and submitted to the technical committee of EMHA for additional review.

7.5 STEP 3: REVIEW AND CONSENSUS-BUILDING

The EMHA's Mental Health Committee has reviewed the proposed strategy.

Participants who tested the technique were picked deliberately. The evaluators comprised members of the EMHA technical committee (TC) formed by the Association for Ethiopian Mental Health, experts and MH advisors from developing partners, lecturers from universities, and working in curative and community settlement. The chosen participants were either approached face-to-face or by telephone, and the research goals were discussed.

After their agreement, they were provided with a hard copy of the proposed guidelines with the validation tool and a letter of the validation process.

The groups comment on various issues relating to MH and evaluate strategies, MH, ANC instructions, guidelines and related documents. Seven experts were involved in the review of the guidelines (five from TWGs and two from implementation city administrative). Some had been interested in revising the national guidelines and had expertise in designing guidelines. The group was asked to evaluate the guidelines based on clarity, exhaustiveness, applicability, flexibility/adaptability, credibility, and validity criteria.

Table 7.1 sets out the characteristics of the participants, including work positions, supervisors, organisation experience, and academic qualifications.

Table 7.1: Evaluation experts' attributes

Descriptor	Frequency
Position	
EMHA Technical Committee coordinator	1
Oromia region community Mental health focal person	1
Hawass University Psychiatry Department head	1
Jimma University psychiatry department Head	1
Amanuel Mental specialised hospital community mental health specialist	1
FMOH Health policy analyst	1
Oromia regional health bureau FH technical working group coordinator	1
Total	7
Employed by	
Ministry of Education	3
FOMO	2
Developing partner	1
Oromia Regional Health Bureau	1
Total	7
Expertise	
Public health	5
Guideline expert	1
Management/programme coordinator	3
Curriculum/methodology	1
Police analyst	1
Maternal health expert	1
Social science expert	1
Child and adolescent psychiatry expert	1
Academic	
Doctoral Degree	1
PhD Candidate	1
PhD Fellow	3
Master's Degree	3
Total	7

7.6 STEP 4: FINALISING THE STRATEGIES

Each domain has a unique set of methods. The activities mentioned are based on the recommendations for change provided during the phase review. The measures have been prioritised as helpful (standard priority), essential (medium priority), and critical (high priority).

These priority ratings will assist PHC and the community in the implementation of the plan and in ensuring its inclusion in the delivery plan.

A board responsible for implementation (Who) is also included as a link to other strategic plans and documents within the Council (Link).

The TCs supported the strategy but raised concerns regarding flexibility and adaptability in various settings. This may be avoided by keeping uniformity in the amenities and PHCU. The Ethiopian Standard Agency (ESA) has taken the initiative to enhance the quality and performance of each institution through a rigorous evaluation process in collaboration with the FMOH and Regional Health Bureau and this effort will assist in implementing the plan at each service delivery level.

Furthermore, the Ethiopian Food, Medicine, and Healthcare Administration and Control Authority (FMHACA) determined that human capital, physical facilities, and service standards are required for the operation of a health institution and license renewals. As a result, it may aid in resolving some of the issues involved with expanding the suggestions to other health facilities, such as health centres. Because the study focused on the district health office, it was assumed that the regional health office and PHCU administration would provide the money for extra human resources and MH intervention structure arrangement.

The strategy is accurate and credible. Table 7.2 summarises the findings of the strategy and its remarks.

Table 7.2: Results of the validated strategy

Criteria	Clarity	Comprehensive-ness	Applicability	Flexibility and adaptability	Credibility
Comments from technical Committees, including relevant experts	Unambiguous instruction wording The majority of recommendations are detailed but are also general Opinions that are reasonable and very clear Provider position well addressed	Important groups (women and young people) are well served, but there is still a lack of pregnancy status Implications of the resources should be well addressed Very well integrated It is practical	Provide relevant evidence for current health situations This is more applicable where the reference relation is high	Health centres can differentiate	Evidenced and can be practised The best scenario for PHC setting and valid
Not acceptable					
Acceptable with the recommended change			1		1
Acceptable as described	7	7	6	7	6

7.7 EVIDENCE SUPPORTING THE PROPOSED PREVENTION STRATEGY

The institution of medicine report has proposed a framework of mental health intervention for mental disorders based on the classification of prevention of physical illness and the classic public health distractions between primary, secondary, and tertiary preventions (Mrazek & Haggerty 1994). The WHO recommended mental health prevention rests under the primary prevention of public health classification and includes universal, selective, indicated preventive intervention.

Available treatment methods have shown little effect on the burden associated with maternal CMDs during pregnancy or shift expected trajectories to less debilitating outcomes during postnatal.

In this tradition of maternal common mental disorder, the cumulative lifetime effect of risk factors progressively increases vulnerability to maternal CMDs. Gaps between knowledge, risk factors, and practice need to be bridged. Future steps on the proposed strategy will be an emphasis on the improvement of primary prevention through mass and individual education, early detection, linking positives to treatment and linking treated to the community will be an important and cost-effective mechanism to get sustainable maternal mental health with essential support from society and policymakers.

7.8 COUNTRY PROFILE

This section highlights the country profile and the mental health professionals of Ethiopia where the study was conducted to propose a strategy for the community-based prevention of the maternal common mental disorder in urban Oromia Ethiopia.

Ethiopia is the oldest independent and second-most populous country in Africa. It has a unique cultural heritage with a diverse population mix of ethnicity and religion. It served as a symbol of African independence throughout the colonial period and was a founding member of the United Nations and the African base for many international organisations.

Geography and climate

Ethiopia is located in the North-Eastern part of Africa, also known as the Horn of Africa. It borders six countries - Eritrea, Djibouti, Somalia, Kenya, South Sudan, and Sudan. The country occupies an area of 1.1 million square kilometres ranging from 4,620 m above sea level at Ras Dashen Mountain to 148 m below sea level1 at the Danakil (Dallol) Depression. More than half of the country lies above 1,500 metres.

The predominant climate type is tropical monsoon, with a temperate climate on the plateau and hot in the lowlands. There are topographic-induced climatic variations broadly categorised into three: the “Kolla”, or hot lowlands up to approximately 1,500 meters above sea level, the “Wayna Degas”, which range 1,500-2,400 meters above sea level and the “Dega” or cool temperate highlands 2,400 metres above sea level.

Demographic profile

According to projections based on the 2007 population and housing census, the overall population in 2015 will be 90 million (CSA 2015). Ethiopia is home to about 80 different spoken languages, representing a diverse range of nations, cultures, and peoples. A household's average size is. The population's pyramidal age structure has remained mostly youthful, with 44.9 percent of the population under the age of 15 and over half (52 percent) of the population between the ages of 15 and 65. Only 3% of the overall population is above 65 years old. Although the male-female ratio is nearly equal, women of reproductive age account for 23.4 percent of the population. The fertility trend on average (Central Statistical Agency 2016:32).

Current role of different mental health professionals in Ethiopia for mental health prevention

Addis Ababa University also started a PhD programme in mental health epidemiology in 2011, and about 10 PhD graduates are available today and assigned to education institutions.

Postgraduate training for graduate health professionals is available in the country through a collaboration programme with Gondar University and Amanuel Mental Specialized Hospital, which then applies to Bahirdar University, the University of Gondar, and Jimma University, among others. This team of mental health professionals works across the Ethiopian health system, including virtually all of the country's universities, and is allocated to the health office, hospital, PHC facilities, research centres, administrative roles, and united nations and non-governmental organisations. Since the first graduates obtained their Masters of Science in Clinical and Community Mental Health (ICCMHs) in August 2011, it has been a watershed moment in the country's expansion of mental health care promotion, prevention, and research, in addition to curative services. They also serve as liaisons between community and clinical services. They maintain positive working relationships with clinicians, skilled medical assistants, clinical nurses, social workers, clinical psychologists, and all other health and non-health practitioners involved in the synergistic impact of achieving mental health. It is expected that these all-mental health practitioners' students, independent of clinical treatment, will play a particularly important role in developing mental health societal belief systems. They occupy a unique

position at the nexus of expert and lay knowledge, with belief systems that do not naturally correspond to conventional assumptions and objectives. Clinical science and policy efforts are interwoven into practitioners' daily practice, social experience, and community values.

This prospective first graduate has also formed the Ethiopian Mental health association to work for the right of mental health professional graduates and work with the government to share to fill the gap.

The Socio-Ecological model

The Socio-Ecological Model is a multi-level framework that allows us to comprehend the many settings in which risk and protective variables are present. The model also allows us to investigate how contexts interact and choose multi-level preventative strategies that will have the greatest effect.

About the model

The Socio-Ecological Model is founded on the concept that an individual does not live alone and that his or her behaviour is impacted by the surrounding environment, which is composed of several layers. The next level influences and is impacted by the preceding level. As multiple risk and protective variables function inside each level, this mutual relationship and complex interaction help us comprehend human development and behaviour. The four tiers are as follows:

Individual

Individual-specific characteristics such as age, education, income, health, and psychological disorders that may be related to drug use are included. For example, undergraduate students with inadequate self-regulation, a control issue, and mental instability are more prone to drink alcohol.

Relationship

Include family members, friends, teachers, and other close relationships in a person's closest social circle, which broadens their experience and may influence their behaviour.

Society

Large cultural impacts, such as social and cultural norms, are included. Health, economic, educational, and social policies that lead to economic and/or social inequities among people are also key variables functioning at this level. Furthermore, the places in which social interactions occur, such as schools, offices, and communities.

Risk and protective factors are influential overtime

Risk and protective variables can have a long-term impact on a person's life. Poverty and family dysfunction are risk factors. Risk and protective variables can also influence or be influenced by elements in a specific environment, such as the family. Successful parenting has been demonstrated to mitigate the effects of a variety of risk factors, including deprivation, divorce, parental bereavement, and parental sickness. The more a researcher knows about risk and protective factors, the better equipped they will be to develop appropriate processes and strategies.

Not all people or populations are at the same level of risk

When prevention tactics and activities are related to the amount of risk the target group faces, they are most effective. As Chapter 2 explains, prevention programs and activities fall into three basic groups.

Universal programmes and practices

They are meant to reach large groups or populations and take the widest approach. Preventive strategies and activities may target entire neighbourhoods, workplaces, or classrooms.

Programmes and procedures that are selective

Target people or groups who have more risk factors (and possibly less protective variables) than the general population, putting them at a higher risk of substance misuse.

Indicated programmes and practices

Individuals who exhibit early signs of drug usage but have not yet been diagnosed with a substance use disorder are targeted.

The researchers created a method for the prevention of common mental disorders based on the concept of public health. The 'Selective primary prevention' approach, which includes the socio-ecological model, targets all pregnant women and women in the reproductive age range.

7.9 APPLYING THE MODEL TO PREVENTION OF MATERNAL COMMON MENTAL DISORDERS (CMDs)

The Socio-Ecological Model emphasizes the significance of collaboration at all levels to address the multitude of issues that affect individuals and communities. In a society where parents see underage drinking as a rite of passage or where alcohol merchants are eager to sell it to young adults, a severe school regulation prohibiting alcohol use on school premises, for example, would likely have minimal impact.

The benefit of prevention of maternal common mental disorders in SEM

Highlighted, PHC is defined as 'essential health care' Made freely available by means appropriate individuals and families within society, made clear, PHC is defined as “essential health care” (WHO & UNICEF 2018:46) made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost the community and country can afford. This proposed strategy guides different approaches to therapy using the prevention of maternal common mental disorders at the community level.

Approaches of therapy

The paper explores possible suggested prevention strategies across the continuum of where people are as individuals, within their peer and family support, and at the societal levels, when they may be at risk for a prenatal common mental disorder.

A strategy for moving forward there is an agreement that decreasing lifestyle-related risk must address a complex and interconnected mix of etiological factors, from individual behaviours to cultural norms and policy environments (Cerulli, Winterfeld, Younger, &

Krueger 2019:38). To start designing systematic approaches to the treatment of specific mental disorders, policy options need to be linked with epidemiology and biological sciences. We would, therefore, argue that there is a continuing need to generate quality epidemiological evidence to address the shortcomings identified in the literature outlined in Chapter 2.

Because the maternal common mental disorder is so widespread that it affects millions of families in communities across the nation, it is important to interfere with a comprehensive approach to public health with the socio-ecological model. A public health strategy attempts to promote population health and well-being, prevent illness, and reduce disease impairment through coordinated efforts that reach and include all individuals affected by a given issue. Because maternal CMD impacts women, their children, their spouses, and other family members, community participation at all levels is crucial. Efforts should incorporate a public health strategy to combat CMDs among prenatal and postnatal mothers.

- Identify the CMDs of the mother.
- Early intervention and treatment links between mothers and their peers and families.
- Prevent mental health problems from occurring in female youth.

Early identification for mothers

Maternal CMD is being monitored. One strategy to guarantee an early diagnosis of difficulties is to monitor maternal CMD and CMD in the family on a daily basis. Screenings can be done in physicians' offices and clinics during routine check-ups, at parents' homes, and at community events and health fairs. Given the high prevalence of CMD among urban Oromian women, screenings at home, health posts, and health centre offices may be particularly effective. Wherever screenings occur, qualified practitioners must perform them (Self, WHDA, HEWs, nurses, social workers, health forces, clinicians) and use validated instruments.

Early identification and intervention are critical in assisting women in receiving adequate care, avoiding the debilitating consequences of CMDs, and ensuring that families receive the necessary aid, resources, and therapies. Sensitive societies should include a variety

of stakeholders in order for this to happen. Local organizations may play a key role in promoting community awareness of maternal CMDs, including the significance of early detection and intervention and where to seek support.

Early intervention and treatment

There is a range of successful popular motherly mental illness therapies, including conventional cognitive and behavioural therapy, medication, peer support, and social and client family support. A healthcare professional must test and assess her before any of these services are provided by a mum.

Interpersonal therapy (IPT)

Interpersonal therapy is an evidence-based approach that was initially developed for specific mental illnesses in adults. IPT focuses on CMD education, interpersonal aspects of a person's past that led to CMD, and ways of treating CMD symptoms established. IPT has been widely used for treating CMD and postpartum depression in adults and adolescents.

Peer support

Peer support is an evidence-based method built on the principle that someone who has had a mental health disorder may help others who have experienced the same disorder. Peer-led specialists can run support and skill-building groups, assist people in accessing the healthcare system, and provide counselling and other services. Participation in peer support groups has been linked to the following outcomes:

- A better understanding of mental health and the services available.
- A rise in the utilization of mental health services
- Better results for persons suffering from mental illnesses.

Peer support measures involving peer volunteers with a group of women experiencing postpartum depression were linked to a substantial reduction in CMD symptoms. According to research, peer-to-peer support groups have been shown to assist women with not just CMD but also other life issues.

Client family support groups

Parents with CMDs will be able to engage, learn, provide aid, and receive support in a secure and friendly setting. To successfully promote mental health and wellbeing, most customer family support group programs address developing an individual's mental health and welfare, enhancing the relationship between the client and all connections of relatives who have CMD moms.

Cognitive behaviour (CBT)

CBT therapy is a treatment that is frequently used to assist people in coping with their negative thoughts, feelings, and behaviours. CBT is one of the most effective therapies for CMD and is frequently used in conjunction with antidepressant medications. According to our concept, CBT will be offered in the Antenatal class of the community by trained HEW to confirmed CMD moms who begin pharmaceutical therapy at PHCU.

Medication interventions

Medication is a highly successful CMD approach that necessitates a wide range of medications. Women can learn about their options and begin to examine what would work best for them by speaking with a mental health care professional.

Pregnant women have unique needs and should discuss them with their treating physician. After screening and receiving a validated CMD scale, the HEW will link the CMD client to the PHCU.

IDP camp living arrangements include cramped group sites, which will necessitate adjustments. MHPSS can help with community outreach and communication by including them in psychosocial support initiatives.

7.10 PROPOSED PREVENTION STRATEGY FOR MATERNAL COMMON MENTAL DISORDERS AT THE COMMUNITY-BASED LEVEL

The following acronyms identify implementation of actions:

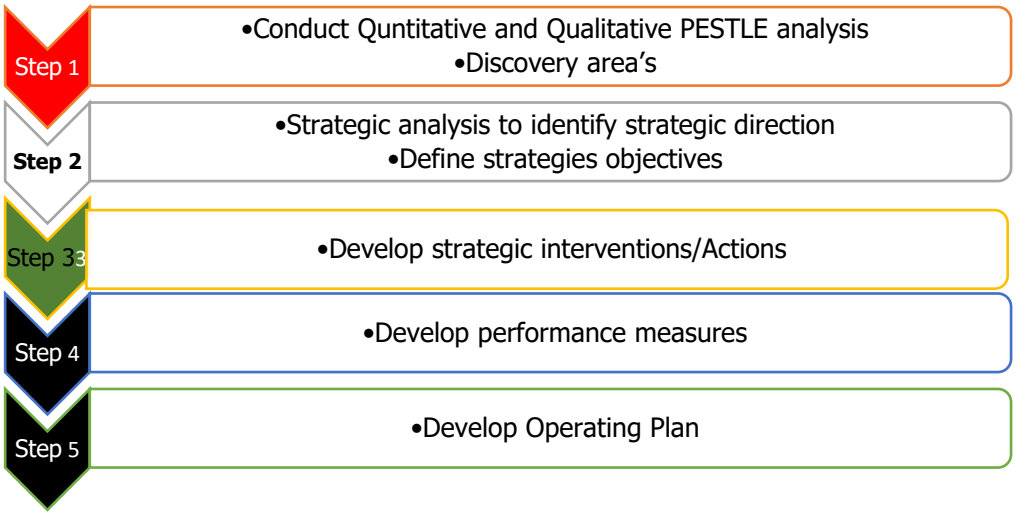

Figure 7.2: Acronyms that identify implementation of actions

Table 7.3: Summary of concluding statements regarding strategy development

Goal	The goal is the overarching aim for each of the 3 domains
Strategy	Each goal has several strategies that achieve each goal
Action	The actions are the steps that need to be taken to achieve the strategies
ID	Each action has an identification number/areas
Who	PHC responsible for the implementation of the area of action is identified by the following acronyms: All = All divisions/areas WHDA = Woman Health Development Army HEW = Health Extension Worker PHC MH Officer = Primary Health Care Mental Health Officer
Outcome	Better long-term outcomes for people with mental health conditions

7.11 STRATEGIC DIRECTIONS

Strategic directions 1: Improve early screening and diagnose of the pregnant and post-natal mothers for common mental disorders (CMDs)

Key strategic objectives

Objective 1: Raising the use of ANC.

Objective 2: Screen all pregnant mothers.

Objective 3: Help Moms pear to pear at ANC-class attendance.

Objective 4: Build a community-to-facility referral system; and vice versa.

Key activities to objective 1

The health extension worker and WHDA are responsible to **increase** ANC/PNC/PMTCT utilisation.

Activity 1: Early pregnancy detection should be connected for ANC.

Activity 2: To declare all pregnant mothers in her catchment area.

Activity 3: Should have all the required details about ANC, PNC registration book, distribution.

Activity 4: The HEW tracks all needed pregnant mothers on time to attend their ANC appointments.

Activity 5: Distribution date and also document meeting with ANC.

Activity 6: The default ANC visit should be tracked

Key activities to objective 2

All pregnant mothers should be **screened** for CMD 3 times (1st visit, after 28-week gestation and post-natal).

Activity 7: The HEW should screen pregnant mothers for CMD during their ANC visits post-natal visit.

Activity 8: The mother should be screened also after completing the ANC class.

Activity 9: Strength referral and network between facilities and the community.

Key activities to objective 3

All mothers who have some symptoms of CMD should **link** to an antenatal class.

Activity 10: On the ANC class trained HEW and WHDA / Expert pear should be support mother on individual counselling on the 1st class individual counselling risk-based psychotherapy).

Activity 11: After 2 classes attended pear take over the support group counselling (group psychotherapy).

Activity 12: The mother should attend the class once every week to the nearby pear.

Activity 13: Provide education and community support materials.

Activity 14: The pear visits the CMD mother at home after the group counselling is completed.

Activity 15: Then the CMD mothers will do telephone checks each other after the home visit is completed.

Activity 16: If the CMD symptoms are not absent while the ANC class activities are completed screen the mother for CMD, link the mental health officer.

Key activities to objective 4

Activity 17: HEWs shoulder the tremendous responsibility of providing services to families and communities.

Activity 18: Develop a referral system from community to facility and vice versa.

Activity 19: The WHDA should report and link all new pregnant mothers found in her catchment to HEW.

Activity 20: HEW should link mothers who have some symptoms to AND class and confirm cases to PHCU mental health officer.

Activity 21: Mothers asses themselves for CMD by the tool or App and report to WHDA.

Strategic direction 2: CMD clients' self-help (women when feeling sad or overwhelmed, or experiencing a difficult time)

Key strategic objectives

Objective 5: Positive coping strategies.

Objective 6: Life skills.

Objective 7: Effective approach when bullying.

Objective 8: Form friendships and maintain healthy relationships.

Objective 9: Healthy relationships.

Objective 10: Healthy lifestyles.

Objective 11: Self or peer assessment.

Key activities to objective 5

The pregnant woman should be learning **positive coping strategies**.

Activity 22: Seeking help from a trusted and empathic family member.

Activity 23: Confiding in people they trust so that others know what they are going through.

Activity 24: Avoiding using alcohol or drugs to cope with their emotions.

Activity 25: Sticking to their usual routine, and maintaining interests or hobbies.

Activity 26: Trying something new that they can gain new skills from or that they may find entertaining, fun, or challenging.

Activity 27: Using the advice from women health development army or health extension workers or other resources to learn cognitive-behavioural coping strategies.

Activity 28: Using relaxation methods (e.g. progressive muscle relaxation, autogenic training, breathing exercises, self-hypnosis).

Activity 29: Working out the cause or triggers of their negative feelings and developing strategies to manage these feelings.

Key activities to objective 6

The pregnant woman should be learning to use **effective communication strategies**, including …

Activity 30: Communicating assertively, rather than passively or aggressively.

Activity 31: Seeing things from another person's point of view, negotiation, and conflict resolution.

Activity 32: Identifying and responding appropriately to non-verbal behaviour.

Activity 33: Speaking to others respectfully.

Activity 34: Listening to others and asking questions if they don't know what the person means.

Activity 35: Using strategies that can help them avoid arguments when discussing sensitive topics (e.g., using I-messages like “I feel…”, using a calm voice, offering a solution).

Activity 36: Not putting other people down.

Activity 37: Telling people respectfully if they are offended by what has been said.

Activity 38: knowing how to plan for a difficult or sensitive conversation with people in their social network (e.g., family members, peers, an employer or colleague, coach).

Key activities to objective 7

If the pregnant **woman is being bullied**, they should …

Activity 39: Seek help from a friend.

Activity 40: Seek help from a family.

Activity 41: Talk to a woman Health Development Army or counsellor to see if they can help.

Activity 42: Approach the person who is bullying them and tell them that their behaviour is unwanted and that they won't put up with it if they feel safe and confident to do so.

Activity 43: If the pregnant woman is being bullied in the workplace, they should talk to a manager or supervisor about the problem, and if this doesn't work they should.

Activity 44: check any relevant workplace policies or contact organisations that may be able to assist (e.g., local workers' compensation authority or a trade union).

Key activities to objective 8

The pregnant woman ought to learn how to form friendships and maintain good relations.

Activity 45: Take the time each week to plan their time, note deadlines, and commitments priorities.

Activity 46: Learn to identify symptoms of stress or anxiety or need a break (e.g. feeling irritable, not sleeping well, having difficulty concentrating).

Activity 47: Practice routine target setting: set realistic achievable targets, move from smaller to larger objectives, and track progress.

Activity 48: Find a work-life balance that feels right for them.

Activity 49: Seek help and support from family and friends, or Junior programmes available, the pregnant woman should … learn **how to form friendships** and maintain healthy relationships.

Activity 50: Take time every week to plan their time, note deadlines, and priorities their commitments.

Activity 51: Learn to recognise signs that they might be stressed or anxious or need a break (e.g. feeling irritable, not sleeping well, having difficulty concentrating).

Activity 52: Practice regular goal setting: set specific, achievable goals, work from smaller to larger goals, and monitor progress.

Activity 53: Find a balance between their work and home life that feels right for them.

Activity 54: Seek assistance and support from family and friends, or available services Junior, senior if they are leaving home.

Activity 55: Take time to consider the emotional impact that leaving home may have, and to prepare themselves for this, if they are considering leaving home for the first time.

Key activities to objective 9

The pregnant woman should… use strategies to build or **maintain a positive relationship with their family** (e.g., keeping the lines of communication open, respecting rules as much as possible, disagreeing without being disrespectful).

Activity 56: Stay connected with supportive friends and family.

Activity 57: learn about other avenues of support that are available to them if they have an unhealthy or dysfunctional relationship with their parents.

Activity 58: Spend time with peers who have positive goals and are involved in positive activities.

Activity 59: Avoid isolating themselves.

Activity 60: Avoid or minimise contact with people who tend to make them stressed or feel bad about themselves.

Activity 61: Be involved in their community (e.g., join a sporting club, faith/spiritual community, or youth group).

Key activities to objective 10

If the young person is in **a romantic relationship,** they should …

Activity 62: Communicate openly with their partner without shouting or yelling.

Activity 63: They should listen to each other, respect each other's opinions, and be willing to compromise.

Activity 64: Respect their partner's culture, beliefs, opinions, and boundaries.

Activity 65: Make consensual sexual decisions.

Activity 66: Be honest with your partner, although they may still choose to keep certain things private.

Activity 67: Respect their partner's need for personal space.

Activity 68: If the young person decides to become sexually active, they should practise safe sex healthy relationships.

Pregnant women should use strategies to build or maintain a **positive relationship with their parent/s** (e.g., keeping the lines of communication open, respecting rules as much as possible, disagreeing without being disrespectful).

Activity 69: Stay connected with supportive friends and family.

Activity 70: learn about other avenues of support that are available to them if they have an unhealthy or dysfunctional relationship with their parents.

Activity 71: Spend time with peers who have positive goals and are involved in positive activities.

Activity 72: Avoid isolating themselves.

Activity 73: Avoid or minimise contact with people who tend to make them stressed or feel bad about themselves.

Activity 74: be involved in their community (e.g., join a sporting club, faith/spiritual community, or youth group).

The young woman should know that healthy relationships can **reduce their risk of common** mental disorders, while unhealthy relationships can increase their risk.

Activity 75: learn to recognise an unhealthy relationship.

Activity 76: take steps to end an unhealthy relationship.

Activity 77: Know about resources that can help them with their relationships.

Activity 78: Take time to evaluate the quality of their interpersonal relationships, and end those that are unhealthy or unsupportive.

Key activities to objective 11

Pregnant women should know that **using alcohol affects** the chemistry of the brain, increasing the risk of CMD.

Activity 79: While alcohol use can cause short-term improvements in mood, it usually has the opposite effect in the long term, and can lead to feelings of depression.

Activity 80: Because areas of the brain are generally still developing into their twenties, they are more likely to experience the negative effects of alcohol at this time.

Activity 81: Heavy alcohol use can cause brain damage resulting in learning difficulties, memory problems, and anxiety and depression (CMD).

Activity 82: Those who use alcohol regularly are more likely to experience alcohol dependence, depression, other mental health problems, and more general problems in life (e.g., conflict at home or school/work, financial problems).

The young woman should know about strategies to avoid or **limit drinking alcohol** in situations where there is peer pressure to drink.

If the young woman decides to drink alcohol, they should …

Activity 83: Think about how much, when, and why they drink know about strategies to keep themselves safe while drinking.

Activity 84: Know about strategies to cut back on drinking (e.g., alcohol-free days) if they are concerned that they might be drinking too much.

Activity 85: Know about resources that can help them manage their alcohol use.

Activity 86: Seek professional help if they are worried about, or want help to manage, their drinking.

The young woman should know that …

Activity 87: Adolescents are particularly at risk for (Khat) **drug-related harms** since their brains are undergoing rapid, extensive development.

Activity 88: Although the immediate effect of drug use may be pleasant and cause feelings of relaxation or euphoria, it usually has the opposite effect in the long term, and can lead to feelings of depression.by

Activity 89: Those who use drugs regularly are more likely to experience dependence on the drug, CMD, other mental health problems, and more general problems in life (e.g., conflict at home or school/work, financial problems, and memory problems).

Activity 90: The risks for depression associated with drug use may be greatest for those who use both drugs and alcohol.

Activity 91: Using illicit drugs affects the chemistry of the brain, increasing the risk of CMD.

Activity 92: Those who start using drugs earlier (early adolescence) are more likely to experience CMDs, other mental health problems, and general life problems (e.g., conflict at home or school/work, financial problems, and memory problems).

The young person should seek professional help if they are worried about, or want help to **manage their drug use.**

Activity 93: Learn about strategies to keep themselves safe, if they decide to use illicit drugs.

Activity 94: Talk to a trusted friend or family member if they are worried about, or want help to manage their drug use.

Activity 95: know about strategies to cut back on using (e.g., drug-free days), Junior, senior if they are concerned that they might be using too much.

Activity 96: Use resources to help them quit smoking.

Activity 97: Seek professional help if they have difficulty quitting smoking.

Activity 98: Junior, senior. The young person should **practice good sleep hygiene** (habits that promote healthy sleep such as Junior, seniors maintaining a regular sleep pattern, improving their sleeping environment, relaxing their mind, and avoiding drugs).

Activity 99: Maintain a regular sleep schedule: get enough sleep at night and have Junior, senior a bedtime and rising time that varies little from day to day.

Activity 100: Aim to get 8–10 h of sleep a night.

Activity 101: Take a break from using electronic devices (texts, emails, calls) during their scheduled sleep time.

Activity 102: Regularly engage in exercise or physical activity (e.g. sport, walking, swimming).

Activity 103: Follow physical activity guidelines if available.

Activity 104: Limit their intake of junk and processed foods (e.g., chips, fried foods, chocolate, and ice cream).

Activity 105: Eat regular meals and not skip breakfast.

Activity 106: Be aware of resources that can help them to get active

Activity 107: Have some exposure to natural sunlight every day.

Activity 108: Try to achieve or maintain healthy body weight.

Activity 109: Avoid dieting, over-exercising, or other unhealthy methods of losing weight.

Activity 110: Recreation and vacation

The young person should **take time to laugh**, have fun and be around people who make them feel good.

Activity 111: Take time to learn about what makes them feel good and remember to include some of those things in their day.

Activity 112: Participate in sport as part of a healthy lifestyle.

Activity 113: Limit the amount of time they spend online, playing video games, and watching television.

Activity 114: Learn about and use strategies to keep themselves safe from different sources and online (e.g., by adjusting their privacy settings, not sharing personal information with people that they don't know, etc.).

Activity 115: Get involved in structured extracurricular activities.

Activity 116: Avoid over-scheduling of extracurricular activities.

Activity 117: Try a variety of activities and interests to help them find out what they are interested in and what they are good at.

Key activities to objective 12

A pregnant woman should assess **herself for CMD** when she feels bad.

Activity 118: Training how to use apps, and screening tool for WHDA and HEWs.

Activity 119: Encourage self-and pear screening, using a screening tool or apps.

Activity 120: Pregnant women should refer to themselves if she has symptoms of CMD to WHDA.

Activity 121: Pregnant women have to make themselves ready to join ANC class or Mental health officer at PHCU according to their CMD status

Strategic direction 3: Support CMD clients' family

Activity 122: The pear and WHDA are responsible to support CMD clients who have a dispute in their relationship, like husband, brother sisters, mother, mother-in-law, friends.

Activity 123: Empowering housebound mothers, towards self-employment.

Activity 124: Empowering Working with other pear groups.

Activity 125: CMD mother should twig and practice CMD clients' self-help protocol.

Strategic direction 4: promote public awareness on maternal CMDs, control of alcohol and substance use

Key strategic objectives 12

Objective 12: Develop IEC/BBC materials mental disorders.

Objective 13: Promote public awareness on maternal CMD.

Objective 14: Control of alcohol and substance.

Objective 15: Engagement with and role of local actors.

Key activities to objective 13

Activity 126: Develop maternal CMDs pamphlets, brochures, radio coverage, apps quick screening tool to detect CMD and apps self-diagnosis of CMDs.

Key activities to objective 14

Raise public awareness of Mental Health and maternal CMDs.

Activity 127: Disseminate information about mental health prevention and advocacy through social mobilisation workshops to community representatives, schoolteachers, churches/mosques, community leaders, WHDA, traditional healers, community campaigns.

Activity 128: Use opportunities in commemoration days to disseminate the prevention information.

Activity 129: Create networking with other relative sectors.

Activity 130: Create public awareness using targeted IEC/BCC materials.

Key activities to objective 15

Raise public awareness of alcohol and substance-related health risk.

Activity 131: Establish an anti-substance community campaign in schools and different youth groups.

Activity 132: The community should give information to HEW about alcohol and substance health-related risks in the community.

Key activities to objective 16

Engagement with and role of local actors.

Activity 133: Ensure cultural and linguistic-sensitive knowledge and communicate with community members, faith leaders, youth advocates, women leaders, health workers, traditional healers, and community volunteers, creating focal points for blocks and parts or neighbourhood task teams.

Activity 134: Strengthen risk communication and community engagement activities to ensure women, children, and their families know how to prevent maternal CMD and are encouraged to seek assistance while also contributing to improving mental health care, prevention, and control of the substance.

Activity 135: Weekly team debriefing meetings, led by a trained counsellor or a trained manager, could serve as a peers' experts support system, helping spread information, discussing creative solutions, planning team activities, and adopting referral system and reporting skills while remaining alert to one another.

Activity 136: Community leaders play a key role in raising awareness and creating positive coping messages using means such as radio shows, listening group demonstrations, and songs/slogans that distance society.

The figure below, organised by the levels of the modified socio-ecological model, summarises maternal common mental disorder prevention strategies.

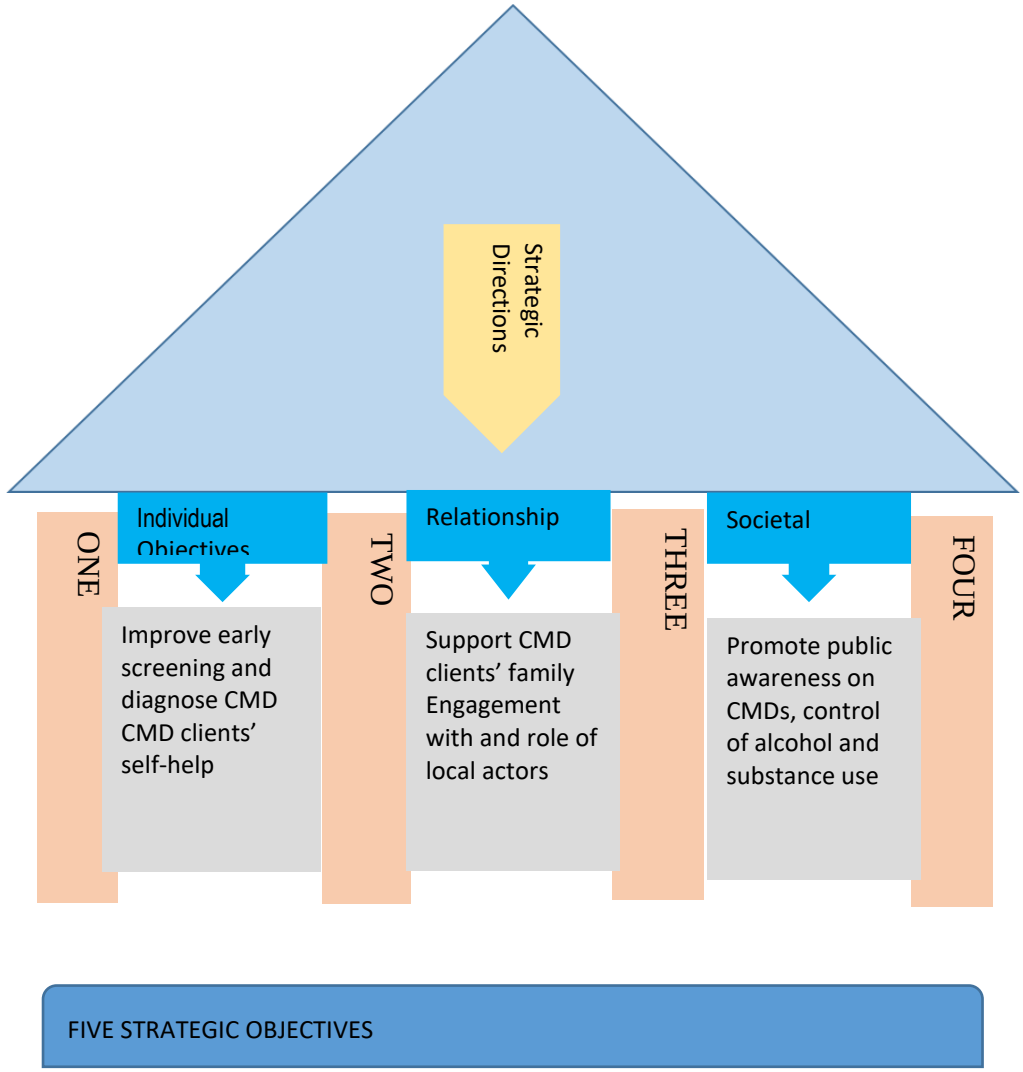

Figure 7.2: Modified socio-ecological model of maternal CMDs prevention strategy

We employed a modified socio-ecological model of mental health prevention in our plan, so it comprises three domains: individual, interpersonal, and society. Improve early screening and diagnosis of pregnant and post-natal mothers for CMDs, CMD clients' self-help (women when feeling sad, overwhelmed, or experiencing a difficult time and support CMD clients' family, promote public awareness on maternal CMDs, control of alcohol and substance use. There are 136 stated actions under 15 objectives, with who and when they will be completed also specified. To measure the outcome, outcome indicators are provided (see Table 7.4).

Table 7.4: Community-based prevention strategy for maternal CMD

	Domain	Strategic direction 4	Objectives 15	Who 136	Outcome indicators	No
1	Individual	Improve early screening and diagnosis of the mother for common mental disorders	ANC visit	ANC /HEW	Symptom identified	
			PNC visit	ANC /HEW	CMD confirmed	
			PMTCT visitors	PMTCT/HEW	Took antenatal class	
					Treated PHCU/link	
		CMD clients' self-help	Individual therapy	HEW/WHDA	Number	
2	Relationship	Support CMD clients' family	Consulted by pear	Pear	Number	
			Family therapy	WHDA	Number	
3	Societal	Promote public awareness on maternal common mental disorders, control of alcohol and substance use	Group session	HEW	No group session	
		Engagement with and role of local actors	Peers' experts support system	HEW	Number of linked	

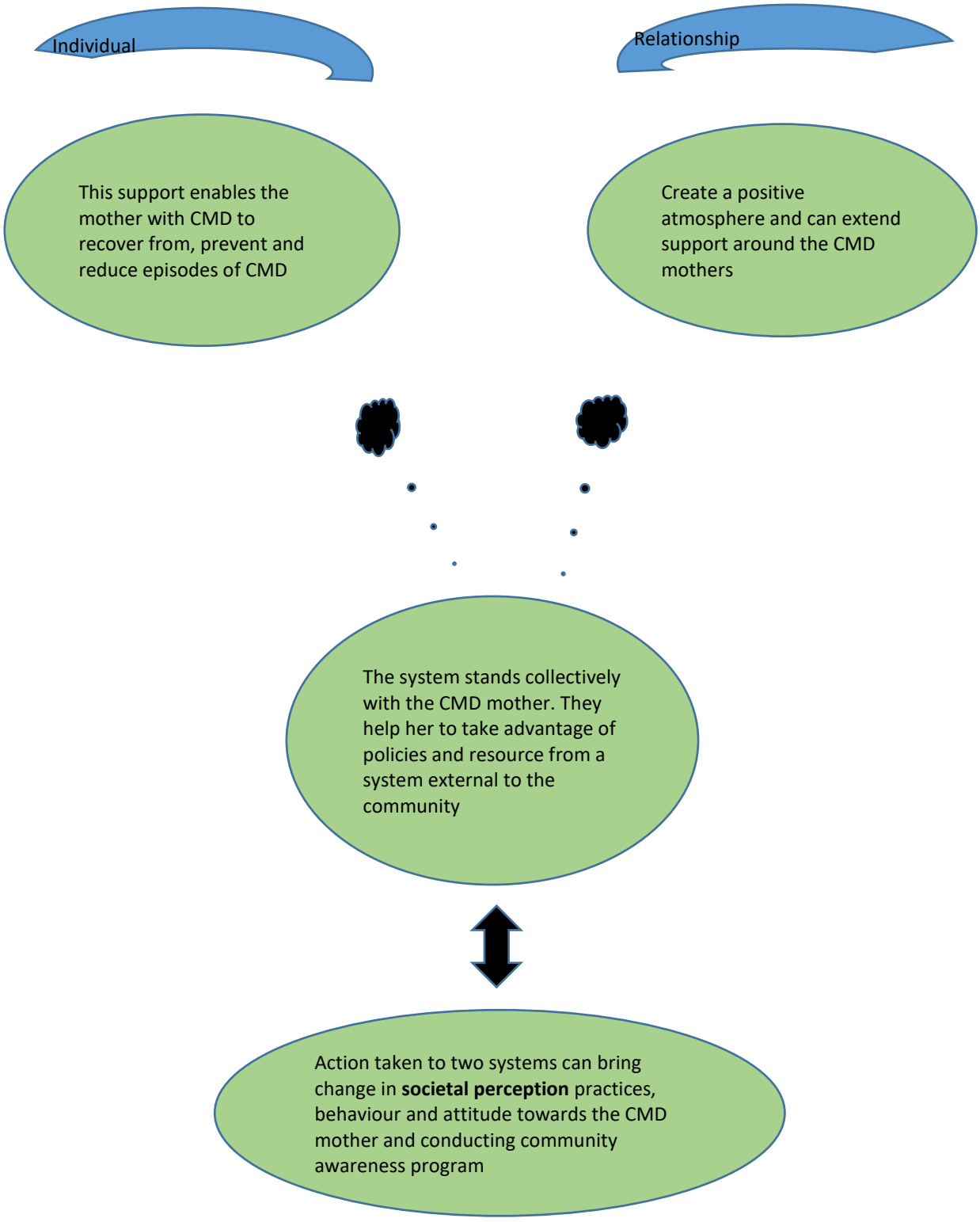

Figure 7.3: Socio-ecological strategy for community-based prevention of maternal CMD

7.12 SUMMARY

Overall, this chapter gave a thorough overview of the suggested strategies and how they were created. The researcher hypothesized a biopsychosocial model to forecast the maternal common mental disorders by the suggested community-based prevention strategy process. Consequently, it was determined that this plan was the best for the community.

Finally, this brief paper proposes a CMD community-based preventive strategy that makes use of government system settings that span the socio-ecological model domains where the vulnerability may exist in people's lives and relationships. This strategy for lowering risk and improving protection should be supplemented by a comprehensive application of public health laws, by identifying the groups most at risk and collaborating with communities to develop policies and programs that meet their needs, improving coordination, collaboration, and opportunities for engaging community leaders and members in prevention.

The next chapter will be the last input of the paper, which is the conclusion, strengths and limitations, and recommendations.

CHAPTER 8: CONCLUSION, STRENGTHS AND LIMITATIONS, RECOMMENDATIONS

8.1 INTRODUCTION

The development of techniques for community-based maternal CMD prevention was covered in depth in the preceding chapters.

Based on the study's findings, the researcher concludes this chapter's research goal, objectives, and questions. The findings will indicate if the study's goals were accomplished or not. The chapter will also highlight the study's shortcomings before concluding with suggestions for how the strategy should be applied in community-based maternal CMD prevention.

8.2 CONCLUSION

This research will help determine the prevalence of maternal CMDs services that will be implemented in Oromia, Ethiopia. Our findings have implications for the establishment of maternal mental health preventative services not just in the urban Oromia district, but also in Oromia as a whole and in Ethiopia.

There is no prevention strategy, routine screening, or treatment for maternal mental problems in community-based settings of urban Oromia Ethiopia.

Using existing resources and government health systems in primary care, this initiative developed a coordinated, step-by-step intervention to deliver CMD prevention and mental health treatment to pregnant women. The proposal demonstrates the potential and acceptability of a tiered care strategy to provide mental health treatment at the primary care level through routine screening and referrals at ANC, PNC, and PMTCT facilities.

8.3 CONTRIBUTION OF THE STUDY

The researchers determined the prevalence of maternal common mental disorders, as well as risk and protective variables. The findings of this study emphasized the importance of improving primary care mental health services, particularly for pregnant women. We contribute to the creation of a plan that integrates the public health approach

of selected prevention with community-based prevention of maternal CMD, which is a first in the research region. as well as recommendations.

8.4 STRENGTHS AND LIMITATIONS OF THE STUDY

The researcher identified the following strengths and shortcomings of the study.

8.4.1 Strengths

The study used an appropriate sampling technique to select the participants in phase 1 of the quantitative study to examine the prevalence and factors associated with maternal CMD. In phase 2 of qualitative, the participants selected had a lived experience of having CMD or anyone they know and the availability of prevention services.

In each phase and step, validity and reliability techniques were used to avoid biases and increase the findings' credibility. Using a mixed-methods design enabled the researcher to answer the research questions.

8.4.2 Limitations

A potential limitation in this study was fear of possible consequences, for the mothers, of disclosing mental health or social difficulties or any dissatisfaction with the health service.

These concerns may have existed despite the carefully informed consent procedure detailing anonymity processes. We could also have lost some of the meaning of respondents' experiences and perspectives in the process of translating the transcripts from the local language into English.

The study was also undertaken in a semi-urban primary health setting, which therefore does not reflect the situation in big cities and rural settings of Ethiopia.

Where interviewing as a method for data collection can provide a compelling and rich source of information, participants may have found it difficult to articulate experiences where they may have delivered substandard care, which may have influenced their responses.

8.4.3 Recommendations

We propose that professionals and stakeholders in the field of mental health shift their attention to create both a social, ecologic approach a comprehensive and diversified public health approach for this population with an emphasis on community-based processes and prevention.

The Department of Health should plan to bring women's mental health 'into the mainstream' and advocate improving the mental health of women and their children by increasing access to psychological care and support in the community.

Ethiopia's Mental health system is mostly curative, with mental health promotion and illness prevention mainly overlooked. In the context of mental health, it is vital to prioritize prevention and promotion above therapy.

By promoting greater community engagement (to reduce stigma, fear, and distrust of mental health services among the communities), providing better data (such as gender, sociodemographic, and lifespan monitoring) and improved dissemination of information, good practice and health promotion helps facilitate the delivery of more culturally aware and responsive services.

More recently, the government underscored its commitment to Improving Access to Psychosocial support during the COVID-19 outbreak for all sections of the population. This should be extended to routine work with more emphasis on the female youth population related to maternal mental health.

According to respondents, initiatives are needed that will improve perinatal mental health care for all women. While acknowledging the particular needs of urban women, participants asserted that perinatal mental health services are ‘poor’, ‘patchy’, or ‘virtually absent’ for all women. In light of information concerning the negative consequences of perinatal mental disorders for women and their children and various programs to enhance women's mental health care for communities more broadly, this work remains underdeveloped and is now critically needed.

The study learned that CHIS might be an effective means of addressing poor but absent or inconsistent provisions. However, further evidence for the clinical and cost-effectiveness of these networks is required.

A surprising number of professional groups were reportedly involved in the delivery of perinatal mental health care provision at PHC. Nevertheless, psychiatry professionals or mental health specialists are not available in the study area PHC unit. Assigning mental health professionals in PHC units is critical to support Mothers with prenatal CMD and the general service users managing mental health disorders by clarifying boundaries between inter-professional roles and relationships, as there was evidence of the potential for misunderstanding, with potentially negative consequences for women.

For truly joined-up services to become a reality, these findings also suggest that more needs to be done to improve the links between community, primary and secondary care, and between the statutory and voluntary sectors. In light of evidence that UHEW women currently favor community-based models, perhaps a greater emphasis should be placed on creating care pathways in which non-statutory provision is more formally integrated into mainstream services. Such a strategy might also go some way towards addressing voluntary sector agencies' concerns about their financial viability – especially in financially straitened times.

A further recommendation is that all health professionals working with patients should be subject to annual mandatory competency training in basic mental health care to increase confidence, and self-awareness, and enhance clinical skills and expertise. Currently, this level of attention to mental health literacy in the form of competency training in the generalist healthcare setting does not exist.

8.5 FURTHER STUDY

- Intervention and impact assessment of strategy for community-based maternal CMDs.
- Mental disorders in children and youth born from CMD mothers are they mentally sound and receiving sufficient support.

- A comparative study on how the PHCU psychiatric community health services of different regions of Ethiopia deal with the needs of young female youth living with mental disorders.
- Further research that attempts to disentangle the multitudinous interacting social, medical, behavioural, cultural, and biological factors that impact mental illness risk is required. Maternal mental health observational research, with the best evidence syntheses, would also be a valuable and timely contribution to this developing field.

8.6 RESEARCHER'S REFLECTIONS AND EXPERIENCES

Prevention begins with planning and having a healthy pregnancy, develops into good eating and fitness habits in childhood, is supported by preventive services at all stages of life, and promotes the ability to remain active, independent, and involved in one's community as we age. Prevention strategy builds on the fact that lifelong health starts at birth and continues throughout all stages of life.

Preventing disease requires more than providing people with information to make healthy choices. While knowledge is critical, communities must reinforce and support health, for example, by making healthy choices easy and affordable. The Federal government alone cannot create healthier communities. City administrates, regional governments, tribal, local, and businesses, health care, education, and community and faith-based organisations are all essential partners in this effort.

Maternal mental health, is a sensitive topic that is not freely discussed in the community because of its association with stigma and discrimination. Every Mother, in one way or another, has experienced physical or emotional blueness, especially first during her pregnancy. Most observed pregnant mothers by the researcher in the area of assignment at prenatal clinics and maternity wards and PMTCT during the work assignment started as Diploma Clinical Nurse, Professional BSC Nurse, and MSc Level Clinical and Community Mental Health professionals were related to common mental health problem. Our reflection on the researcher's embarrassing experiences required the researcher to bracket feelings to get away from preventing maternal common mental disorders from this kind of health problem from Ethiopian mothers.

While the researcher's journey started while practising in the mental health service for her master's community attachment,. Then, she planned to enrol in UNISA 2016 to develop strategies for community-based prevention of maternal CMDs in urban Oromia, Ethiopia.

This was not a stress-free journey; there were moments of doubt and confusion. Indeed, conducting this study was challenging. At times the researcher doubted her ability to complete the programme. In the midst of it, the study empowered the researcher personally and professionally. The study enriched the researcher's knowledge and skills in intimate care facilitation. She slowly understood qualitative research and strategy development since her previous research experience was only in the quantitative method. Today she is proud of the outcome of hard work and dedication.

Data collection was conducted between May 2017 and June 2019. The researcher found conducting and transcribing interviews strenuous and emotionally draining due to the nature of the topic. When encountering such feelings, the researcher had to ensure that she brackets her feelings and experiences. It was not an easy exercise. Data analysis and deducing the key concepts from the findings, developing attributes of the key concepts, and developing a model, as well as drawing a graphic presentation of the model, was a taxing and challenging exercise that demanded long hours of concentration and sacrifice.

Furthermore, she initially found developing a strategy very difficult, which at times caused considerable anxiety and stress. Nevertheless, the proficient guidance, expertise, support, and patience of her supervisor were very helpful for understanding strategy development and finally developing and describing a graphic strategy for the prevention of Maternal CMD. Also, it was helpful for the supervisor to correct language and grammar as the researcher progressed with the chapters.

The researcher also had to meet the demands of being a student, a mother, and a full-time employee, involved in volunteer activities as President of the Ethiopian mental health association and other community development head volunteer activities; she frequently felt overwhelmed with no time for social life and rest. Completing this study and developing the strategy is a big milestone and has developed the researcher into a better scholar and expert in intimate care.

8.7 CONCLUDING REMARKS

In phase 1, the study evaluated the prevalence of CMD in pregnant women and the risk and protective variables for acquiring or being protected from CMD. In phase two, the women investigated their lived experiences with mental health and the status of CMD in pregnant mothers. The approach for community-based prevention of maternal CMDs was designed during the third phase.

This community strategy is a resource to assist communities and other organisations in selecting population-based programmes and policies to enhance mental health and prevent disorders. This chapter completed the study, acknowledged limitations, and provided suggestions for mental health services, prenatal health practice, and research.

This strategy is a resource to assist individuals, communities, and other organisations in selecting population-based initiatives and policies to promote mental health and prevent disorder. This chapter summarised the findings, addressed limitations, and provided suggestions for mental health services, prenatal health care, and research.

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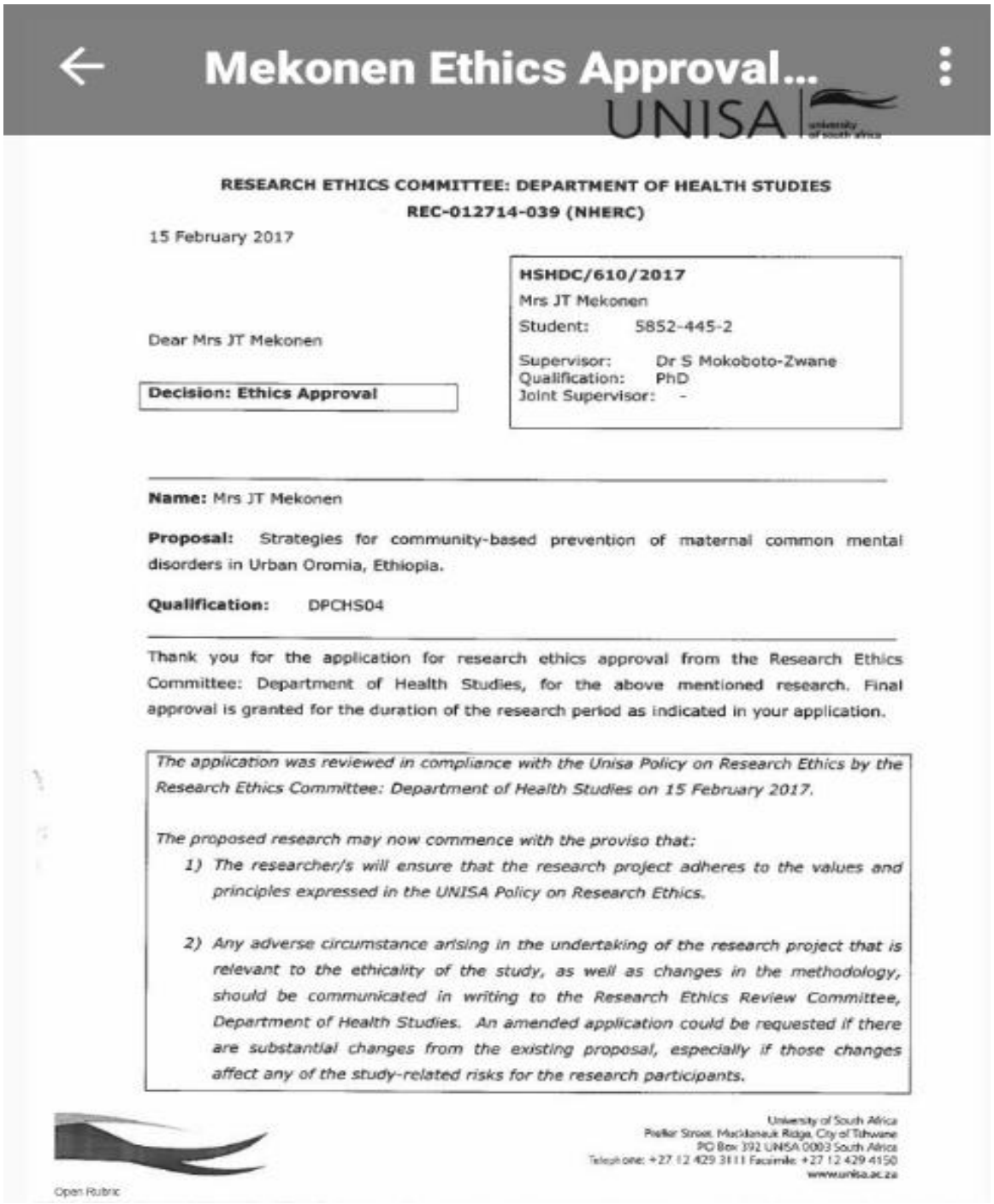
ANNEXURES

ANNEXURE 1: Ethical clearance, Department of Health Studies, UNISA



Mekonen Ethics Approval...

UNISA

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

15 February 2017

HSHDC/610/2017
Mrs JT Mekonen
Student: 5852-445-2

Supervisor: Dr S Mokoboto-Zwane
Qualification: PhD
Joint Supervisor: -

Dear Mrs JT Mekonen

Decision: Ethics Approval

Name: Mrs JT Mekonen

Proposal: Strategies for community-based prevention of maternal common mental disorders in Urban Oromia, Ethiopia.

Qualification: DPCHS04

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 15 February 2017.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

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Open Rubric

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
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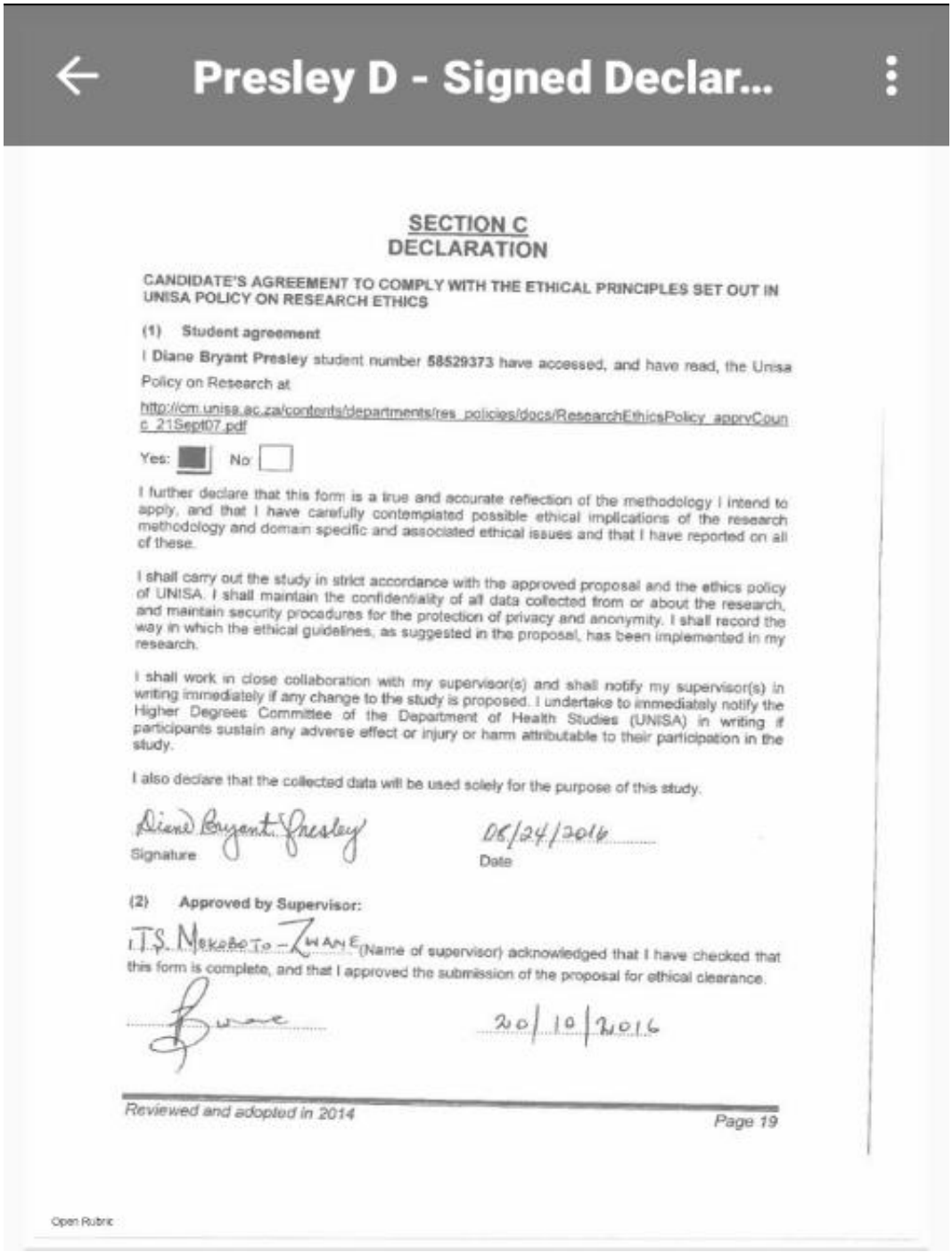
ANNEXURE 2: Researcher's declaration



Presley D - Signed Declar...

SECTION C
DECLARATION

CANDIDATE'S AGREEMENT TO COMPLY WITH THE ETHICAL PRINCIPLES SET OUT IN UNISA POLICY ON RESEARCH ETHICS

(1) Student agreement

I **Diane Bryant Presley** student number **58529373** have accessed, and have read, the Unisa Policy on Research at

http://cm.unisa.ac.za/contents/departments/res_policies/docs/ResearchEthicsPolicy_apprvCounc_21Sept07.pdf

Yes: ■ No: □

I further declare that this form is a true and accurate reflection of the methodology I intend to apply, and that I have carefully contemplated possible ethical implications of the research methodology and domain specific and associated ethical issues and that I have reported on all of these.

I shall carry out the study in strict accordance with the approved proposal and the ethics policy of UNISA. I shall maintain the confidentiality of all data collected from or about the research, and maintain security procedures for the protection of privacy and anonymity. I shall record the way in which the ethical guidelines, as suggested in the proposal, has been implemented in my research.

I shall work in close collaboration with my supervisor(s) and shall notify my supervisor(s) in writing immediately if any change to the study is proposed. I undertake to immediately notify the Higher Degrees Committee of the Department of Health Studies (UNISA) in writing if participants sustain any adverse effect or injury or harm attributable to their participation in the study.

I also declare that the collected data will be used solely for the purpose of this study.

Diane Bryant Presley — Signature

08/24/2016 — Date

(2) Approved by Supervisor:

I T.S. Mokgobo-Zwane (Name of supervisor) acknowledged that I have checked that this form is complete, and that I approved the submission of the proposal for ethical clearance.

20/10/2016

Reviewed and adopted in 2014 *Page 19*

Open Rubric

ANNEXURE 3: Letter seeking consent to Oromia Health Bureau

18 SEPTEMBER, 2017

UNISA-ET/KA/ST/29/18-09-17

Oromia Regional Health Bureau Board of Research and
Ethical Clearance Committee (RHABRECC)
ADDIS ABABA

Dear Madam/Sir,

The University of South Africa (UNISA) extends warm greetings. By this letter, we want to confirm that Mrs. Jalle Teferi Mekonen (student number 58524452) is a PhD student in the Department of Health Studies at UNISA. Currently, she is at the stage of data collection on her doctoral research entitled "***Strategies for the community based prevention of maternal common mental disorders in urban Oromia, Ethiopia***".

This is therefore to kindly request you to assist the student in any way that you can. Attached, please find the ethical clearance that she has secured from the Department of Health Studies.We would like to thank you in advance for all the assistance that you will provide to the student.

Sincerely,

Tsige GebreMeskel Aberra

Deputy Director – Academic and ICT Support

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ANNEXURE 4: Letter of approval from Oromia Regional Health Bureau

BIIROO EEGUMSA FAYYAA
OROMIYAA

OROMIA HEALTH BUREAU
የኦሮሚያ ጤና ጥበቃ ቢሮ

Lakk/Ref. No. BEGOLHBJJSH/11-8/40
Guyyaa/Date 11/2/2010

W/ra/E/F/ Magaaloota 18 tiif

Bakka jiranitti

Dhimmi: Xalayaa deeggarsaa ilaala

Akkuma beekamu Biiroon keenya ogeeyyii, dhaabbilee akkasumas namoota qorannoo gaggeessuuf piroppoozaala dhiyeeffatan piroppoozaala isaanii madaaluun akkanumas iddoo biraatti ilaalchisanii fudhatama argatee (approved) dhiyaateef, piroppoozaala isaanii ilaaludhaan waraqaa deeggarsaa ni-kenna. Haaluma kanaan mata-duree "Strategies for Community-Based Prevention of Maternal Common Mental Disorders in Urban Oromia, Ethiopia" jedhu irratti godina keessan keessatti hojjachuuf piroppoozaalii isaanii Koree "Health Research Ethical Review Committee" Biiroo keenyaatti dhiyeeffataniiru. Haaluma kanaan Koree "Health Research Ethical Review Committee" Biiroo keenyaa piroppoozaala kana ilaaluun mirkaneesseeqorannoon kun akka hojiirra oolu murteessee jira.

Waan kana ta'eef hojii qorannoo kanarratti deeggarsa barbaachisaa ta'e akka gootaniif, akkanumas akka hordoftan jechaa. **Addee Jaallee Tafarii** qorannoon kun qaacceffamee xumurame fiiriisaa kooppii tokko Biiroo Eegumsa Fayyaa Oromiyaatiif akka galii godhu garagalchaa xalayaa kanaatiin isaan beeksifna. Anis, **Addee Jaallee Tafarii qorannoon** kun qaacceffamee xumurame fiiriisaa kooppii tokko Biiroo Eegumsa Fayyaa Oromiyaatiif akka galii godhu mallattoo kiyyaan mirkaneessa.

Nagaa wajjin

Mallattoo _____

Maqaa"**Addee Jaallee Tafarii" tiif**

Lak. Bilbilaa 0921775633

Guyyaa **1/2/2010**

G/G

- **Addee Jaallee Tafarii tiif**

Address: Tel: +251-11-371-72-77, Fax: +251-11-371-72-27 P.O.Box.24341 E-mail: ohbhead@telecom.net.et ADDIS ABABA/FINFINNE-ETHIOPIA

ANNEXURE 5: Letter of permission from Town Administrative To PHCU

Bulchiinsa Mootummaa Naannoo Oromiyaatti
Biiroo Eegumsa Fayyaa Oromiyaatti
Waajjira Eegumsa Fayyaa Bu/M/Sabbataa

በኦሮሚያ ክልልላዊ መንግስት በኦሮሚያ ጤና ቢሮ
የሰበታ ከተማ ጤና አጠባበቅ ጽ/ቤት
Sebeta Town Health Office

Lakk

Guyyaa

Bufatalee Fayyaa 4 tiif

Bakka Jirtanitti

Dhimmii:- Xallayyaa Deegarsaa Keenuu ilaala

Akkuma mata-duree irratti ibsamuuf yaalameetti Xallayyaa Biroo Eegumsa Fayyaa Oromiyaa irraa Lakk –BEFO/HBTFH/1-8/40 , Guyyaa 01/02/2010 nu bareefameen Addee **Jaallee Tafariin** qorannoo mata dureen isaa " **Strategies for Community –based Prevention of Maternal Common Mental Disorders in Urban Oromia , Ethiopia**"jedhuu irratti Magaala keenya keesatti hojachuuf Pirooppoozaalii isaanii BEFO dhiyeefatani qorannoon kuun akka gageefamuu muurtaa'e jiraa.

Haaluma Kanaan Hojii qorannoo kana irratti deegarsa Barbaachisaa ta'e hundaa akka gotaaniif issin beeksifnaa.

Nagaa Wajjin

G.G

- *Addee Jaallee Tafarii tiif*
  B/I

+2510113381166, 0113383933, 0113383934 + 2510113384008

ANNEXURE 6: Confidentiality binding form English version

Declaration by participant

I ..... voluntarily consent to participate in the above-mentioned research project. The background, purpose, risks and benefits of the study have been explained to me. I also understand that I may withdraw from the study at any time without consequences. I understand that my participation in the study will be acknowledged, although my identity and the identity of health facility will be withheld.

I understand that my participation in the study is voluntary.

…….. ……..

Participants' signature Date

....

Witness Date

Declaration by data collector

I, _____ (Data collector) declare that:

- I explained the information in this document.
- I encouraged her to ask questions and took adequate time to answer them.
- I am satisfied that she adequately understands all aspects of the research, as discussed above.
- I did/did not use an interpreter. (If an interpreter is used then the interpreter must sign the declaration below.

…… ……

Signature of data collector Date

ANNEXURE 7: Confidentiality binding tool translated in local language (Oromiffa)

Unka waliigaltee

Yaada/hima/ibsa gama Hirmaataa/ttuu

Ani namni maqaan koo _____ jedhamu, qorannoo armaan olitti ibsame keessatti hirmaachuuf fedhii fi hayyamummaa koo guutun itti waliigaleera. Kaayyon, bu'aan/barbaachisummaan, miidhaan fi haalli waliigala qorannichaa haala naaf galuu danda'uun naaf ibsameera. Anis sirriitti hubadheera. Yoo natti toluu baate (feenan) yeroon barbaadetti miidhaa/rakkina tokko malee akkan addaan kutee bahu (akkan dhiisuu) danda'us hubadheera. Eenyummaan kooti fi haalli waantota ayyaa wajjin wal-qabatanii yoo iciitin qabamanillee, hirmaannan koo akka beekamtii qabaachuu danda'us bareera.

Qorannoo kana keessatti hirmaachuun koo fedhii fi hayyamummaa koo qofaan akka ta'e hubadheera.

…… ……..

Mallattoo hirmaataa/ttuu Guyyaa

....

Ragaa Guyyaa

Yaada/hima/ibsa warra odeeffannoo funaananii

Ani namni maqaan koo _____ jedhamu waantota armaan gadii raawwachuu koo nan ibsa/hima/mirkaneessa.

- Odeeffannoo guutuu barreeffama kana keessa jiru haala ishiif galuun ibseefira.
- Akka himaatan/ttun kun gaafii yoo qabaatte/te gaafatuufis jajjabeessera. Gaaffiwwan ka'anis deebii ga'aa ta'e kennuuf yeroo fudhadhee itti yaadera
- Haaluma armaan olitti ibsameen haala qorannichaa kallatti maraan haala ga'aa ta'een hubachuu ishiitti garaa of gaheera.

- Turjumaanatti hin fayyadamne. (Yoo turjumaanni jiraate, ibsa armaan gadii turjumaanichumatu mallatteessa)

…… ……

Mallattoo nama odeeffannoo funaanuu Guyyaa

ANNEXURE 8: Informed consent form translated by local language (Oromiffa)

Unka waliigaltee

Barataa/ttuu Qorannoo Taasiu: Jaallee Tafarii Mokonniin RN, MSc.

Gorsaa fi Qajeelchan gama Barnootaa (Academic Supervisor) – Tereezaa Mokobootoo-Zwaanee Profeesara (Professor Theresa Mokoboto-Zwane)

Kolleejjii Humaan Saaynsii (College of Human Sciences)

Yuunivaristii Saawuz Aafrikaa (University of South Africa)

Lakk. Toora bilbilaa: + 251921775633

Imeelii (Email): jallet_2003@yahoo.com

Mata-duree Qorannichaa: Tarsiimoowwan/maloota Ittisa Rakkina Fayyaa (dhukkuba) Qor-qalbii/sammuu Baramoo Haawwanii Hawaasa Bu'uureffatan: Itoophiyaa, Baadiyyaa Oromiyaa Keessatti.

Maalummaa Qorannichaa:

Qorannoon kun qorannoo kaadhimamtuu/barattuu Doktorummaa Yuunvarsiitii Saawuz-Aafrikaa kan taate kan Jaallee Tafariitin taasifamuudha. Isinis qorannoo fi qo'annoo kana keessatti akka hirmaattaniif affeeramtaniirtu. Sababni affeeramtaniif ammo waan dubartoot ulfaa (garaatti baatan) wajjin hojjatanii fi hawaasa kana keessatti ammo nammotni isaan wajjiin waan wal daangessuuf (qunnamaniif). Qorannichi kan fuulleffate, Itoophiyaa, Baadiyyaa Oromiyaa keessatti sadarkaa hawaasattitarsiimoowwan rakkina fayyaa (dhukkuba) qor-qalbii/sammuu babbaramoo Haawwanii ittiin ittisan gad-fageenyaan qorachuu fi adda baasuu (ibsuuf)dha.

Itti hirmaachuuf yoon waliigalaee, maal maaltu gaafatamaa?

Haala fi bakka siif mijatutti nama qorannoo kana gaggeessu waliin qaaman teessanii gaafiiwwan muraasa afaaniin akka gaafatamtuuf (af-gaafiin nama dhuunfaa akka taasifamuuf) ni affeeramta. Yammuu af-gaafin kun taasifamu baadiyyaa Oromiyaa keessatti waantota rakkina fayyaa qor-qalbii bebbekamoo haawwaniitiif nama saaxilani fi waantota rakkina kana fidan ilaalchisee; yaada, ilaacha dhuunfaa keeti fi waan beektu akka nama gaaficha si gaafatuuf akka qoodduu carraan siif kennama. Dabalataan, sadarkaa hawaasatti tooftawwan/maloota ykn akaataa rakkoowwan kana ittisuuf faayiddaarra oolanis ilaachisee yaada ati kenniitu baay'ee barbaachisaadha. Af-gaafichi sa'aa tokkoo ol hin fudhatu. Nama qorannoo kana gaggeessuuf dhumarratti yaadota hirmaattota irraa walitti qabaman qaaccessuu/xinxaaluu fi gabaasa isa dhuma qopheessuuf akka mijatuuf jecha, af-gaafichi meeshaa sagalee waraabdun ni waraabama. Dabaltaanis yaadannoon ni qabatama (yaadachiisaa irraatti ni barreeffama)

Qorannookanairratti hirmaachun koo iccitidhaan ni qabamaa?

Yaadni fi odeeffannoon ati nuuf kennitu/qooddu amma danda'ametti iciitidhaan eegama/qabama. Fakkeenyaaf maqaa fi teesson kee hin barreeffamu/hin qabamu/. Kana jechuun waantotni ati akka nama dhuunfaatti qorannoo kana keessatti hirmaachuu kee adda baasanii agarsiisan fkn maqaan kee, naannoo jireenya kee, teessoo kee, lakkofsa bilbila kee fkn hundi ni baduu (hin barbaachisanii) jechuudha. Kan qorannoo kana irratti hirmaatu si qofa miti, nama heddu. Kanaaf yaadni fi odeeffannoon ati nuuf qooddu qophaatti osoo hin ta'in kan warra kaanii faana walitti makamee/qabamee waan ilaalamuuf, yaada/odeeffannoo ati kennite namni adda baasee beekuu danda'u hin jiru (odeeffannoon tokko kan eenyuu akka ta'e adda baasanii beekun hin danda'amu) jechuu dha.

Bar-gaaffiwwan guutamanii xumuraman namni tokkoyyuu (qorataa/ttuu sana malee) akka hin argine ni taasifama. Kana jechuun, akka namni tokko hin argineef ykn fuudhuu hin dandeenyeef bar-gaaffiwwan guutamanii xumuraman kunneen samsamaniiti walitti qabamanii bakka kuufama isaanitti geeffamu jechuudha. Meeshan sagaleen irraatti warabames qorattittiidhaan hanga wagga 3tti qollofamee taa'a. Kanajechuun namni biraa waa gochuu hin danda'uujechuudha. Gabaasa dhumaa qorannoo kana irratti maqaan nama dhuunfaa ykn waantotni eenyummaa nama dhuunfaa tokko ibsan hin galan (hin

ammataman). Argannoon qorannoo kanaa karaa adda addaatin waantota adda adda irraattis yoo kan barreeffamaan bayu ta'e eenyummaan hirmaattota qorannichi amma danda'ametti hin saaxilamu- iciitin qabama jechuudha.

Marii-garee ilaalchisee warra maricha irratti hirmaatef eenyumman kee dhoksuun hin danda'amu. Qorattichi/ttiinhirmaattotni marii garee kana biroon iciitii marichaa ni eeguu jedhee waadaa hin galu (itti gaafatamummaa hin fudhatu/ttu). Waanti gochuu dandeenyu garuu waantota asitti mari'anne kana akka iciitin qabamuu fi asii alatti baatanii qaama biraattii akka hin dubbanneef gara gadii kanatti akka mallatteessitan gochuu qofa.

Qorannoo kana irratti hirmaachuu kootif rakkoo narra gahuu ni jiraa?

Qorannoo kana irratti hirmaachuu keetif rakkoon kana jedhame sirra gahu hin jiru. Garuu gaaffiiwwan keenya tokko tokko namatti tolu baachuu danda'u. Kan nama dhimma nama dhuunfaa tuqan ta'uu malu. Kan namatti himuuf namatti ulfaatan ta'uu malu. Yoo sitti tolu baatee ykn yoo deebisuuf fedhii hin qabne ta'e gaafii sana deebisuu dhiisuuf mirga guutuu qabda.

Faayidaan Qorannoo kana maali?

Qorannoo kana keessatti hirmaachuu keetif faayidaan/kenni maallaqa qorannoon kun siif keennu hin jiru. Haata'u garuu, hirmannaan kee faayidaa guddaa qaba. Tokkoffaa, sadarkaa hawaasatti tarsiimoo ittisa rakkina fayyaa (dhukkuba) qor-qalbii/sammuu baramoo ta'anii ilaalchisee yaada furmaata (maaltu akka ta'uu qabu) qorataan/ttun kennu/itu irraatti gumaacha guddaa taasisa. Kan biroo ammoo yaadni ati akka nama dhuunfatti kennite kun sagantaa/maammata fayyaa haawwanii irratti xiyyeeffatee bayu fooyyessuuf haalan gargaara. Dabaltaanis hirmaannan kee kun haala adeemsa baruumsa/barnoota nama qorannoo kana taasisuu irratti gumaacha ol aanaa qaba.

Yoon hirmaachuuf itti waliigalellee yeroo barbaadetti hirmaannaa koo addaan kutuu nan danda'aa?

Hirmaannan ati qorannaa kana keessatti gootu guutuma guututti kan fedhii kee irratti hundaa'edha. Yoo feete hirmaachuuyyuu diduu ni dandeessa. Yoo feete erguma irratti hirmaachuuf waliigaltee hirmaachuu jalqabdeeyyuu yeroo feete addaan kutuu ni

dandeessa. Addaan kutuu keetif ammoo waanti adabamtus hin jiru, fayidaan silaa siif malu kan sirra hafus (kan dhabdus) hin jiru.

Yoon yaada fi gaaffii qabaadhehoo?

Qorannoon kun kan taasifamaa jiru Jaallee Tafarii Makonniin nama jedhamuun. Qorannichi ammo kan taasifama jiru sadarkaa barnoota ishii diigrii sadaffaa (doktorummaa) ittiin guuttachuuf. Dhimmi fi yaadni adda addaa qorannoo kana irratti hirmaachuuf waliigaluuf Jaallee Tafarii Makonniin waliin mari'achuu feetan yoo jiraate, gammachuun sin simmatteeti sin waliin dubbatti. Qorannoo kana irratti hirmaachuun gutumaan gututti fedhii fi haayyamummaa keessan irratti kan huundaa'e waan ta'eef, kun guutumatti filannoo keessan. Yoo feetanis addaan kuttanii bayuu ykn dhiisuu ni dandeessu. Namni qorannoo kana gaggeessu murtii keessan kamiyyuu ni kabaja. Yaada fi gaaffii yoo qabattan ni simatama. Karaa teessowwan armaan gadiitin na qunnamuu dandeessu

Mekonen JT, RN MSc 58524452@mylife.unisa.ac.za or jallet_2003@yahoo.com

PhD Supervisor:

Professor Theresa Mokoboto-Zwane - email: mokobtsb@unisa.ac.za

Hirmaatna keessaniif durseen isin galateeffadha. Galata guddaa qabdu

ANNEXURE 9: Informed consent form English version

Student Investigator: Jalle Teferi Mekonen RN, BSN, MSc.

Academic Supervisor – Professor Theresa Mokoboto-Zwane

College of Human Sciences

University of South Africa

Telephone: + 251921775633

Email: jallet_2003@yahoo.com

Title of the study: Strategies for the community-based prevention of maternal common mental disorders in urban Oromia, Ethiopia.

What is the research about?

This is a research being conducted by **JALLE TEFERI MEKONEN**, a PHD student at the University of South Africa. You are invited to participate in this research because you are working with pregnant women and peoples have interface with them at this community. The study intends to explore and describe the strategies for the community prevention of maternal common mental disorders in urban Oromia, Ethiopia.

What will I be asked to do if I agree to participate?

You will be invited to participate in a face-to-face individual interview with the researcher at your own convenience. During the interview, you will be given the opportunity to share your personal opinions and views regarding risk and protective factors that influence maternal common mental disorders at community level in urban Oromia, Ethiopia in addition your opinion regarding approaches or mechanisms for the community level prevention of maternal CMD, is very important.

The interview will not take more than one hour. The interview will be audio-recorded and notes will also be taken to allow the researcher to analyses and write the final report for the study.

Would my participation in this study be kept confidential?

The information you will share with the researcher will be kept confidential as much as possible. Your name or address is not required. which means we will remove anything that could identify you as taking part in this study, such as names and villages. Your answers to our questions will be combined with answers from many other people, so that no one will know that the answers you give us today belong to you.

Completed questionnaires will not be shared with other interviewers and will be transported and stored in sealed envelopes and measures will be taken to ensure that they will not be left anywhere where somebody could see them or take them. The tape will be locked away by the researcher for a period of three years. No individual names or identity will be used in the report. Should an article be written about this research project, your identity will be protected to the maximum extent?

On the focus group discussion, your identity will be known to other focus group participants and the researchers cannot guarantee that others in these groups will respect the confidentiality of the group. We will ask you to sign below to indicate that you will keep all comments made during the focus group confidential and not discuss what happened during the focus group outside the meeting.

What are the risks of this research?

There are no known risks associated with your participation in this research. Some of our questions may be of a sensitive nature; some questions may make you feel uneasy. You do not have to answer any questions if you do not want to.

What are the benefits of this research?

This research will not have any monetary benefit to you as a participant. However, your experiences will assist the researcher to make recommendation regarding CMD strategies using for the community prevention and you will help us to improve a program that focuses on improving the health of mothers. Your participation will also contribute to the learning process of the researcher.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part in the research. You may choose to withdraw your participation at any time should you decide to participate in the research and you will not be penalized or lose any benefits which you otherwise qualify for.

What if I have questions and Complaints?

This research is being conducted by Jalle Teferi MEKONEN for completing her academic doctoral studies program. If there are any concerns that you may wish to discuss with Jalle Teferi MEKONEN to agreeing to enter the study, she would be pleased to talk with you. It is entirely your choice to participate and you are free to withdraw at any time and the researcher will respect your decision. Your questions and comments are welcome.

Mekonen JT, RN MSc 58524452@mylife.unisa.ac.za or jallet_2003@yahoo.com

PhD Supervisor:

Professor Theresa Mokoboto-Zwane - email: mokobtsb@unisa.ac.za

Please accept in advance my thanks for your participation.

ANNEXURE 10: Phase 1: Survey questionnaire English version

Phase 1 study

Q0001	Participant Identification Number				

Q0002	Phase of recruitment	Phase 1	1

Form 1: Socio-demographic details

Form 1: SOCIO-DEMOGRAPHIC DETAILS			
1001_1	Are you living in Oromia since the past 12 months? And are going to live the coming 6 months in the same area?	Yes	1
		No	0
	If the answer is 'no' then the person MUST NOT be entered into the study.		
1002_1	How old are you?	___ ___ years	
1003_1	Are you able to read and write	Yes	1
		No	0
1004_1	How many years of education have you completed? (state exact number)	___ ___ years	
1005_1	What is your marital status?	Single	1
		Married	2
		Co-habiting (living together but not legally married)	3
		Divorced	4
		Widowed	5
		Separated	6
1006_1	What is your ethnicity?	Oromo	1
		Amhara	2
		Tigray	3
		SSNPR	4
		Somali	5
		Other (specify)_____	6
1007_1	What is your religion?	Orthodox Christian	1
		Muslim	2
		Protestant Christian	3
		Catholic	4
		Other (specify)_____	5

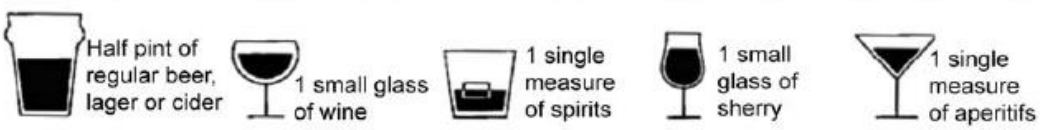
1008_1	Where do you live?	Urban	1
		Rural	2
1009_1	How many adults (18 years or over) live in your home (excluding patient)?	___ ___adults (18 years or over)	
1010_1	How many children (under 18 years) live in your home?	___ ___ children (<18 years)	

FORM 2: GENERALISED ANXIETY DISORDER 7 (GAD 7)			
	This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability. Over the last 2 weeks, how often have you been bothered by any of the following problems?		
2001_1	Feeling nervous anxiety or on edge	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
2002_1	Not being able to stop or control worrying…….	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
2003_1	Worrying too much about different things....	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
2004_1	Trouble relaxing	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
2005_1	Being so restless that it is hard to sit still……	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
2006_1	Becoming easily annoyed or irritable.....	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
2007_1	Feeling afraid as if something awful might happen	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
	GAD-7 Score =_____ + _____ + _____		

FORM 3: PATIENT HEALTH QUESTINNEIRE (PHQ 9): (SCPMCMDPHASE 1 QUESTIONNAIRE)			
	During the last 4 weeks, how much have you been bothered by any of the following problems?		
3001_1	Little interest or pleasure in doing things……	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
3002_1	Feeling down, depressed, or hopeless……	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
3003_1	Trouble falling or staying asleep, or sleeping too much	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
3004_1	Feeling tired or having little energy.....	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
3005_1	Poor appetite or overeating.....	Not at all	0
		Several days	2
		More than half the days	2
		Nearly every day	3
3006_1	Feeling bad about yourself — or that you are a failure or have let yourself or your family down.	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
3007_1	Trouble concentrating on things, such as reading the newspaper or watching television……..	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
3008_1	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual……	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
3009_1	Thoughts that you would be better off dead of or hurting yourself in some way…….	Not at all	0
		Several days	1
		More than half the days	2
		Nearly every day	3
	PHQ-9 Score = _____		

Form 4: Fast Alcohol Screening Test

This is one unit of alcohol…



…and each of these is more than one unit

4001_1	How often have you had 6 or more units (if female), or 8 or more units (if male), on a single occasion **in the past year**?	Never	0
		Less than monthly	1
		Monthly	2
		Weekly	3
		Daily or almost daily	4
4002_1	How often **during the past year** have you failed to do what was normally expected from you because of your drinking?	Never	0
		Less than monthly	1
		Monthly	2
		Weekly	3
		Daily or almost daily	4
4003_1	How often **during the past year** have you been unable to remember what happened the night before because you had been drinking?	Never	0
		Less than monthly	1
		Monthly	2
		Weekly	3
		Daily or almost daily	4
4004_1	Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No	0
		Yes, but not in the last year	2
		Yes, during the last year	4
4005_1	Add together the responses for 1001_1, 1002_1, 1003_1 and 1004_1 Total score ___ ___		

5001_1	In the past 12 months, have you used khat more than five times?	Yes	1	
		No	0	
	If no, → Form 6001 If yes, → 5002_1			
5002_1	In the past 12 months when you were using khat most frequently, about how often did you use it?	Almost every day	1	
		3 or 4 days a week	2	
		1 or 2 days a week	3	
		1 to 3 days a month	4	
		Less than once a month	5	
5003_1	When did you last use khat at all?	___ ___ weeks ago		
5004_1	In the past 12 months, did using khat frequently interfere with your work at school, on a job or at home?	Yes	1	*
		No	0	
5005_1	In the past 12 months, has your use of khat led to problems with your family, friends, at work, or at school?	Yes	1	*
		No	0	
5006_1	In the past 12 months, has your use of khat led to problems with the police?	Yes	1	*
		No	0	
	If the answers to 5004_1, 5005_1 or 5006_1 are 'no' → 5008_1			
5007_1	In the past 12 months, did you continue to use khat after you knew that it was causing you any of these problems?	Yes	1	* X If 'yes' →1
		No	0	
5008_1	In the past 12 months, have there been times when you used khat in situations where you could get hurt—for example, when riding a bicycle, driving a vehicle, operating a machine, or anything else?	Yes	1	*
		No	0	
5009_1	In the past 12 months, did you find that you had to use much more khat than before to get the effect you wanted?	Yes	1	X If 'yes' →1
		No	0	
5010_1	In the past 12 months, did you find that the same amount of khat had less effect on you than it once did?	Yes	1	
		No	0	
5011_1	In the past 12 months, have you felt such a strong desire or urge to use khat that you could not keep from using it?	Yes	1	*
		No	0	
5012_1	In the past 12 months, did you ever want khat so badly, that you could not think of anything else?	Yes	1	
		No	0	

5013_1	In the past 12 months, have you wanted to stop or cut down your use of khat?	Yes	1	X If either is yes (1) or unable to cut down (2) → 1
		No	0	
5014_1	When you cut down in the past 12 months, were you able to cut down khat for at least one month?	Yes	1	
		No	0	
		Unable to cut down for one month	2	
5015_1	In the past 12 months, has there ever been a period when you spent a great deal of time using khat, getting khat, or getting over the effects of khat?	Yes	1	X If 'yes' →1
		No	0	
5016_1	In the past 12 months, have you had periods when you used more khat than you intended to or when you used khat for much longer periods than you intended to?	Yes	1	X If 'yes' → 1
		No	0	
5017_1	In the past 12 months, have you often started using khat and found it difficult to stop before you became intoxicated or high?	Yes	1	
		No	0	
5018_1	When you stopped or cut down on khat in the past 12 months, did you have any of the problems like those listed on this card? (read out)	Yes	1	X If either 5018_1 or 5019_1 is 'yes' → 1
		No	0	
	fatigue or exhaustion sweating diarrhoea anxious depressed irritable restless trouble sleeping tremors (hands tremble) stomach ache headache weakness nausea or vomiting fits or seizures muscle aches or cramps runny eyes or nose yawning intense craving seeing/hearing things that weren't really there heart beating fast change in appetite fever			
5019_1	In the past 12 months, did you use khat or another drug just like it to keep from having problems?	Yes	1	
		No	0	
5020_1	In the past 12 months, have you had any medical Problems as a result of using khat?	Yes	1	*
		No	0	

5021_1	In the past 12 months, did you continue to use khat after you knew that it was causing you any of these health problems?	Yes	1	* X If 'yes' →1
		No	0	
5022_1	In the past 12 months, have you had any emotional or psychological problems from using khat-- such as being uninterested in your usual activities, being depressed, suspicious or distrustful of people, or having strange thoughts?	Yes	1	*
		No	0	
5023_1	In the past 12 months, did you continue to use khat after you knew that it was causing you any of these emotional or psychological problems?	Yes	1	* X If 'yes' →1
		No	0	
5024_1	In the past 12 months, have you given up or greatly reduced important activities in order to get or to use khat -- activities like work, or associating with friends or relatives?	Yes	1	* X If 'yes' → 1
		No	0	
5025_1	In the past 12 months, did you do this (give up or reduce important activities) to use khat for a whole month, or several times over two months?	Yes	1	
		No	0	

Form 6: SOCIOECONOMIC STATUS			
6001_1	What is your occupational status	Employed/self-employed	1
		Farmer	2
		Housewife	3
		Student	4
		Unemployed	5
		Other (specify)_____	6
6002_1	What is the occupational status of the main breadwinner in this house?	Employed/self-employed	1
		Farmer	2
		Housewife	3
		Student	4
		Unemployed	5
		Other (specify)_____	6
6003_1	What is the main source of drinking water for members of your household?	River	1
		Protected well	2
		Unprotected well	3
		Lake or pond	4
		Pipe	5
		Unprotected spring	6
		Protected spring	7
		Other (specify)_____	8
6004_1	What kind of toilet facility do members of your household usually use?	Flush latrine (functional)	1
		Flush latrine (non-functional)	2
		Pit latrine (functional)	3
		Pit latrine (non-functional)	4

		Field	5
		Other (specify)_____	6
6005_1	Do you share this toilet facility with other households?	Yes	1
		No	0
6006_1	Does your household have electricity?	Yes	1
		No	0
6007_1	Does your household have a radio?	Yes	1
		No	0
6008_1	Does anybody in your household have a mobile telephone?	Yes	1
		No	0
6009_1	Do you have a separate room which is used as a kitchen?	Yes	1
		No	0
6010_1	[Observe main material of roof]	Thatched	1
		Corrugated iron sheet	2
		Other (specify)_____	3
6011_1	Has anyone in your household, including yourself, gone hungry in the last month due to lack of resources/food?	Yes	1
		No	0
6012_1	Compared to other people in your sub-district *(kebele)*, do you think you have the same amount of money? Less money? Or more money?	Less	1
		More	2
		The same	3
6013_1	Do you or your family have any debts that you can't pay?	Yes	1
		No	0
6014_1	In case of emergency, do you think that you alone could raise enough money to house and feed your family for 4 weeks?	Yes	1
		No	0

Form 8: Client Service Receipt Inventory

Form 7: Oslo-3 Social Support Scale (SCPMCMD Phase1 questionnaire)		
7001_1	How many people are so close to you that you can count on them if you have serious problems?	
	None	1
	1 or 2	2
	3 to 5	3
	6 or more	4
7002_1	How much concern do people show in what you are doing?	
	A lot of concern and interest	5
	Some concern and interest	4
	Uncertain	3
	Little concern and interest	2
	No concern and interest	1
7003_1	How easy can you get practical help from neighbours if you should need it?	
	Very easy	5
	Easy	4
	Possible	3
	Difficult	2
	Very difficult	1

	In the past 3 months when you have had a health problem, what face-to-face contacts have you had with these professionals? (EXCLUDING in-patient care)					
8001_1	Health extension worker	Yes	1			
		No	0	If no, → 8002_1		
	A	Where were you seen?			Health post	1
					Home	0
	B	How many times? (in last 3 months)			___ ___ times	
	C	Time taken for travel (both ways)			___ ___ hours	
	D	Travel Cost			___ ___ ___ ___ Birr	
	E	Accommodation cost			___ ___ ___ ___ Birr	
	F	How many adults accompanied you?			___ ___ adults	
	G	Total time taken with HEW / at health post (includes waiting, consultation and investigations)			___ ___ hours	
	H	Total cost of medication and investigations			___ ___ ___ ___ Birr	
8002_1	Health center	Yes	1			
		No	0	If no, → 8003_1		

		A	How many times? (in last 3 months)			___ ___ times
		B	Time taken for travel (both ways)			___ ___ hours
		C	Travel cost			___ ___ ___ ___ Birr
		D	Accommodation cost			___ ___ ___ ___ Birr
		E	How many adults accompanied you?			___ ___ adults
		F	Total time taken at health center (includes waiting, consultation and investigations)			___ ___ hours
		G	Total cost of medication and investigations			___ ___ ___ ___ Birr
8003_1	Public hospital (for out-patient care)			Yes	1	If no, → 8004_1
				No	0	
		A	How many times? (in last 3 months)			___ ___ times
		B	Time taken for travel (both ways)			___ ___ hours
		C	Travel cost			___ ___ ___ ___ Birr
		D	Accommodation cost			___ ___ ___ ___ Birr
		E	How many adults accompanied you?			___ ___ adults
		F	Total time taken at hospital (includes waiting, consultation and investigations)			___ ___ hours
		G	Total cost of medication and investigations			___ ___ ___ ___ Birr
8004_1	Private / NGO Hospital (for out-patient care			Yes	1	If no, → 8005_1
				No	0	
		A	How many times? (in last 3 months)			___ ___ times
		B	Time taken for travel (both ways)			___ ___ hours
		C	Travel cost			___ ___ ___ ___ Birr
		D	Accommodation cost			___ ___ ___ ___ Birr
		E	How many adults accompanied you?			___ ___ adults
		F	Total time taken at hospital (includes waiting, consultation and investigations)			___ ___ hours
		G	Total cost of medication and investigations			___ ___ ___ ___ Birr
8005_1	Private clinic (out-patient service)			Yes	1	If no, → 8006_1
				No	0	

		A	How many times? (in last 3 months)		___ ___ times
		B	Time taken for travel (both ways)		___ ___ hours
		C	Travel cost		___ ___ ___ ___ Birr
		D	Accommodation cost		___ ___ ___ ___ Birr
		E	How many adults accompanied you?		___ ___ adults
		F	Total time taken at private clinic (includes waiting, consultation and investigations)		___ ___ hours
		G	Total cost of medication and investigations		___ ___ ___ ___ Birr
8006_1	Pharmacy / drug vender		Yes	1	If no, → 8007_1
			No	0	
		A	How many times? (in last 3 months)		___ ___ times
		B	Time taken for travel (both ways)		___ ___ hours
		C	Travel cost		___ ___ ___ ___ Birr
		D	Accommodation cost		___ ___ ___ ___ Birr
		E	How many adults accompanied you?		___ ___ adults
		F	Total time taken at pharmacy		___ ___ hours
		G	Total cost of medication and investigations		___ ___ ___ ___ Birr
8007_1	Holy water		Yes	1	If no, → 8008_1
			No	0	
		A	How many times? (in last 3 months)		___ ___ times
		B	Time taken for travel (both ways)		__ ___ hours
		C	Travel cost		___ ___ ___ ___ Birr
		D	Accommodation cost		___ ___ ___ ___ Birr
		E	How many adults accompanied you?		___ ___ adults
		F	Total time spent at holy water (for all visits in the last 3 months)		___ ___ hours
		G	Total cost of consultation and intervention		___ ___ ___ ___ Birr
8008_1	Religious leader or priest		Yes	1	If no, → 8009_1
			No	0	
		A	How many times? (in last 3 months)		___ ___ times

		B	Time taken for travel (both ways)			___ ___ hours
		C	Travel cost			___ ___ ___ ___ Birr
		D	Accommodation cost			___ ___ ___ ___ Birr
		E	How many adults accompanied you?			___ ___ adults
		F	Total time taken with priest / religious leader / healer (includes waiting and consultation)			___ ___ hours
		G	Total cost of consultation and intervention			___ ___ ___ ___ Birr
8009_1	Muslim healer / Kalicha		Yes	1	if no, → 8010_1	
			No	0		
		A	How many times? (in last 3 months)			___ ___ times
		B	Time taken for travel (both ways)			___ ___ hours
		C	Travel cost			___ ___ ___ ___ Birr
		D	Accommodation cost			___ ___ ___ ___ Birr
		E	How many adults accompanied you?			___ ___ adults
		F	Total time taken with kalicha (includes waiting and consultation)			___ ___ hours
		G	Total cost of consultation and intervention			___ ___ ___ ___ Birr
8010_1	Herbalist		Yes	1	If no, → 2311	
			No	0		
		A	How many times? (in last 3 months)			___ ___ times
		B	Time taken for travel (both ways)			___ ___ hours
		C	Travel cost			___ ___ ___ ___ Birr
		D	Accommodation cost			___ ___ ___ ___ Birr
		E	How many adults accompanied you?			___ ___ adults
		F	Total time taken with herbalist (includes waiting and consultation)			___ ___ hours
		G	Total cost of consultation and intervention (e.g. herbal remedy)			___ ___ ___ ___ Birr
8011_1	Wogesha		Yes	1	If no, → 2312	
			No	0		
		A	How many times? (in last 3 months)			___ ___ times
		B	Time taken for travel (both ways)			___ ___ hours

		C	Travel cost			___ ___ ___ ___ Birr
		D	Accommodation cost			___ ___ ___ ___ Birr
		E	How many adults accompanied you?			___ ___ adults
		F	Total time taken with wogesha (includes waiting, consultation)			___ ___ hours
		G	Total cost of consultation and intervention			___ ___ ___ ___ Birr
8012_1	Sorcerer (Tenquaye)		Yes	1		
			No	0	If no, → 2313	
		A	How many times? (in last 3 months)			___ ___ times
		B	Time taken for travel (both ways)			___ ___ hours
		C	Travel cost			___ ___ ___ ___ Birr
		D	Accommodation cost			___ ___ ___ ___ Birr
		E	How many adults accompanied you?			___ ___ adults
		F	Total time taken with Tanquaye (includes waiting, consultation)			___ ___ hours
		G	Total cost of consultation and intervention			___ ___ ___ ___ Birr
8013_1	Another traditional healer		Yes	1		
			No	0	If no, → 2314	
	A	How many times? (in last 3 months)				___ ___ times
	B	Time taken for travel (both ways)				___ ___ hours
	C	Travel cost				___ ___ ___ ___ Birr
	D	Accommodation cost				___ ___ ___ ___ Birr
	E	How many adults accompanied you?				___ ___ adults
	F	Total time taken with traditional healer (includes waiting, consultation)				___ ___ hours
	G	Total cost of consultation and any intervention				___ ___ ___ ___ Birr
8014_1	In the past 12 months, have you needed any in-patient care for a health problem?		Yes	1	If no, thank the participant and proceed to the Caregiver Questionnaires	
			No	0		
8015_1	Public / government hospital?		Yes	1		
			No	0	If no, → 8016_1	
	A	In the past 12 months, how many times were you in hospital? (as an in-patient)				___ ___ times

	B	In the past 12 months, how many days (IN TOTAL) were you in hospital (as an in-patient)?				__ ___ ___ total number of days
	C	Time taken for travel (both ways)				___ ___ hours
	D	Travel Cost				___ ___ ___ ___ Birr
	E	Accommodation cost				__ ___ ___ ___ Birr
	F	How many days did any adult stay with you?				___ ___ ___ adults
					Adult 1	___ ___ days
					Adult 2	___ ___ days
					Adult 3	___ ___ days
	G	Total cost of medication and investigations and procedures				___ ___ ___ ___ Birr
9001	Public / government /Mental health hospital?		Yes	1	If no, thank the participant and proceed to the Caregiver Questionnaires	
			No	0		
9001_1	A	In the last 12 months, how many times were you in hospital? (as an in-patient)				___ ___ times
	B	In the last 12 months, how many days (IN TOTAL) were you in hospital (as an in-patient)?				___ ___ ___ total number of days
	C	Time taken for travel (both ways)				___ ___ hours
	D	Travel Cost				___ ___ ___ ___ Birr
	E	Accommodation cost				___ ___ ___ ___ Birr
	F	How many days did any adult stay with you?				__ ___ adults
					Adult 1	___ ___ days
					Adult 2	___ ___ days
					Adult 3	___ ___ days
	G	Total cost of medication and investigations and procedures				___ ___ ___ ___ Birr
9001_1	A	Is there anybody who helped you or taught you, about mental disorders how could prevent or how it looks like?				Yes
						No
						I don t remember
9002_1	B	Do you know where to go if you feel distress or feeling that you are going to have mental illness				Yes
						No
9003_1	C	If yes for Q 9002_1, where are you preferring to go get rid of mental illness.				Religious leaders /Muslim, Christian holy water.
						Traditional healer
						WHDA or HEW

			Health center/Hospital /pharmacy

ANNEXURE 11: Phase 1: Survey questionnaire local language (OROMIFFA)

Survey question/ Bar-gaaffii

Phase 1 study/ Qorannoo Gulantaa Duraa

Q0001	Participant Identification Number/adda footuu/baastuu hirmaattotaa				

Q0002	Phase of recruitment/ Gulantaa calallii	Guluntaa 1	1

Unka 1: Haala hawaasummaa, jireenyaa fi maalummaa hirmaattotaa

Form 1: SOCIO-DEMOGRAPHIC DETAILS/ Unka 1: Haala hawaasi-maalumma hirmaatichaa gad-fageenyaan			
1001_1	Waggaa 1 asi (ji'a 12 asi) Oromiyaa keessa jiraataa jirta? Are you living in Oromia since the past 12 months? And are going to live the coming 6 months in the same area?	Eeyyee	1
		Lakkii	0
	Yoo deebin "Lakkii" ta'ee namni kun qorrannicha irratti hirmaachuu hin danda'u		
1002_1	Umuriin kee hgami/ waggaan/ganni kee meeqa? How old are you?	___ ___ waggaa _____	
1003_1	Barreessuu fi waan barreeffame dubbisuu ni dandeessaa? Are you able to read and write?	Eeyyee	1
		Lakkii	0
1004_1	Barnoota irra waggaa meeqaf turte? How many years of education have you completed? (state exact number)	___ ___ Waggaa_____	
1005_1	Haalli gaa'ila kee maal fakkaata? What is your marital status?	Kan hinfuune/hin heerumne	1
		Kan heerumete/fuudhe	2
		Waliin jiraanna garuu seeran wali hin fuune	3
		Divorced/ Kan seeran adda baayan	4
		Widowed/ haadha hiyyeessa/kan haati warraa jala duute	5
		Separated/ Kan hiikte/hike	6
1006_1	Sabbummaan keen maalinni? What is your ethnicity?	Oromoo	1
		Amaara/Sidaama	2
		Tigree/Tirgee	3
		SSNPR/ Warra kibbaa	4
		Somali/Soomaalii	5
		Other (specify) Kan Biraa (Ibsi)_____	6
1007_1	What is your religion? Waldaa amantaa kam keessa jirta?	Orthodox Christian/ Ortodoksii- kiristaana	1
		Muslim/ Islaamaa	2

		Protestant Christian/ Protestaantii-Kiristaana	3
		Catholic/Kaatolikii	4
		Waaqeffannaa /Other (specify)_____	5
1008_1	Where do you live? Essa jiraatta?	Urban/Magaalaa	1
		Rural/Baadiyyaa	2
1009_1	How many adults (18 years or over) live in your home (excluding patient)? Nama dhukkubsatu osoo hin dabalatin ga'eessota (Kan umriin 18f sanaa oli ta'e) meeqatu mana keessan keessa jira (waliin jiraattu)? (kan u)	___ ___adults (18 years or over) Ga'eessota (umuriin 18 >=)	
1010_1	How many children (under 18 years) live in your home? Maatii keessan keessa daa'imni/ijoollen (kan umuriin isaanii 18 gadi ta'e) nama meeqatu jira?	___ ___ daa'ima/ijoollee (<18 years)	

Unka 2: GENERALISED ANXIETY DISORDER/ Cinqama/dhiphina/sodaa/oormaa/yaaddoo dimshaashaa 7 (GAD 7)			
	This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.nsa Bar-gaaffiin kunuunsa fayyaa gaarii aa argachuuf qaama baay'ee barbaachisaadha. Deebin ati deebistu rakkina ati qabdu akka beeknuf/hubannuuf sirriitti nu gargaara. Gaaffii mara amma dandeessu haqumaan deebisi. Over the last 2 weeks, how often have you been bothered by any of the following problems? Torban lamaan darban kana keessa waantota (rakkoolewwan) armaan gadii irratti ammam yaadda'aa/sodaachaa turte?		
2001_1	Feeling nervous anxiety or on edge ..... Cinqamuu/dhiphachuu/sodaachuu/oormaa/yaaddahuu	Not at all /Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ walakkaan oli (harka caalu) ni jira	2
		Nearly every day /Guyyuma maraa ni jira jechuun ni danda'ama	3
2002_1	Not being able to stop or control worrying..... Oormaa/sodaa/yaaddoo koo to'achuu dadhabuu	Not at all /Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ walakkaan oli (harka caalu) ni jira	2
		Nearly every day /Guyyuma maraa ni jira jechuun ni danda'ama	3
2003_1	Worrying too much about different things.... Waantota adda adda irratti haalan yaadda'uu (oormaa/soda/dhiphina cimaa keessa jiraachuu)	Not at all /Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ walakkaan oli (harka caalu) ni jira	2
		Nearly every day /Guyyuma maraa ni jira jechuun ni danda'ama	3
2004_1	Trouble relaxing ..... Bohaaruu/bashannanuu/gammaduu/taphachuu dadhabuu	Not at all /Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ walakkaan oli (harka caalu) ni jira	2
		Nearly every day /Guyyuma maraa ni jira jechuun ni danda'ama	3
2005_1	Being so restless that it is hard to sit still.....	Not at all /Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1

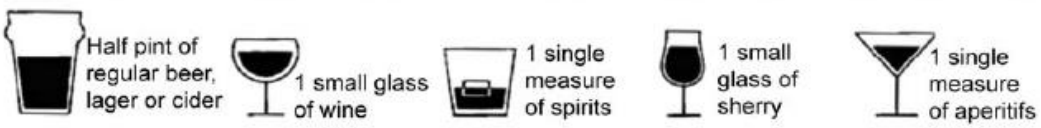
	Boqonnaa sammuu/qalbii/yadaa dhabuu irraa kan ka'e gad-taa'uu dhiisuu	More than half the days/ walakkaan oli (harka caalu) ni jira	2
		Nearly every day /Guyyuma maraa ni jira jechuun ni danda'ama	3
2006_1	Becoming easily annoyed or irritable..... Waanuma salphaaf (akkuma salphaatii) aaruu/dallanuu/	Not at all /Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ walakkaan oli (harka caalu) ni jira	2
		Nearly every day /Guyyuma maraa ni jira jechuun ni danda'ama	3
2007_1	Feeling afraid as if something awful might happen Waan badaa/gadhee/fokkisaa wayiitu raawwatuuf/ta'uuf/uumamuuf deema jedhanii yaadda'uu/sodaachuu/ooruu/saalfachuu	Not at all /Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ walakkaan oli (harka caalu) ni jira	2
		Nearly every day /Guyyuma maraa ni jira jechuun ni danda'ama	3
	GAD-7 Score =_____ + _____ + _____		

FORM 3: PAITENT HEALTH QUESTINNEIRE (PHQ 9): (SCPMCMDPHASE 1 QUESTIONNAIRE)/ Unka 3: bar-gaaffii haala fayyaa yaalamaa/mtuu (dhukkubsataa/ttuu) [PH 9]			
	During the last 4 weeks, how much have you been bothered by any of the following problems? Torban afran darban kana keessa waantota (rakkoolewwan) armaan gadii irratti ammam yaadda'aa/sodaachaa turte?		
3001_1	Little interest or pleasure in doing things…… Waantota adda addaa hojjachuu/dalaguu irratti fedhii xiqqoo qabaachuu ykn gammaduu dhabuu/dhiisuu	Not at all/ Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ Walakkaan oli (harka caalu) ni jira	2
		Nearly every day / Guyyuma maraa ni jira jechuun ni danda'ama	3
3002_1	Feeling down, depressed, or hopeless…… Abdii kutannaa, mukaawuu, of-jibbuu.....	Not at all/ Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ Walakkaan oli (harka caalu) ni jira	2
		Nearly every day / Guyyuma maraa ni jira jechuun ni danda'ama	3
3003_1	Trouble falling or staying asleep, or sleeping too much Hirribi nama qabuu diduu, kan barbaadamuu ol rafuu, hirriba keessaa jeeqamuu/tasgabbayanii rafuu dadhabuu	Not at all/ Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ Walakkaan oli (harka caalu) ni jira	2
		Nearly every day / Guyyuma maraa ni jira jechuun ni danda'ama	3
3004_1	Feeling tired or having little energy..... Dadhabbii namattii dhagayamuu/ laafuu/ human dhabuu	Not at all/ Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ Walakkaan oli (harka caalu) ni jira	2
		Nearly every day / Guyyuma maraa ni jira jechuun ni danda'ama	3
3005_1	Poor appetite or overeating..... Fedhiin waa nyaachuu gad-bu'uu, kan barbaadamuu ol nyaachuu	Not at all/ Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	2
		More than half the days/ Walakkaan oli (harka caalu) ni jira	2
		Nearly every day / Guyyuma maraa ni jira jechuun ni danda'ama	3
3006_1	Feeling bad about yourself — or that you are a failure or have let yourself or your family down. Ilaalchi/bakki ofiif qabdu gad'bu'uu, of-jibbuu, akka namaa gadiitti of ilaaluu, akka nama milkaa'uu hin dandeenyetti of ilaaluu ykn	Not at all/ Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ Walakkaan oli (harka caalu) ni jira	2
		Nearly every day / Guyyuma maraa ni jira jechuun ni danda'ama	3
3007_1	Trouble concentrating on things, such as reading the newspaper or watching television ..... Tasgabbayanii waan tokko irratti (fkn. Galaalcha/baarullee dubbisuu, televizhiinii ilaaluu ....)xiyyeeffachuu dadhabuu irratti rakkina qabaachuu	Not at all/ Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ Walakkaan oli (harka caalu) ni jira	2
		Nearly every day / Guyyuma maraa ni jira jechuun ni danda'ama	3
3008_1		Not at all/ Gonkumaa hin jiru	0

	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual…… Suuta deemuu ykn dubbachuu ykn ammo faallaa kanaa: baay'ee ariifatanii dubbachuu, jarjartiin adeemuu, kan barameen ala nannaawaa tokkotti marmaaruu ..... (Haala namni biraa hubachuu danda'uun)	Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ Walakkaan oli (harka caalu) ni jira	2
		Nearly every day / Guyyuma maraa ni jira jechuun ni danda'ama	3
3009_1	Thoughts that you would be better off dead of or hurting yourself in some way……	Not at all/ Gonkumaa hin jiru	0
		Several days/ Guyyoota baay'ee ni jira	1
		More than half the days/ Walakkaan oli (harka caalu) ni jira	2
		Nearly every day / Guyyuma maraa ni jira jechuun ni danda'ama	3
	PHQ-9 Score = _____		

Form 4: Fast Alcohol Screening Test/ Unka 4:

This is one unit of alcohol…Kanneen armaan gadii alkoolii yuunitii 1



…and each of these is more than one unit/ warri kanaa gadii marti isaanii ammoo alkoolii yuunitii 1 oli.

4001_1	How often have you had 6 or more units (if female), or 8 or more units (if male), on a single occasion **in the past year**?	Never/ gonkumaa dhugee hin beeku	0
		Less than monthly/ darbee darbee- ji'a 1 ol fa'a turee	1

	Wagga 1 darbe keessatti al-tokkotti alkoolii yuunitii 6 fi sanaa oli (dubartootaaf), yuunitii 8 fi sanaa oli (dhiiraaf) hagam fudhatta/dhugda turte?	Monthly/ji'a ji'aan	2
		Weekly/ torbani torbanitti	3
		Daily or almost daily/ guyyuma guyyaan nan dhuga jechuun ni danda'ama	4
4002_1	Waggaa darbe keessa dhugaatii alkoolii irraa kan ka'e waan sirraa eegamu raawwachuu/dalaguu kan dadhabde hagami?	Never/ gonkumaa dhugee hin beeku	0
		Less than monthly/ darbee darbee- ji'a 1 ol fa'a turee	1
		Monthly/ji'a ji'aan	2
		Weekly/ torbani torbanitti	3
		Daily or almost daily/ guyyuma guyyaan nan dhuga jechuun ni danda'ama	4
4003_1	Waggaa darbe keessa waan dhugaa turteef waan halkan darbe raawwatame hagam dagatte?	Less than monthly/ darbee darbee- ji'a 1 ol fa'a turee	0
		Monthly/ji'a ji'aan	1
		Weekly/ torbani torbanitti	2
		Daily or almost daily/ guyyuma guyyaan nan dhuga jechuun ni danda'ama	3
		Never/ gonkumaa dhugee hin beeku	4
4004_1	Waggaa darbe keessa firoonni kee, michhuuwwan kee, hiriyoonni kee, doktarri ykn hojjataan fayyaa biroon waa'ee alkoolii dhuguu kee kanatti dhimmamaniiruu ykn ammo akka ati dhuguu dhiistu si gorsaniiruu?	No/ Lakkii	0
		Yes, but not in the last year/ Eeyyen, garuu waggaa darbe miti	2
		Yes, during the last year/ Eeyyen wagguma darbe keessa	4
4005_1	Add together the responses for 1001_1, 1002_1, 1003_1 and 1004_1 Total score (qabxii waliigalaa) ___ ___		

Form 5: CIDI Substance Use/Unka 5: gaafiwwan waa'ee araada waantota sammuu addoochanii qabaachuu

5001_1	In the past 12 months, have you used khat more than five times? / Ji'oota/baatiwwan 12 (waggaa 1) darban keessa jimaa/caatii yeroo 5ii ol qamaatertaa (itti fayyadamteertaa)?	Yes/Eeyyee	1	
		No/Lakkii	0	
	If no, → Form 600-1 / "Lakkii " yoo ta'e, gara Unka 6001 darbi (→ 600-1) If yes, → 5002_1/ "Eeyyee" yoo ta'e → 5002_1			
5002_1	Ji'oota 12 (waggaa 1) darban keessa yammuu jimaa/caatii baay'inaan fayyadamaa/qama'aa turte sana, yeroo hagamiin qama'aa turte?	Almost every day/ Guyyuma hunda jechuun ni danda'ama	1	
		3 or 4 days a week/ torbaniti guyyaa 3-4	2	
		1 or 2 days a week/ Torbanitti guyyaa 1-2	3	
		1 to 3 days a month/ Ji'atti guyyaa 1-3	4	
		Less than once a month Jiatii guyaa tokkoo gadii	5	
5003_1	When did you last use khat at all?/ Isa dhumaa jimaa/caatii kan qamaate yoomi?	___ ___ weeks ago/ Torban _____ dura		
5004_1	In the past 12 months, did using khat frequently interfere with your work at school, on a job or at home? Ji'oota 12 (waggaa 1) darban keessa jimaa irra deddeebitee fayyadamuun/qama'uun kee hojii kee mana baruumsaa, bakka dalagaa kee ykn ammo kan mana keetii irratti dhiibbaa taasisee/godhee/fidee turee?	Yes/Eeyyee	1	*
		No/Lakkii	0	
5005_1	In the past 12 months, has your use of khat led to problems with your family, friends, at work, or at school? Ji'oota 12 (waggaa 1) darban keessa jimaa/caatii fayyadamuun/qama'uun kee hariiroo ati maatii kee, michhuuwwan/hiriyoota kee, miiltowwan kee bakka hojii wajjin qabdu ykn mana baruumsaa keessatti qabdu irratti rakkoo uumee turee?	Yes/Eeyyee	1	*
		No/Lakkii	0	
5006_1	In the past 12 months, has your use of khat led to problems with the police? / Ji'oota 12 (waggaa 1) darban keessa jimaa/caatii fayyadamuun/qama'uun kee poolisii wajjin walitti si buusee turee?	Yes/Eeyyee	1	*
		No/Lakkii	0	
	If the answers to 5004_1, 5005_1 or 5006_1 are 'no' → 5008_1 Yoo deebin 5004_1, 5005_1 ykn 5006_1 "Lakkii" ta'ee, → 5008_1			

5007_1	In the past 12 months, did you continue to use khat after you knew that it was causing you any of these problems? Ji'oota 12 (waggaa 1) darban keessa jimaa/caatii fayyadamuun/qama'uun kee rakkoowwan armaan olitti eeraman sitti fiduu erga beekteellee, itti fayyadamuu isaa/qama'uu ittuma fuftee?	Yes/Eeyyee	1	* X Yoo "eeyyee" ta'e →1
		No/Lakkii	0	
5008_1	In the past 12 months, have there been times when you used khat in situations where you could get hurt—for example, when riding a bicycle, driving a vehicle, operating a machine, or anything else? / Ji'oota 12 (waggaa 1) darban kana keessa haalota balaarra si buusuu danda'an keessa osoo jirtuu yeroon ati jimaa fayyadamtee/qamaate ni jiraa? (Fkn bishikliitii oofaa, konkolaataa oofaa, maashiniirra hojjachaa ykn kan biro dalagaa)	Yes/Eeyyee	1	*
		No/Lakkii	0	
5009_1	In the past 12 months, did you find that you had to use much more khat than before to get the effect you wanted? / Ji'oota 12 (waggaa 1) darban kana keessa mirqaanaa/gammachuu/mukuu irraa bilisa ta'uf barbaaddu argachuuf, yeroon itti jimaa kanaan dura fayyadamtu caalaa si barbaachuse ni jiraa?	Yes/Eeyyee	1	X Yoo "eeyyee" ta'e →1
		No/Lakkii	0	
5010_1	In the past 12 months, did you find that the same amount of khat had less effect on you than it once did? / Ji'oota 12 (waggaa 1) darban kana keessa yeroon itti gammachuun/mirqaanan hangi jimaa kanaan dura fayyadamtuun walfakkaatu gadi ta'e si mudate jiraa?	Yes/Eeyyee	1	
		No/Lakkii	0	
5011_1	In the past 12 months, have you felt such a strong desire or urge to use khat that you could not keep from using it? / Ji'oota 12 (waggaa 1) darban kana keessa yeroon itti fedhiin cimaan jimaa qama'uu (kan gonkumaa jimaa fayyadamuu/qama'uu dhiisuu hin dandeenyee) si mudatee jiraa?	Yes/Eeyyee	1	*
		No/Lakkii	0	
5012_1	In the past 12 months, did you ever want khat so badly, that you could not think of anything else? / Ji'oota 12 (waggaa 1) darban kana keessa yeroon itti jimaa akka malee barbaaddee/soqxee gonkumaa waan biraa yaaduu dadhabdee ni jiraa?	Yes/Eeyyee	1	
		No/Lakkii	0	
5013_1	In the past 12 months, have you wanted to stop or cut down your use of khat? / Ji'oota 12 (waggaa 1) darban kana keessa jimaa fayyadamuu/qama'uu dhiisuf ykn addan kutuuf yaaltee turtee?	Yes/Eeyyee	1	X Yoo "eeyyee" ta'e → (1) yknaddaan kutuu hin
		No/Lakkii	0	
5014_1	When you cut down in the past 12 months, were you able to cut down khat for at least one month?	Yes/Eeyyee	1	
		No/Lakkii	0	

	/ Ji'oota 12 (waggaa 1) darban kana keessa yeroo jimaa qama'uu addan kutuuf yaalte sana, yoo xiqqaatee xiqqaate batii tokkoof addaan kutuu dandeessee turtee?	Unable to cut down for one month/ Baatii tokkoof addaan kutuu hin dandeenye.	2	dandeenye (2) → 1
5015_1	Ji'oota 12 (waggaa 1) darban kana keessa jimaa barbaaduf/soquuf, jimaa qama'uuf ykn mirqaanaa jimaaf jecha kan ati itti yeroo kee guddaa/olaanaa itti balleessite/dabarsite ni jiraa?	Eeyyee	1	X Yoo "eeyyee" ta'e →1
		Lakkii	0	
5016_1	Ji'oota 12 (waggaa 1) darban kana keessa yeroon itti jimaa hanga fayyadamuu/qamaa'uu barbaaddu ol qamaate ykn ammo yeroo dheeraa amma sillaa itti qama'uu barbaaddu ol itti balleessite/dabarsite ni jiraa?	Eeyyee	1	X Yoo "eeyyee" ta'e →1
		Lakkii	0	
5017_1	Baatiwwan darban 12 kana keessa jimaa/barcaa qama'uu/fayyadamuu eegaltee yeroon ati mirqaanaa ol-aanaa bira osoo hin ga'in dhiisuuf yaaltee rakkattee (dadhabde) ni jiraa?	Eeyyee	1	
		Lakkii	0	
5018_1	Baatiwwan 12 darban kana keessa yammuu jimaa qama'uu (fayyadamuu) addaan kuttee (dhiistee) sana, mallaattoowwan armaan gadiitti tarreeffaman si mudataniiruu?**(ol kaasi dubbisiif!)**	Eeyyee	1	X If either 5018_1 or 5019_1 is 'yes' → 1
		Lakkii	0	
	Dadhabbii cimaa/qaamni nama caccabuu Dafquu/huuruu Gad-teessisaa/gara-yaasaa/albaasuu Yaadda'uu/ooruu/sodaachuu/cinqamuu Mukaawuu/gadduu/mataan-gad-nama-cabuu Aaruu/dallanuu/nyakanyakuu Boqonnaa dhabuu/jeeqamuu/tasgabbii dhabuu Hirriba dhabuu/hirriba irratti jeeqamuu Kirkiruu (harki si hollachuu/kirkiruu/urgufamuu) Dhukkubbii garaa/garaan si dhukkubuu Bowwaafannaa mataa (mataan si bowwaafachuu) Laafuu Lollucuu ykn haqqisuu/hoqqisuu/gad-deebisiisuu Gaggabdoo/ofi wallaalanii kufuu Qaamni si adooduu/maashaan kee si dhukkubuu Imimmaan harcaasuu/ijji si boowuu/funyaaniin dhangala'aan si yaa'uu Irra deddeebi'anii amuummachuu/ baay'isuu Waa argachuuf akka malee dharra'uu/hawwuu Waan qabatamaan hin-jirre (hin mul'anne) arguu ykn sagalee qabatamaan hin-jirre dhagayuu Rukuttaan onnee dabaluu (saffisaa rukuchuu) Fedhiin waa nyaachuu jijjiiramuu/hir'achuu Hoo'inni qaamaa keetii dabaluu (gubaa qaamaa)			
5019_1	In the past 12 months, did you use khat or another drug just like it to keep from having problems?	Eeyyee	1	
		Lakkii	0	

	Baatiwwan darban 12 kana keessa rakkoolee adda addaa irraa of ittisuuf jecha jimaa ykn waantota sammuu nama adoocha kan biroo fayyadamtee ni beektaa?			
5020_1	Baatiwwan darban 12 kana keessa jimaa fayyadamuu keerraa kan ka'e si dhukkubee (dhukkuba qaamaa) beekaa?	Eeyyee	1	*
		Lakkii	0	
5021_1	Baatiwwan darban 12 kana keessa jimaa qama'uun akka si miidhu/dhukkubsu (dhukkubbii qaama armaan olitti kaasne) erga beekte boodallee jimaa qama'uu/fayyadamuu ittuma fuftee?	Eeyyee	1	* X Yoo "eeyyee" ta'e →1
		Lakkii	0	
5022_1	Baatiwwan 12 darban kana keessa jimaa fayyadamuu keetirraa kan ka'e rakkoolee currisaa fi qor-qalbiin walqabatan (saayikolojii) kan akka hojiiwwan kee idilee irratti fedhii dhabuu, yeroo baay'ee yaadda'uu/sodaachuu/dawwaawuu; shakkii baay'isuu ykn nama amanuu dadhabuu; waan badaa , kan hin eegamne yaaduu... fi kkf si mudatanii beekuu?	Eeyyee	1	*
		Lakkii	0	
5023_1	Baatiwwan darban 12 kana keessa jimaa qama'uun akka si miidhu/dhukkubsu (rakkoolee currisaa fi qor-qalbii waliin walitti hidhatan armaan olitti kaasne) erga beekte boodallee jimaa qama'uu/fayyadamuu ittuma fuftee?	Eeyyee	1	* X If 'yes' →1
		Lakkii	0	
5024_1	Baatiwwan darban 12 kana keessa jimaa qama'uuf/fayyadamuuf ykn ammo argachuuf jecha hojiiwwan siif akkaan barbaachisoo ta'an kan akka dalagee keetii, jiruu hawwaasummaadhaa ... fi kkf wayi dhiistee/dhaabdee ykn ammo haalan gad xiqqeessitee?	Eeyyee	1	* X If 'yes' → 1
		Lakkii	0	
5025_1	Baatiwwan 12 darban kana keessa jimaa fayyadamuuf/qama'uuf jecha hojiiwwan barbaachisoo ta'an baatii tokko guutuuf ykn ammo ji'a lama keessaatti yeroo hedduuf dhiisterta ykn haalan gad-xiqqeessiteertaa?	Eeyyee	1	
		Lakkii	0	

Unka 6: Haala Hawaas-dinagde			
6001_1	Hojiin/dalagaan kee idilee maali?	Qaxaramaa (hojii dhuufaa ofiis ta'uu mala)	1
		Qonnaan bulaa	2
		Haadha warra mana keessa tajaajiltu	3
		Barataa/ttuu	4
		Kan hojii/dalagaa hin qabne	5
		Kan biroo (ibsi)_____	6
6002_1	Dalagaan/hojiin idilee nama maatii kana gargaaruu (qarshii ykn galii biroo argatuun ta'uu mala)maali?	Qaxaramaa (hojii dhuufaa ofiis ta'uu mala)	1
		Qonnaan bulaa	2
		Haadha warra mana keessa tajaajiltu	3

		Barataa/ttuu	4
		Kan hojii/dalagaa hin qabne	5
		Kan biroo (ibsi)_____	6
6003_1	Maddi bishaan dhugaatii maatii keeti irra-caalaatti kami/maali?	Bishaan laga yaa'uu	1
		Eela dallaa qabuu (kan eegamu)	2
		Eela dallaa hin qabne (kan hin eegamne)	3
		Haroo ykn bishaan kuufame	4
		Bishaan ujummoo	5
		Burqaa bishaanii uumamaa dalla hin qabne (kan hin eegamne)	6
		Burqaa bishaanii uumamaa dalla qabu (kan eegamu)	7
		Kan biroo (ibsi)_____	8
6004_1	Gosa mana fincaanii isa kami maatin kee irra-caalaa fayyadama?	Mana fincaanii bishaan qabu (kan dalagu)	1
		Mana fincaanii bishaan qabu (kan hin dalagne)	2
		Bool'a mana fincaanitiif gad qotame(kan dalagu)	3
		Bool'a mana fincaanitiif gad qotame(kan hin dalagne)	4
		Raasaa/bakkee/goodaa/urufa	5
		Kan biroo (ibsi)_____	6
6005_1	Mattin kee mana fincaanii kana maatii biro wajjin walitti fayyadamuu?	Eeyyee	1
		Lakkii	0
6006_1	Maatin kee ibsaa/ifaa/korreentii ni qabuu?	Eeyyee	1
		Lakkii	0
6007_1	Maatiin kee raadiyoo ni qabuu?	Eeyyee	1
		Lakkii	0
6008_1	Miseensa maatii keetii keessaa namni bilbila mobaayilii qabu jiraa?	Eeyyee	1
		Lakkii	0
6009_1	Mana ykn kutaa-manaa wayii kan of-danda'e bakka itti nyaata bilcheeffattan ni qabduu?	Eeyyee	1
		Lakkii	0
6010_1	Baaxin mana keessan maali? [Waan baaxin manichaa irraa tolfame ilaali]	Citaa, dhallaaduu ykn galabaa/gaabaa goggogaa	1
		Qorqorroo ykn sibiilaa	2
		Kan biroo(ibsi)_____	3
6011_1	Baatii darbe kana keessa maatii keessan keessaa -sis dabalatee, waanti nyaatan (qabeenyi) dhabamuu irraa kan ka'e namni beelaye jiraa?	Eeyyee	1
		Lakkii	0
6012_1	Compared to other people in your sub-district *(kebele)*, do you think you have the same amount of money? Less money? Or more money? Hangi/baay'inni maallaqaa/qarshii maatiii keetii yammuu namoota biroo (warra olla/ganda/aanaa keessanii) wajjin wal-bira qabamee laalamu maal fakkata?	Warra kaanii gadi	1
		Warra kaanii oli	2
		Kan warra kaanii wajjin walqixa	3
6013_1	Sirra ykn maatii keerra liqaan/idaan ofirraa kanfaluu hin dandeenyewayii ni jiraa?	Eeyyee	1
		Lakkii	0
6014_1	Yeroo rakkoo/hatattamaa/muddamaa ykn ammo yeroo balaan wayii uumame, ofuma kootif	Eeyyee	1
		Lakkii	0

	maallaqa barbaachisu walitti qabee maatii kana turban afuriif (4) nyaatan nan danda'a jettee yaaddaa?		

Unka 7: Oslo-3 Sfartuu Gargaarsa Hawaasummaa (SCPMCMD Bar-gaaffii gulantaa 1)		
7001_1	Namoota baay'ee sittiidhiyaatan kan yoo rakkoo jabduun/cimaan si mudate waammachuu dandeessu meeqa qabda?	
	Homaa hin qabu	1
	1 ykn 2	2
	3 - 5	3
	jahaaf sana oli (>= 6)	4
7002_1	Wantota ati hojjattuuf namootni biroo hagam/ammam dhimmamu/quuqamu?	
	Quuqama/dhimmama fi fedhii guddaa ni qabu	5
	Quuqama/dhimmama fi fedhii amma tokko ni qabu	4
	Hin beekamu(beekuf/tilmaamuf rakkisaadha)	3
	Quuqama/dhimmama fi fedhii xiqqoo qabu	2
	Quuqama/dhimmama fi fedhii homaayyuu hin qaban	1
7003_1	Yoo rakkoon wayii si mudate, gargaarsa ollaa keerraa qabatamaan argachuun?	
	Baay'ee salphaadha	5
	Salphaadha	4
	Ni danda'ama	3
	Rakkisaadha	2
	Baay'ee Rakkisaadha	1

	Baatiwwan 3 darban kana keessa yammuu rakkinni fayyaa si mudate sana (dhukkubsatte), yaalif/waldhaanamuuf wiirtuwwan fayyaa (ogeessa fayyaa) armaan gadii bira qaaman dhaqxeertaa/deemtertaa? (Warra ciisanii yaalaman/wal-aanaman osoo hin dabalatin)					
8001_1	Hojjataa/ttuu Ikisteenshinii Fayyaa (HIF)	Eeyyee	1	“Lakkii” yoo ta’e, → 8002_1		
		Lakkii	0			
	A	Eessatti ilaalmte/yaalamte?		Keellaa Fayyaatti	1	
				Manatti	0	
	B	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)		Yeroo ___ ___		
	C	Adeemsa dhaqaa-galaaf sa’aatii meeqa sitti fudhate?		Sa’aatii___ ___		
	D	Geejibaaf/Imalaaf qarshii ammam kanfalte?		Qarshii___ ___ ___ ___		
	E	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?		Qarshii___ ___ ___ ___		
	F	Yammuu gara keellaa fayyaa deemtu sana nama ga’eessota meeqatu si gaggeesse?		Ga’eessota___ ___		
	G	Turtiin HIFwaliin keellaa fayyaatti goote kun (yeroo dabaree eeggattu, yeroo marii fi yeroo qorannoo fa’aa dabalatee) dimshaashumatti yeroo hagamii sitti fudhate?		Sa’aatii___ ___		
	H	Baasin dimshaashaa/waliigalaa Yaalii fi qorannoof baaste meeqa/hagami?		Qarshii ___ ___ ___ ___		
8002_1	Buufata/wiirtuu fayyaa	Eeyyee	1	“Lakkii” yoo ta’e, → 8003_1		
		Lakkii	0			
	A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)		Yeroo ___ ___		
	B	Adeemsa dhaqaa-galaaf sa’aatii meeqa sitti fudhate?		Sa’aatii___ ___		
	C	Geejibaaf/Imalaaf qarshii ammam kanfalte?		Qarshii___ ___ ___ ___		
	D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?		Qarshii___ ___ ___ ___		
	E	Yammuu gara buufata fayyaa deemtu sana nama ga’eessota meeqatu si gaggeesse?		Ga’eessota___ ___		
	F	Turtiin ati buufata fayyaatti goote kun (yeroo dabaree eeggattu, yeroo marii fi yeroo qorannoo fa’aa dabalatee) dimshaashumatti yeroo hagamii sitti fudhate?		Sa’aatii___ ___		
	G	Baasin dimshaashaa/waliigalaa Yaalii fi qorannoof baaste meeqa/hagami?		Qarshii ___ ___ ___ ___		
8003_1	Hospitaala Ummataa (deddeebi’anii yaalamtootaaf)	Eeyyee	1	“Lakkii” yoo ta’e, → 8004_1		
		Lakkii	0			
	A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)		Yeroo ___ ___		
	B	Adeemsa dhaqaa-galaaf sa’aatii meeqa sitti fudhate?		Sa’aatii___ ___		

		C	Geejibaaf/Imalaaf qarshii ammam kanfalte?			Qarshii___ ___ ___ ___
		D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?			Qarshii___ ___ ___ ___
		E	Yammuu gara hospitaalaa deemtu sana nama ga'eessota meeqatu si gaggeesse?			Ga'eessota___ ___
		F	Turtiin ati hospitaalatti goote kun (yeroo dabaree eeggattu, yeroo marii fi yeroo qorannoo fa'aa dabalatee) dimshaashumatti yeroo hagamii sitti fudhate?			Sa'aatii___ ___
		G	Baasin dimshaashaa/waliigalaa Yaalii fi qorannoof baaste meeqa/hagami?			Qarshii ___ ___ ___ ___
8004_1	Hospitaala dhuunfaa/DhMT (deddeebi'anii yaalamtootaaf)		Yes	1	"Lakkii" yoo ta'e, → 8005_1	
			No	0		
		A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)			Yeroo ___ ___
		B	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?			Sa'aatii___ ___
		C	Geejibaaf/Imalaaf qarshii ammam kanfalte?			Qarshii___ ___ ___ ___
		D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?			Qarshii___ ___ ___ ___
		E	Yammuu gara hospitaalaa deemtu sana nama ga'eessota meeqatu si gaggeesse?			Ga'eessota___ ___
		F	Turtiin ati hospitaalatti goote kun (yeroo dabaree eeggattu, yeroo marii fi yeroo qorannoo fa'aa dabalatee) dimshaashumatti yeroo hagamii sitti fudhate?			Sa'aatii___ ___
		G	Baasin dimshaashaa/waliigalaa Yaalii fi qorannoof baaste meeqa/hagami?			Qarshii ___ ___ ___ ___
8005_1	Kilinika dhuunfaa (deddeebi'anii yaalamtootaaf)		Eeyyee	1	"Lakkii" yoo ta'e, → 8006_1	
			Lakkii	0		
		A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)			Yeroo ___ ___
		B	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?			Sa'aatii___ ___
		C	Geejibaaf/Imalaaf qarshii ammam kanfalte?			Qarshii___ ___ ___ ___
		D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?			Qarshii___ ___ ___ ___
		E	Yammuu gara kiliinikaa deemtu sana nama ga'eessota meeqatu si gaggeesse?			Ga'eessota___ ___
		F	Turtiin ati kilinka dhuunfatti goote kun (yeroo dabaree eeggattu, yeroo marii fi yeroo qorannoo fa'aa dabalatee) dimshaashumatti yeroo hagamii sitti fudhate?			Sa'aatii___ ___
		G	Baasin dimshaashaa/waliigalaa yaalii fi qorannoof baaste meeqa/hagami?			Qarshii ___ ___ ___ ___
8006_1	Mana-qorichaa /Faarmaasii/warra qorsa/dawwaa kennan		Eeyyee	1	"Lakkii' yoo ta'e, → 8007_1	
			Lakkii	0		

		A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)			Yeroo ___ ___
		B	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?			Sa'aatii___ ___
		C	Geejibaaf/Imalaaf qarshii ammam kanfalte?			Qarshii___ ___ ___ ___
		D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?			Qarshii___ ___ ___ ___
		E	Yammuu gara man-qorichaa deemtu sana nama ga'eessota meeqatu si gaggeesse?			Ga'eessota___ ___
		F	Turtiin ati faarmaasitti goote yeroo hagamii sitti fudhate?			Sa'aatii___ ___
		G	Baasin dimshaashaa/waliigalaa yaalii fi qorannoof baaste meeqa/hagami?			Qarshii ___ ___ ___ ___
8007_1	Xabala		Eeyyee	1	"Lakkii" yoo ta'e, → 8008_1	
			Lakkii	0		
		A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)			Yeroo ___ ___
		B	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?			Sa'aatii___ ___
		C	Geejibaaf/Imalaaf qarshii ammam kanfalte?			Qarshii___ ___ ___ ___
		D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?			Qarshii___ ___ ___ ___
		E	Yammuu gara Xabalaa deemtu sana nama ga'eessota meeqatu si gaggeesse?			Ga'eessota___ ___
		F	Turtiin ati faarmaasitti goote yeroo hagamii sitti fudhate?			Sa'aatii___ ___
		G	Baasiin waliigalaa gorsaa fi tajaajila achii argatteef baaste/kanfalte hagami?			Qarshii ___ ___ ___ ___
8008_1	Ooggantoota waldaa amantii Kirstaanaa/Qeesii		Eeyyee	1	"Lakkii" yoo ta'e, → 8009_1	
			Lakkii	0		
		A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)			Yeroo ___ ___
		B	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?			Sa'aatii___ ___
		C	Geejibaaf/Imalaaf qarshii ammam kanfalte?			Qarshii___ ___ ___ ___
		D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?			Qarshii___ ___ ___ ___
		E	Yammuu achi deemtu sana nama ga'eessota meeqatu si gaggeesse?			Ga'eessota___ ___
		F	Turtiin ati Qeesicha/oogganaa waldaa amantii/fayyisaa waliin goote (kan dabaree itti eeggattee fi yeroo marii/gorsaa dabalatee) yeroo hagamii sitti fudhate?			Sa'aatii___ ___
		G	Baasiin waliigalaa gorsaa fi tajaajila achii argatteef baaste/kanfalte hagami?			Qarshii ___ ___ ___ ___
8009_1	Oogganaa Amantii Islaamaa Shekkota/fayyisaa ykn Qaallichaa		Eeyyee	1	"Lakkii" yoo ta'e, → 8010_1	
			Lakkii	0		

		A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)			Yeroo ___ ___
		B	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?			Sa'aatii___ ___
		C	Geejibaaf/Imalaaf qarshii ammam kanfalte?			Qarshii___ ___ ___ ___
		D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?			Qarshii___ ___ ___ ___
		E	Yammuu achi deemtu sana nama ga'eessota meeqatu si gaggeesse?			Ga'eessota___ ___
		F	Total time taken with kalicha (includes waiting and consultation) Turtiin ati Sheekkicha/oogganaa amantii Islaamaa/fayyisaa ykn Qaallichaa waliin goote (kan dabaree itti eeggattee fi yeroo marii/gorsaa dabalatee) yeroo hagamii sitti fudhate?			Sa'aatii___ ___
		G	Baasiin waliigalaa gorsaa fi tajaajila achii argatteef baaste/kanfalte hagami?			Qarshii ___ ___ ___ ___
8010_1	Warra mukaa fi biqiltuu addaa addaa irraa qorsa qopheessan (Qorsa Aadaa)			Eeyyee	1	"Lakkii" yoo ta'e, → 2311
				Lakkii	0	
		A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)			Yeroo ___ ___
		B	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?			Sa'aatii___ ___
		C	Geejibaaf/Imalaaf qarshii ammam kanfalte?			Qarshii___ ___ ___ ___
		D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?			Qarshii___ ___ ___ ___
		E	Yammuu achi deemtu sana nama ga'eessota meeqatu si gaggeesse?			Ga'eessota___ ___
		F	Turtiin ati warra qorsa aadaa kennan waliin goote (kan dabaree itti eeggattee fi yeroo marii/gorsaa dabalatee) yeroo hagamii sitti fudhate?			Sa'aatii___ ___
		G	Baasiin waliigalaa gorsaa fi tajaajila achii argatteef baaste/kanfalte hagami (fkn. qoricha aadaa siif kennameef)?			Qarshii ___ ___ ___ ___
8011_1	Ogeeyyii nama cabe, miidhame, buqqa'e, wal-gadhiisefaa … dhidhiibbafii waan akkanaatin deebisan/fayyisan			Eeyyee	1	"Lakkii" yoo ta'e, → 2312
				Lakkii	0	
		A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)			Yeroo ___ ___
		B	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?			Sa'aatii___ ___
		C	Geejibaaf/Imalaaf qarshii ammam kanfalte?			Qarshii___ ___ ___ ___
		D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?			Qarshii___ ___ ___ ___

		E	Yammuu achi deemtu sana nama ga'eessota meeqatu si gaggeesse?				Ga'eessota___ ___
		F	Turtiin ati warra kana waliin goote (kan dabaree itti eeggattee fi yeroo marii/gorsaa dabalatee) yeroo hagamii sitti fudhate?				Sa'aatii___ ___
		G	Baasiin waliigalaa gorsaa fi tajaajila achii argatteef baaste/kanfalte hagami?				Qarshii ___ ___ ___ ___
8012_1	Warra Xonqaayii (daftaraa, warra seexana gabbaru)			Eeeyyee	1		
				Lakkii	0	"Lakkii" yoo ta'e, → 2313	
		A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)				Yeroo ___ ___
		B	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?				Sa'aatii___ ___
		C	Geejibaaf/Imalaaf qarshii ammam kanfalte?				Qarshii___ ___ ___ ___
		D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?				Qarshii___ ___ ___ ___
		E	Yammuu achi deemtu sana nama ga'eessota meeqatu si gaggeesse?				Ga'eessota___ ___
		F	Turtiin ati warra kana waliin goote (kan dabaree itti eeggattee fi yeroo marii/gorsaa dabalatee) yeroo hagamii sitti fudhate?				Sa'aatii___ ___
		G	Baasiin waliigalaa gorsaa fi tajaajila achii argatteef baaste/kanfalte hagami?				Qarshii ___ ___ ___ ___
8013_1	Fayyistoota aadaa kan biroo			Eeyyee	1		
				Lakkii	0	"Lakkii" yoo ta'e, → 2314	
		A	Yeroo meeqaf? (baatiwwan 3 darban kana keessa)				Yeroo ___ ___
		B	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?				Sa'aatii___ ___
		C	Geejibaaf/Imalaaf qarshii ammam kanfalte?				Qarshii___ ___ ___ ___
		D	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?				Qarshii___ ___ ___ ___
		E	Yammuu achi deemtu sana nama ga'eessota meeqatu si gaggeesse?				Ga'eessota___ ___
		F	Turtiin ati warra kana waliin goote (kan dabaree itti eeggattee fi yeroo marii/gorsaa dabalatee) yeroo hagamii sitti fudhate?				Sa'aatii___ ___
		G	Baasiin waliigalaa gorsaa fi tajaajila achii argatteef baaste/kanfalte hagami?				Qarshii ___ ___ ___ ___
8014_1	Baatiwwan 12 darban kana keessa rakkina fayyaa keetif wiirtuu fayyaa ciistee/achi turtee yaalamuuf barbaaddee (yaalamtee) turtee?			Eeyyee	1	"Lakkii" yoo ta'e deebin, hirmaaticha/ttii galateeffadhuutii gara gaafilee kunuunsatti ce'i/darbi.	
				Lakkii	0		
8015_1	Hospitaala ummataa/mootum maattii?			Eeyyee	1		
				Lakkii	0	"Lakkii" yoo ta'e, → 8016_1	
		A	Baatiwwan 12 darban kana keessa, yeroo meeqaaf hospitaala dhaqxe/deemte (akka nama achi turee/ciisee yaalamuutti)?				Yeroo___ ___

	B	Baatiwwan 12 darban kana keessa, guyyaa meeqaaf (dimshaashumatti)hospitaala turte (akka nama achi turee/ciisee yaalamuutti)?			Guyyaa__ ___ ___
	C	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?			Sa'aatii___ ___
	D	Geejibaaf/Imalaaf qarshii ammam kanfalte?			Qarshii___ ___ ___ ___
	E	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?			Qarshii___ ___ ___ ___
	F	Namni si dhukkubsachiisu kamiyyu yaa ta'uu (ga'eessi namaa) guyyaa meeqaaf si waliin achi ture/turte?			Baay'ina namaa si waliin achi turee ___ ___ ___
					Namni duraa: Guyyaa___ ___
					Namni 2ffaa: Guyyaa___ ___
					Namni 3ffaa: Guyyaa___ ___
	G	Baasiin waliigalaa kan qorannoo, waldhaansaa, adeemsaa ati baaste hagami?			Qarshii___ ___ ___ ___
9001	Hospitaala fayyisa rakkina qor-qalbii ykn sammuu/mataa ummataa/mootumma attii?		Eeyyee	1	"Lakkii" yoo ta'e deebin, hirmaaticha/ttii galateeffadhuutii gara gaafilee kunuunsatti ce'i/darbi.
			Lakkii	0	
9001_1	A	Baatiwwan 12 darban kana keessa, yeroo meeqaaf hospitaala dhaqxe/deemte (akka nama achi turee/ciisee yaalamuutti)?			Yeroo___ ___
	B	Baatiwwan 12 darban kana keessa, guyyaa meeqaaf (dimshaashumatti) hospitaala turte (akka nama achi turee/ciisee yaalamuutti)?			Guyyaa__ ___ ___
	C	Adeemsa dhaqaa-galaaf sa'aatii meeqa sitti fudhate?			Sa'aatii___ ___
	D	Geejibaaf/Imalaaf qarshii ammam kanfalte?			Qarshii___ ___ ___ ___
	E	Achi turuuf (waan akka nyaataa, dhugaatiif ... kkf) qarshii hagam kanfalte/ baaste?			Qarshii___ ___ ___ ___
	F	Namni si dhukkubsachiisu kamiyyu yaa ta'uu (ga'eessi namaa) guyyaa meeqaaf si waliin achi ture/turte?			Baay'ina namaa si waliin achi turee ___ ___ ___
					Namni duraa: Guyyaa__ ___ _
					Namni 2ffaa: Guyyaa__ ___ _
					Namni 3ffaa: Guyyaa__ ___ __
	G	Baasiin waliigalaa kan qorannoo, waldhaansaa, adeemsaa ati baaste hagami?			Qarshii___ ___ ___ ___
9001_1	A	Rakkinni fayyaa qor-qalbii/sammuu/mataa maal akka ta'e, akkamiti akka ittisuun danda'amuu fi waantota akkasii irratti namni/qaamni si barsiise/lenjise ykn si gargaare jiraa?			Eeyyee Lakkii Hin yaadadhu
9002_1	B	Yoo rakkinni fayyaa qor-qalbii/sammuu/mataa si mudate(yoo nama mudata jettee yaadde ykn waanti akkasii yoo sitti dhagayame), yaalamuuf eessa akka deemtu ni beektaa?			Yes No

9003_1	C	Yoo deebin kee gaaffii 9002_1 ta’e, rakkina sana irraa fayyuuf eessa deemta/dhaqxa?	Gara ooggantoota/beektota amantaa adda addaa, xabala
			Gara ogeessota aadaa
			Rayaaa misomaa dubrtoota/Exteenshinii fayyaa
			Gara wiirtuu fayyaa/kilinikaa/hospitaalaa ykn mana-qorsaa/qorichaa

ANNEXURE 12: Phase 2: Qualitative study questions individual interview guide English version

Hello! Thank you for being part of this interview today. We will explore your thoughts, beliefs and feelings surrounding strategies for the community prevention of maternal common mental disorders in your community.

I am particularly interested in your personal opinions and views regarding Identify and describe risk factors for maternal common mental disorders at community-based level in urban Oromia, Ethiopia, I am also interested your opinion regarding Explore and describe outcomes of approaches for community-based level prevention of maternal common mental disorders in urban Oromia Ethiopia I will be concerned on prevalence and associated factors for maternal CMDs.

We have some questions for discussion around these aspects I will appreciate your responses to those questions. You must know that they are no right or wrong answers. Please feel free to express your opinion about what you think and feel.

After conducting the in-depth interview, all data will be identified only by interview session and participant number. No participant names will be used at any time. Any comments quoted in this research will be associated only with a participant number. Once data analysis is complete, audio tapes if used will be destroyed and only written transcripts will remain. Written transcripts will be retained and secured with the researcher as per university policy and then destroyed accordingly.

This interview will last for no more than one hour. Participation in this study is completely voluntary. You may drop out at any time.

1. What do you think about the topic that has brought us here today (Maternal mental health)?
2. Have you heard about common mental disorders (Depression, Anxiety and Somatic symptoms? I'd like to hear more of your thoughts and opinions about the CMD.
3. How prevalent (common) mental illness in this community? who are more affected?

Do you see or heard the person in your community who depressed (hopeless suicide), anxious?

Do you think pregnant mothers are more affected for this common mental disorder than the other community group? Why?

4. Per your experience, what are the reasons for pregnant women:

Having a common mental illness? Please explain?

Prob….What risk factors that influence maternal common mental disorders at your community.

How she pregnant mother protected from mental illness? (protective factors?

5. In the community, who makes the decisions about the when the mother mentally sick to brought to getting care? (Probe: Husbands? Mother-in-laws? Religious or community leaders? Cowives? Others?) How are these decisions made?
6. What methods women use when they want to prevent themselves at home or in the community not to have depression, anxiety (Mental health problem)?

• What do you know about these methods? (Probe: Efficacy? Characteristics? Perception or attitudes of partners?)

• Where from whom do they obtain information about these methods?

• Where do they obtain the method? Is the method works well?

• Describe how these methods are selected to preventing mental health problems.

• What are some reasons women might choose a traditional method over a modern one?

• What are some reasons women might choose a modern method over a traditional one?

• What are some reasons women might not want to use any of these methods?

How involved are religious leaders or traditional leaders in maternal mental health prevention and care? What about husbands?

• What about kebele leader? What about women representative?

• What about women? How involved are HEW, WHDA in mental health care and prevention? What roles do these types of people play? Please explain.

• What roles do these types of people play? Please explain.

7. Are there any mechanisms currently working in our area or region to prevent pregnant mothers from common mental disorders at community level? Please explain
8. What mechanisms or approaches you suggest helping to prevent pregnant mothers from common mental disorders at community level?
9. Let's summarize some of the key points from our discussion. Is there anything else?
10. Do you have any questions?

Thank you for your participation today. Your input is valuable in assisting to discover more about the development of maternal mental disorders, prevention strategies at community level. Your contribution and support to education and research, and ultimately to the quality of maternal Health care, is sincerely appreciated.

ANNEXURE 13: Individual interview guide by local language (OROMIFFA)

Qajeelfama Af-gaaffii

Hayyee! Ana Haa Dhufu! Qaama af-gaaffii kanaa ta'u keessaniif (haayyamamoo taatanii af-gaaffii kana irratti hirmaachuu keessaniif) baay'ee galatoomaa. Af-gaaffii kana irratti waa'ee tarsiimowwan hawaasa bu'uureffate rakkina fayyaa qor-qalbii (sammuu) haadholii (haawwanii) baramoo ta'an ittisuuf oolan ilaalchisee yaada, mudannoo, muuxannoo, fi hubannoo isin qabdan gad-fageenyan irratti mari'anna (qoranna) ykn irratti dubbanna.

Keessattu xiyyeeffannoon koo inni guddaan baadiyyaa Oromiyaa, Itoophiyaa keessatti waantota rakkoowwan fayyaa qor-qalbii haawwanii sadarkaa hawaasatti jiru fidan ykn akka dhufuuf gumaacha godhan fi akkatti rakkoowwan kanneen adda baafatan ilaalchisee yaada fi ilaalcha dhuunfaa isin qabdan baruudha. Waantonni biroon ani irratti xiyyeeffadhu: firiiwwan tarsiimoo rakkowwan kanneen ittisuuf hojiirra oolanii maal akka fakkatu beekuu, babal'ina (sadarkaa tamsa'inaa) rakkoowwan fayyaa qor-qalbii fi waantota isaan kana wajjin hidhata qaban adda baafachuudha.

Dhimmoota amma dura isiniif ibse ilaalchisee gaaffiwwan muraasa (amma tokko) nan qaba. Deebii isin gaaffiwwan kanneenif kennitaniif bakka ol aanaan kennaaf. Hubadhaa! deebin sirrii ykn doggogoraa hin jiru-waanuma isinitti dhagayame naaf himtu jechuudha. Kanaaf, sodaa tokko malee bilisa ta'aatii yaada keessanii fi waan isinitti dhagayame ibsadhaa (naaf himaa).

Yaadotni fi waantotni af-gaaffii kana irratti natty himtan (kaastan) marti kan iccitidhaan qabaman waan ta'eef, sodaa tokko malee bilisa ta'aatii yaada keessanii fi waan isinitti dhagayame natty himaa (ofirraa dubadhaa). Af-gaafficha erga goolabamee booda, odeeffannoon isin irraa walitti qabame kan ittiin adda bayu wayitii af-gaaffii kanaa fi lakkoofsa adda baaftuu hirmaataa/ttuutiin (koodiidhaan). Maqaa hirmaataa/ttuutti fayyadamnee yoomiyyuu (gonkumaa) dhimma itti hin baanu. Odeeffannoowwan af-gaaffii kana irratti isin kennitan kan isaan ittiin adda bayanii taa'an (walitti hidhaman) lakkoofsa adda baastuu hirmaataa ykn ammo waa'ee tarsiimoo ittisa rakkoo fayyaa qor-qalbii baramoo haawwanii daangaa qorannoo kanaa wajjin qofa. Erga qaaccessi odeeffannoo funaanamee raawwatee booda, yoo sagaleen keessan (hirmaataa/ttuu) waraabameera ta'e barbadaa'eti (dhabamisiifameeti) bifa barreeffamaa qofaan taa'a. Kan bifa

barreeffamaatin taa'ee kun ammo qorataa/ttuu bira of-eegannoo guddaadhaan erga turee booda maammata yuunivarsiitichaa irratti hundaawun ni dhabamsiifama.

Af-gaaffin kun sa'aatii tokkoo ol hin fudhatu (hin turu). Af-gaaffii kanarratti hirmaachuun guutumaan guututti fedhii fi haayyamummaa hirmaataa/ttuu kan bu'uureffateedha. Yeroo barbaaddanitti addaan kutuu (dhiistanii deemuu) ni dandeessu. Dirqiin hirmaachuun fi hirmaachisuun hin jiru.

1. Waa'ee mata-duree har'a asitti akka mari'annu nu taasisee kanaa (haala fayyaa qor-qalbii/sammuu/mataa haawwanii) maal yaaddu? Maal isinitti fakkaata?
2. Waa'ee rakkinawwan fayyaa baramoo (baay'inaan beekamanii) qor-qalbii/sammuu: dawwaawuu/mukaawuu, cinqamuu/sodaa/oormaa/yaaddoo, mallattowwan dhukkuba bu'uura qaama hin qabnee, kanaan dura dhageessanii beektuu? Wan kana irratti yaada fi waan isinitti dhagayame sirriitti dhagayuun barbaada
3. Hawaasa kana keessatti babal'inni (sadarkaan tamsa'ina) rakkinna qor-qalbii kun hagami? (baay'inaan jira moo, sirriitti hin jiru moo giddu galeessa?) Warra kamtu caalaatti rakkina kanaaf saaxilamoodha ykn rakkina kanaan dararamaa jira?
4. Hawaasa keessan keessaa namni dawwaawee/mukaawe/mataan gad-cabe (kan abdii kutatee of ajeesuufaa yaale), kan yeroo baay'ee akka malee cinqamu/sodaatu/yaadda'u/ooru kan argitan ykn dhageessan ni jiraa?
5. Dubartootni ulfaa (garaatti baatan) rakkina fayyaa qor-qalbiitiin garee hawaasaa warra kaan caalaa midhamanii jiru (saaxilamoodhaa) jettanii yaadduu? Maalif?
6. Akka muuxannoo, mudannoo fi hubannoo keessanitti, sababootni gurguddoon dubartootni (haadholiin) garaatti-baatan rakkina fayyaa qor-qalbii baramoo ta'aniin akka qabaman (akka saaxilaman) taasisan maal fa'a? Maaloo sirriitti naaf ibsaa.
7. Hawaasa keessan keessatti waantotni/sababootni rakkinni fayyaa qor-qalbii haadholii baramoon akka dhufan taasisan maal fa'a?
8. Hawaasa keessan keessatti waantotni rakkinni fayyaa qor-qalbii haadholii baramoon akka hin dhufne (hin uumamne) taasisan maal fa'a? Akkamitti?
9. Hawaasa kana keessatti haawan rakkina fayyaa qor-qalbii qaban (rakkina kanaan dararamaa jiran ykn rakkina kanaaf saaxilaman) tajaajila fayyaa (waldhaansa, yaalii ykn kunuunsa) yoom argachuu akka qaban kan murteessu eenyu? (Sirriitti qoradhu: abbaa warraa? Soddaatii/amaatii? Beektota ykn ooggantoota hawaasaa/amantii? Masaanuu? Moo kan biroo?
10. Mana isaaniitti ykn hawaasa keessatti rakkinawwan fayyaa qor-qalbii/sammuu baramoo ta'an kan akka dawwaawuu, cinqamuu, yaaddaa'uu, sodaachuu, ooruu … fi kkf ofirraa ittisuuf (akka ittiin hin qabamneef) haawwan maloota kamitti fayyadamu?
    a. Waa'ee maloota kanaa maal beektu? (Qoradhu: amantii/yaada "nan danda'a" jedhu qabaachuu, haalaa-amala, hubannoo ykn ilaalcha abbaa-warraa?)
    b. Waa'ee maloota kanneenii odeeffannoo eessaa/eenyurraa argatu?
    c. Maalota/tooftaalee kanneen mataa isaanii eessaa argatu?
    d. Akkaataa tooftaalee kunniin rakkina fayyaa qor-qalbii ittisuuf itti filataman ibsi.

e. Sababootni gurguddoon haadholiin maloota ammayaa caalaa maloota aadaa filachuu itti danda'an maal fa'a?
f. Sababootni gurguddoon haadholiin maloota aadaa caalaa maloota ammayyaa filachuu itti danda'an maal fa'a?
g. Sababootni gurguddoon haadholiin maloota kana kamiyyuutti fayyadamuu hin feenef/filanneef maal fa'a?
h. Sababni gurguddoon haati takka mala tokko fayyadamuuf erga murteessitee booda yaada ishii jijjiirattuuf maal isinitti fakkaata?

11. Ittisaa fi waldhaansa/yaalii/kunuunsa rakkina fayyaa qor-qalbii/sammuu haawwanii keessatti oogganttotni/beektotni/hayyootni hawaasaa fi amantii akkamitti hirmaachuu danda'uu?
    - Abbaan warraahoo?
    - Ooggantootni gandaa/aradda hoo?
    - Warri bakka-buutotni dubartii hoo?
    - Dubartootni hoo akkamiin hirmaachuu danda'u?
    - Raayaa dubartii miisoomaa hoo fii exteenshinii fayyaa hoojeetuu?

• What about women? How involved are HEW, WHDA in mental health care and prevention? What roles do these types of people play? Please explain.

• What roles do these types of people play? Please explain.

12. Sadarkaa hawasatti dubarttotni ulfaa rakkina fayyaa qor-qalbiitiin/sammuutiin akka hin qabamneef (ykn rakkina sana akka hin horanneef) tooftaalen ammaan tana biyya ykn naannoo keenya keessatti hojiirra oolaa (itti fayyadamamaa) jiran jiruu? Maaloo waan kanarrttisirriitti naaf ibsi.
13. Sadarkaa hawasatti dubarttotni ulfaa rakkina fayyaa qor-qalbiitiin/sammuutiin akka hin qabamneef (ykn rakkina sana akka hin horanneef) tooftaalen ykn malootni akkami osoo hojiirra oolee (fayyadamanii) wayya jetta?
14. Qabxiiwwan ciccimoo marii keenyaa mee irra deebinee yaa kaasnu. Waanti hafe kan biroo jiraa?
15. Gaaffii wayii (waan barbaade yaa ta'uutii) qabduu?

Hirmaatnaa keessan har'aa kanaaf baay'ee galatoomaa. Yaadotni isin har'a kaastan kun tarsiimoo rakkina fayyaa qor-qalbii haawwanii ittisuuf sadarkaa hawaasatti qophaa'u/kaayamu gargaaruu keessatti gumaacha ol-aanaa qabu. Gumaachi fi gargaarsi isin qorannoo, qu'annoo fi dagaagina barnootaa keessattuu qulqullina waldhaansa/yaalii/kunuunsa fayyaa haadholii keessatti qabu, dhugumatti kan baay'ee jajjabeeffamuu/dinqisiifamuu qabuu dha. Galata guddaa qabdu.

ANNEXURE 14: Editing agreement

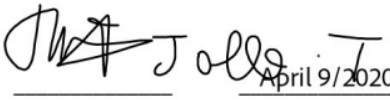
EDITING AGREEMENT

This agreement is between Chanel Serfontein (hereinafter "The Editor") and Jalle Mekonen (hereinafter "The Client").

The Editor hereby undertakes the editing of The Client's thesis titled "STRATEGIES FOR COMMUNITY-BASED PREVENTION OF MATERNAL COMMON MENTAL DISORDERS IN URBAN OROMIA, ETHIOPIA". This document specifies agreed-upon expectations from both parties (The Client and The Editor) and is legally binding once confirmed and signed. It addresses the following:

1. Nature of the work: Academic editing for a PhD.
2. Scope of The Editor's services: Language and format editing according to the prescribed style rules. (please see email correspondence)
3. Timeline: The Editor received the document on 1 April 2021 and the deadline is 27 April 2021.
4. Remuneration: 20c per word. The preliminary quote of R 11 084.20 will be adjusted if the word count changes during the supervisor's read-through/edit. (please see email correspondence)
5. Payment terms: The non-refundable 50% deposit of R 5 610.00 was paid by The Client on 3 April 2021. The outstanding amount of R5 5421.10 is due on or before 30 April 2021.
6. Terms and conditions: Only the final document (just before submission) will be edited. The structure and content should be finalised, fact checked, and edited by both The Client and the supervisor/lecturer before it is sent for professional language editing.
7. What is NOT included in the service: This service does NOT include re-editing if anything on The Client's side changes or if The Client neglects to tell The Editor about a specific style requirement BEFORE editing commences. Should a re-edit be needed The Editor will do so for an extra fee.
8. Disclaimer regarding quality of work: Although The Editor will endeavour to edit the document as thoroughly as possible and according to the style guidelines provided by The Client, the onus is on The Client to accept, reject, or implement any changes suggested. The Editor will not be responsible for the quality of the document if her suggested changes are rejected, and it should be noted that thorough content editing is not in The Editor's scope of practice. The Client is responsible for the content itself (this includes fact checking and ensuring that there is no plagiarism).
9. Confidentiality: The Editor will keep all work and information shared by The Client confidential.

Once confirmed and signed by both parties (The Client and The Editor) this agreement is legally binding, as is anything discussed via email.

Chanel Elizabeth Serfontein		7 April 2021	Pretoria, South Africa
Editor full name	Editor signature	Date	Signed at
Jalle T Mekonen		April 9/2020	ADDIS ABABA/ETHIOPIA
Client full name	Client signature	Date	Signed at

ANNEXURE 15: Letter from the statistician

Date Jan 22, 2022

To UNIVERSITY OF SOUTH AFRICA (UNISA)
College of Human Science
Department of Health Studies
South Africa

Subject: - Assuming the endorsement of the quantitative part of the study.

My name is Mr. Gemechis Teferi is a statistician with experience as a statistician, research assistant, monitoring and evaluation specialist in many organizations. In addition to statistics, I have a certificate in computer science and a Master's degree in public health.

On the request of Ms. Jalle T Mekonen, student No 58524452, who is working on her thesis on 'Strategies for community-based prevention of maternal common mental disorders in Urban Oromia, Ethiopia,' I reviewed the methodology, analysis, presentation, and description of the quantitative part of the study, which is chapters 3 and 4, and assisted her with the task and addressed feedback from her supervisor.

I agreed with each stage of the statistical analysis utilized throughout the process, and I feel they are acceptable for the data and address the objective of the study.

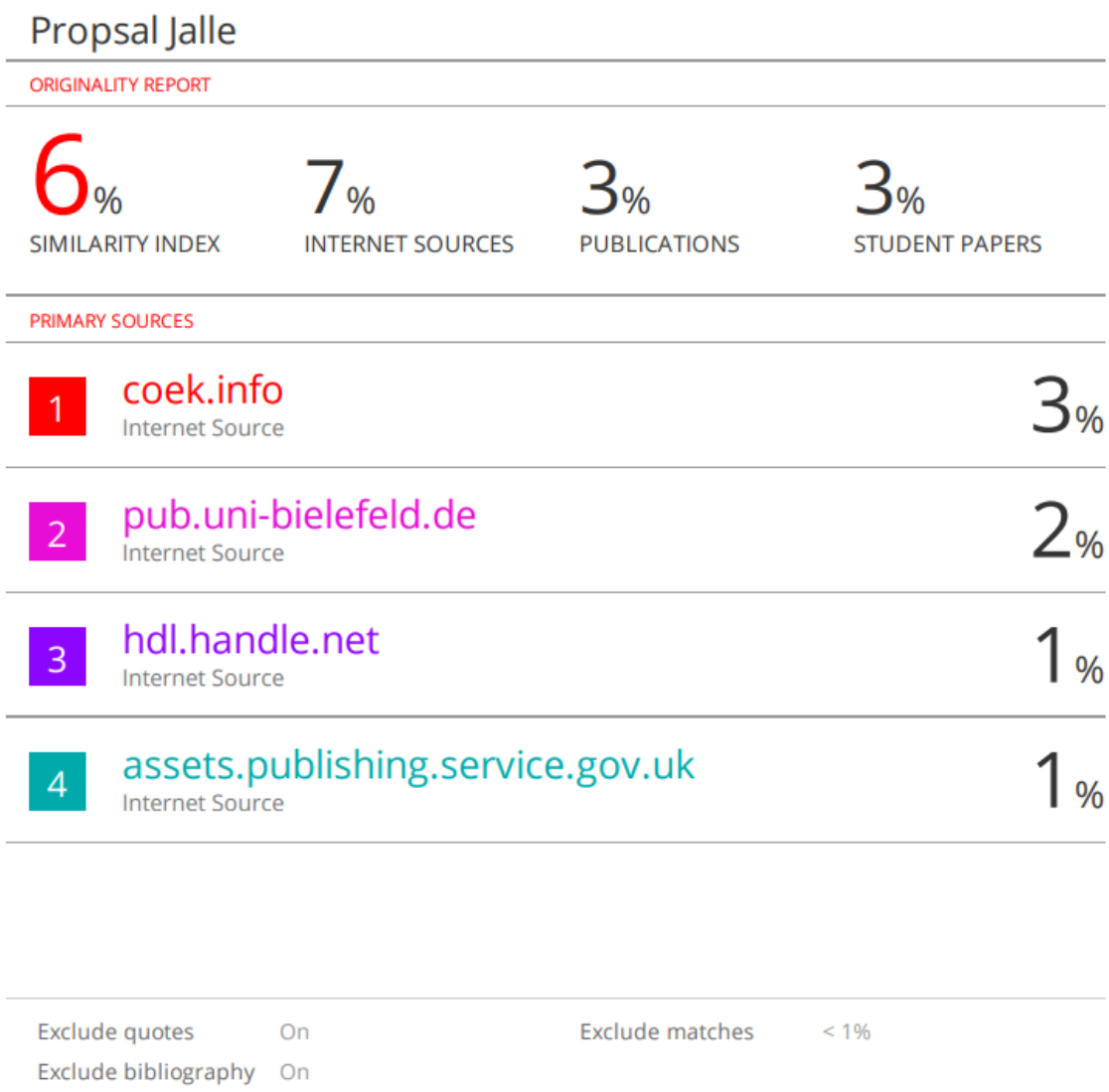
Furthermore, I approved the approach, the findings, and I guarantee the appropriateness of the technique utilized, as well as the correctness of the findings and results.

To ensure my help and qualification, I signed the letter and supplied relevant experience for your review.

Sincerely,

Cc: Prof, TSB MOKOBOTO-ZWANE
South Africa

ANNEXURE 16: Turnitin originality report



Propsal Jalle

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