E-ISSN: 2985-0800

2025
Volume 3 No. 1
January - June

Journal of Social Policy, Social Change and Development

FACULTY OF SOCIAL ADMINISTRATION
THAMMASAT UNIVERSITY

Journal of Social Policy, Social Change and Development

Volume 3 No.1: January – June 2025

ISSN 2985-0800 (Online)

Faculty of Social Administration | Thammasat University
Thailand

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Purpose of the journal

The ***Journal of Social Policy, Social Change and Development*** is an Academic journal of Faculty of Social Administration, Thammasat University Journal are published articles on all dimensions of social policy, social change and development. The academical, philosophical, theoretical, empirical and methodological intuitive understanding and knowledge building in the social policy, social change and development arena. Also, welcome articles from young researchers, Ph.D. scholars, and academicians to submit articles to the journal.

The journal scheduled to be published twice a year:
Issue 1: January – June
Issue 2: July - December

Dean Forwarding Message

Dear Readers,

For the June 2026 Issue of the Journal of Social Policy, Social Change and Development

It gives me great pride introducing the June 2026 issue of the *Journal of Social Policy, Social Change and Development*. This issue reflects the journal's enduring commitment to publishing research that is both academically rigorous and socially impactful. As Dean, I am especially heartened to see such diverse and timely scholarships that bridge disciplines and geographies to address some of the most pressing social challenges of our time.

The featured articles in this issue tackle critical issues from gendered health barriers and postnatal mental health to the psychological aftermath of conflict and the accessibility of education and care for migrant families. The research spans Zambia, South Africa, Ethiopia, and Japan, reminding us of the global interconnectedness of social welfare issues and the importance of context-specific knowledge. What unites these contributions is their grounding in lived experience, their emphasis on equity, and their potential to inform inclusive and responsive policy reforms.

As we continue to grapple with the lingering effects of the COVID-19 pandemic, ongoing conflict and displacement, and structural inequalities in health and education, this issue invites reflection and action. I commend the authors for their dedication to participatory, ethically grounded, and policy-relevant scholarship. Their work is a testament to the power of research to not only understand but also transform society.

I extend my congratulations to the editorial team for curating this excellent issue, and to the wider community of scholars, practitioners, and students who engage with this journal. May this issue inspire dialogue, innovation, and collaboration across sectors and borders in the pursuit of social justice and sustainable development.

Warm regards,

Associate. Prof. Dr. Auschala Chalayonnavin
Dean of Faculty of Social Administration
Thammasat University
Bangkok, Thailand

Editorial Letter

Dear Readers,

It is with great pleasure that we present the June 2026 issue of the *Journal of Social Policy, Social Change and Development*. This edition brings together a compelling collection of research articles that explore health, education, family wellbeing, and mental health in diverse socio-cultural contexts. Each study not only contributes valuable empirical insight but also deepens our understanding of how social policies intersect with lived experiences across global communities particularly among vulnerable and often underrepresented populations.

Our first article, *"Health and Psychosocial Needs and Barriers Among Female Fish Traders in Rural Zambia: A Qualitative Mapping Study"* by Lynn Michalopoulos and colleagues, delves into the complex intersection of gender, livelihood, and health in rural sub-Saharan Africa. Through a grounded qualitative approach, the authors map the lived realities and structural barriers facing women in informal trade. Their findings are vital for informing policies aimed at strengthening economic inclusion, health access, and gender equity in the informal sector.

In **"***The Experiences of Parents in South Africa During the COVID-19 Pandemic: An Ecological Systems Perspective"*, Sipho Sibanda and Megan Lotz employ Bronfenbrenner's ecological framework to analyze the multi-layered challenges faced by South African parents during the pandemic. This article sheds light on the adaptive strategies, institutional gaps, and psychosocial toll of COVID-19, while offering actionable insights for more resilient family and social welfare policies in times of crisis.

The third contribution, *"Examining the Prevalence of Postnatal Depression and Associated Factors Among Women: A Case of Women Delivering at Levy Hospital"* by Felix Phiri and Felix Chibesa, addresses a critical and often under-recognized public health issue. Their study draws attention to the prevalence and determinants of postnatal depression in a Zambian context, highlighting the urgent need for routine mental health screening and culturally appropriate maternal health interventions.

Mental health also remains central in Suleyman Beshir's article, *"Determinants of Community-Based Mental Health Services Utilization Among War Survivor Communities of Gondar and Wollo Zones, Amhara Region"* This research identifies both enabling and limiting factors for mental health service uptake in post-conflict settings of Ethiopia. By foregrounding

community-based approaches, it calls for more decentralized, trauma-informed, and participatory mental health systems in regions shaped by collective violence and displacement.

Lastly, we present Yuki Ohsaka's timely piece, *"Pathways to Access Center-Based Early Childhood Education and Care for Families of Foreign Origin in Japan: A Qualitative Analysis Using Levesque's Framework of Access"* This study offers a nuanced understanding of the accessibility of early childhood services among migrant families in Japan. It reveals how cultural, linguistic, and systemic barriers can shape the early educational trajectories of children from immigrant backgrounds and suggests pathways to improve equity and inclusiveness in early childhood education.

Collectively, the articles in this issue challenge us to think critically about structural inequities, community resilience, and the responsiveness of social policies in diverse global contexts. They serve as reminders of the importance of context-sensitive research and the urgent need for social policies that are inclusive, participatory, and grounded in the realities of those they aim to serve.

We thank our contributors for their rich scholarship and our reviewers for their diligent insights. As always, we invite our readers to engage with these articles, reflect on their implications, and continue fostering scholarship that drives social change.

Warm regards,

Dr. Mahesh Chougule

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Health and Psychosocial Needs and Barriers Among Female Fish Traders in Rural Zambia: A Qualitative Mapping Study

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Abstract

In Zambia, small-scale fisheries employ about 300,000 people in informal, unregulated sectors, which presents significant health risks, especially for female fish traders involved in "fish-for-sex" transactions, which increase vulnerability to HIV and mental health problems**.** This study mapped available mental health, and psychosocial support services (MHPSS) for female fish traders in the Sinazongwe District of Zambia's Southern Province to understand the needs of fish traders, assess service provider capacities, and identify barriers to access. Between July and October 2022, semi-structured interviews were conducted with 30 participants, including fish traders, community members and leaders, and health workers. Data were analyzed using template analysis to identify themes about local health services and challenges to accessing them. Findings from this study, one of the first to focus specifically on the intersection of informal labor, gender-based health disparities, and rural mental health in Zambia — revealed significant barriers to MHPSS access, including a shortage of mental health professionals, poor infrastructure, and stigma. Many fish traders preferred to rely on traditional healers due to cultural beliefs. These findings reveal the need for developing culturally responsive approaches to improve MHPSS access in underserved fishing communities. Such an approach would

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Received 10 February 2025 Revised 30 April 2025 Accepted 13 June 2025

involve local leaders, enhanced outreach, and training for health workers. These steps align with the United Nations Sustainable Development Goals for good health and well-being, gender equality, and reduced inequalities.

Keywords: Female fish traders, Mental health, Psychosocial support, Health service access, Small-scale fisheries, Zambia

Introduction

A growing number of people in Southern Africa seek economic opportunities requiring migration within their country of origin or to neighboring countries. Labor migrants in the region often seek opportunities in the mining, manufacturing, agricultural, and fishing industries. Industrial development in some countries, especially South Africa, Botswana, and Zambia, has attracted skilled and unskilled labor migrants from within and outside the area (International Organization for Migration, 2006). Labor migration remains one of the dominant forms of population movement in Southern Africa. Despite the numerous risks associated with labor migration, communities of migrant workers, like transnational fish traders, remain underserved by health and mental health services. Fishing industry workers are vulnerable to various risk factors. Understanding the potential risks and protective factors is vital to supporting a healthy workforce. Strengthening the health services available to fish traders is critical to the sustainability of the fishing community. Concerted efforts are needed to address the disparities in well-being of the fish traders, which is perpetuated by poor health systems and lack of mental and psychosocial support.

According to the United Nations Statistics Division (UNSD) (2024), the vast majority of small-scale fisheries in the world (97%) are located in developing countries. Ensuring the sustainability of small-scale fisheries is vital to local economies and food sovereignty. The fishing industry in Zambia supports approximately 75,000 fisherfolk, which refers to male fishers and female fish traders (CGIAR Research Program on Fish Agri-Food Systems, 2018). Fisheries account for an extensive employment network in Zambia. However, small-scale fisheries and other related marketing and enterprises are generally unregulated. The informality of the fish trading industry has made it accessible to many, including those without the skills or experience needed in other sectors. As Zambia lacks formal regulations governing fish trade, it is difficult to enact policies that protect those involved, and their well-being is largely overlooked. Fish marketing is predominantly conducted by women who get into the business with seed funding from various sources. Fish trading requires difficult travel to remote locations. The common practice of engaging in transactional sex to obtain fish has resulted in an increased risk among fisherwomen for contracting HIV and other diseases (Lungu & Husken, 2010; Michalopoulos et al., 2017). While these structural and gender-based risks are well-documented, few studies have systematically examined the health and mental health service ecosystem available to women, particularly in these rural fishing communities.

The following research questions guided the study: (1) What are the primary health and psychosocial needs of female fish traders in Sinazongwe? (2) What barriers exist to accessing formal health and MHPSS in this context? (3) What are the capacities and limitations of current service providers in delivering culturally appropriate care? To answer these questions, this study aimed to document and map the health services and MHPSS available to the fish trader community in the

Sinazongwe district in the Southern Province. Specifically, we aimed to (1) understand the needs and challenges of fish traders and surrounding communities in accessing health services (specifically among female fish traders), (2) document community demand for physical health, mental health, and psychosocial support services, and (3) assess service provider capacity, sensitivity, and knowledge related to mental health, and psychosocial support services.

Literature Review

The fisher community is less likely to access healthcare services, potentially due to lack of access and frequent mobility. This is concerning because of the stressful nature of the occupation, which could pose an increased risk for physical and mental health challenges (Lawrie et al., 2004; Michalopoulos et al., 2017; Michalopoulos et al., 2016). Environmental and socioeconomic challenges could compound the risks associated with the fishing occupation (Turner et al., 2018). However, little is known regarding the social determinants of health for the migrant fisher community, particularly the roles played by migration conditions and transnational practices. What is known regarding fishers' access to health and mental health services is scarce (Lungu & Husken, 2010; Michalopoulos et al., 2017).

Fishing is a highly gendered occupation in Zambia; men tend to engage in fishing, and women in fish trading. Female fish traders travel long distances to buy fish from fishermen, process them, and then return to sell them at markets to support their families. Aligned with the experiences of other labor migrants from low and middle-income contexts, female fish traders are often exposed to 3-D jobs (i.e., dangerous, difficult, and demeaning) (International Organization for Migration, 2006; Rasool et al., 2023). Within small-scale fishing communities in Zambia, the phenomenon of "fish-for-sex" has been established as a widespread occurrence (Béné & Merten, 2008; Michalopoulos et al., 2017). This phenomenon refers to the understanding of an arrangement between female fish traders and male fishers, where a female fish trader engages in sexual intercourse with a male fisher to buy fish at reduced cost. Female fish traders are often widowed, divorced, or single and have little education (Béné & Merten, 2008; Michalopoulos et al., 2017). As such, they are often forced into "fish-for-sex" transactions to ensure their access to fish because they typically lack adequate capital to purchase fish. Male fishers will also offer more fish at a lower cost in transactions without the use of condoms, which increases the risk of HIV infection (Michalopoulos et al., 2017).

In Zambia, HIV prevalence is 13.8% among females between the ages of 15-49 and 17.3% among women who slept away from home three or more times in the prior year, indicating an increased risk among migrant women compared to all adults aged 14-59, who have a rate of 11.1% (UNAIDS, 2014; Zambia Statistics Agency, Ministry of Health (MOH) Zambia, and ICF, 2019). Studies have suggested that fish traders in sub-Saharan Africa have HIV rates 2-14 times higher than national averages (Béné & Merten, 2008; MacPherson et al., 2012). Although limited data are available throughout the country, HIV prevalence is estimated at an alarming 24% or higher in some fishing communities in Zambia (Lungu & Husken, 2010). HIV prevention and access to care is therefore critical in this population. As such, although limited, HIV interventions have been developed among fish traders both living with HIV and engaging in HIV risk behaviors. However, this siloed approach does not consider additional risks that may further drive inequities among this population.

In addition to the risks of HIV and gender-based violence associated with "fish for sex" transactions, female fish traders in Zambia face other potentially traumatic events and persistent daily stressors that increase the likelihood of adverse mental health outcomes. Exposure to flooding, being attacked by animals in the rivers/lakes, drownings, and a lack of sanitation at the fishing camps all may contribute to potential mental health problems (Michalopoulos et al., 2017). Also, in many Zambian communities, female fish traders are labeled prostitutes because they engage in "fish-for-sex" transactions (Béné & Merten, 2008). As such, these exposures and associated stigma from the community may increase feelings of isolation, anxiety, depression, and post-traumatic stress (Michalopoulos et al., 2017). Further, home-brewed alcohol (frequently with dangerously high alcohol content) is easily accessible within fishing communities and often used as a coping mechanism among fish traders (Lungu & Husken, 2010; Michalopoulos et al., 2017). Finally, extended travel to and from the fishing camps with little to no access to health and mental health services may also significantly contribute to poor health outcomes among female fish traders in Zambia (International Organization for Migration, 2006; Lungu & Husken, 2010; MacPherson et al., 2012; Michalopoulos et al., 2017).

Despite these documented vulnerabilities, few studies have systematically examined the availability, capacity, and community perceptions of MHPSS in these settings and from the perspective of female fish traders. To date, there is a notable gap in research addressing the intersecting effects of informal labor, mobility, and gender on access to MHPSS in rural fishing communities.

Significance

The Zambian Mental Health Act of 2019, enacted by Parliament, promotes and protects the rights of persons with mental health problems (Munakampe, 2020). Aligned with this Act and by centering the voices of community members, service providers, and female fish traders, this study assessed the current state of mental health and psychosocial support delivery systems among an at-risk migrant population. Findings will inform the development of culturally appropriate interventions, strengthen the existing health system, enhance service delivery, and engage the government, health workers, and community members to improve and monitor MHPSS for migrant populations in Zambia.

Methods

Study Design

This study was conducted between July and October 2022 in the Southern Province of Zambia in the Sinazongwe District on the north shore of Lake Kariba. A qualitative study design was employed using semi-structured interviews. A qualitative approach was used for several reasons. First, no studies to date have examined the local understanding and relevance of health and mental health needs specific to fish traders in Sinazongwe. Second, qualitative methods allow for the expression of unique perspectives and individual experiences. As a highly disenfranchised, understudied, and vulnerable population, qualitative methodology was critical for an in-depth exploration of the lived experiences of fish traders in Zambia. Finally, qualitative methods are an appropriate first step for future quantitative and mixed-method research. This study relied heavily on community engagement and local partners to establish trust with the fish traders and community members, ensure cultural relevance, and build relationships to sustain future potential MHPSS programming. A Zambian male and female researcher conducted the semi-structured interviews in Tonga, the predominant local language spoken in the

Sinazongwe area. Interview guides were translated to Tonga by a certified translator at the University of Zambia and back-translated to English by another certified translator at the University of Zambia to ensure the accuracy of terms. The guides were then prescreened and reviewed for feedback and relevance with the study team, including A local research coordinator, officials from the Ministry of Health in Sinazongwe, and a local partner, the HIV/AIDS Technical Support Foundation (HATSFO).

Sample

The data was collected in the Sinazongwe district, Southern Province of Zambia, among fish traders, community members, community leaders, and health workers. The sample was restricted to residents of the Sinazongwe district within six fishing camps. The current study employed a purposive sample strategy to recruit fish traders, community members, community leaders, and health workers who provided in-depth and detailed information about the fish trading business and the health services available to them. Previous qualitative research has suggested that saturation occurs after 10–15 interviews (Guest et al., 2006). As this was cross-cultural research with an understudied population and different target groups, 30 interviews (N=30) were conducted to ensure saturation.

Recruitment

Local researchers engaged with fish traders, community members, leaders, and health workers to explain the study and its objectives. The research team conducted screening interviews to determine participants' eligibility, followed by the informed consent process.

Ethical Considerations

Ethical approval was obtained by the Zambian Ethics Review Board (Eres Converge) for approval and submitted to the National Research Health Authority (NHRA), as required for research in Zambia. The interviewers obtained informed consent after the participant agreed to the verbal screening interview. Due to varying educational backgrounds, the researchers gave the participants the option to either read the consent themselves or have the researcher read it. All participants were asked to give both verbal and written consent. The researchers verified that all interviews were gathered before they left the data collection site and later put them in a secure location. The researchers received ongoing supervision from the study's principal investigator, including weekly check-ins during data collection.

Data Collection

The data was collected with the project partner, the HIV/AIDS Technical Support Foundation (HATSFO), based in Sinazongwe. All interviews were conducted in a private location accessible to the participants within the camp or health clinic. All interviews were audio-recorded, and the participants' identifying information was not attached to the individual recording. During the interview, the researcher took detailed notes of the participants' answers and also observations of the participants' non-verbal or behavioral cues. Each participant was interviewed one time.

Two interview guides were developed: one for fish traders and one for community members, leaders, and health workers. For fish traders, the semi-structured interview guide covered key content

areas, including an understanding of MHPSS, availability of health and MHPSS services, the process of obtaining services, ways to improve health and MHPSS, the Ministry of Health's (MOH) role in improving services, barriers and challenges in providing health and MHPSS services, benefits of MHPSS, and the quality of health and MHPSS.

For community members, leaders, and health workers, the semi-structured interview guides covered key content areas, including health and MHPSS availability, demand for services from fish traders, ways to improve health and MHPSS, MHPSS training, access to services, as well as MHPSS community needs, barriers, and challenges in providing MHPSS.

Data Analysis

The template analysis approach informed data analysis for the current mapping exercise (Crabtree & Miller, 2022). Template analysis is a structured technique for qualitative data analysis that enables researchers to organize data from the outset by applying *a priori* codes based on the research question, which can then be modified throughout the analytic process. This approach emphasizes hierarchical coding, beginning with broad themes that can be refined into narrower sub-themes as the analysis progresses. Unlike fixed coding methods, template analysis is flexible, allowing researchers to adjust or remove main and sub-themes if they do not align well with the data. Additionally, this method supports incorporating emergent themes that arise directly from the data, even if they were not identified in the original template (Crabtree & Miller, 2022).

The research team employed several strategies to enhance trustworthiness and ensure cultural relevance. First, team members independently conducted an initial review of data from the semi-structured interviews. They then convened to discuss the relevance of each *a priori* code and any newly identified codes. Any discrepancies were discussed until a consensus was reached. Finally, a local research partner in Zambia reviewed all sub-themes to verify cultural accuracy and relevance.

Results

Data was collected in the most prominent and active fishing camps in the Sinazongwe district (see Table 1). Due to differences in the interview instrument, results are compared across four groups: health workers, community leaders, community leaders, and fish traders (see Table 2). The findings for the first six themes were analyzed across the first three groups, while an additional five themes emerged solely for the fish traders. We used a structured Excel sheet to track the a priori themes. This template was revised iteratively during analysis as new sub-themes emerged from the data.

Table 1 Interviews by Fishing Camp

Fishing Camp	Interviews (n)
Siansowa	4
Simuzila	4

Chiyabi	5
Zubandenda	6
Chikelo	4
Nzenga	7
Total	30

Table 2 Interviews by Target Group

Target Group	Participants (n)
Female fish traders	10
Health workers	6
Community leaders	6
Community members	8
Total	30

Services Available

Health workers indicated that health services available at local clinics included services related to HIV, TB, maternal and child health, and cancer screenings. One health worker stated, “We only have psychosocial counselors, but we do not have mental health specialists.” As such, results indicate that fish traders have access to psychosocial counselors trained in basic supportive skills but not specialized health workers trained in evidence-based mental health counseling.

Community members' findings were inconsistent regarding the perception of the availability of mental health services. One respondent noted, “Yes, they are available for everyone in the community.” Others indicated that no such services exist in their community. Community members who noted that services are available also indicated that fish traders have to travel long distances to access services and, when available, “community health workers mainly focus on people living with HIV.”

Unlike the inconsistent findings from the community members, community leaders unanimously indicated that mental health services are unavailable within the fishing community. One participant said, “No, I have never seen anyone come to our community and provide such services. We donate money and book a vehicle to take the patients to the clinic.” Another participant indicated that services are unavailable “due to distances and road network.”

Demand for Services from Fish Traders

Few health workers reported a high demand for fish traders' health and mental health services. Most indicated little to no demand for services. One participant stated that fish traders "normally shy away from obtaining health services. Most of them prefer treating themselves with herbs."

Community members felt that seeking health and mental health services was not the preferred treatment method for fish traders. For example, "they go to the clinic but if there is no proper response on the patient, they go for traditional healers because most of the people in the community believe in rituals." Community members noted a particular lack of demand for mental health services;

> …for mental health illnesses, they don't go to the clinic. This is because they have taken mental health as a spiritual problem which needs to be dealt with by a traditional healer…the community perceives mental health as important though not as an issue to be treated at the hospital.

Despite such findings illuminating the lack of service demand, most community members felt that fish traders experience high stress levels due to economic impoverishment.

Community leaders highlighted the difficulty in accessing MHPSS due to the distance from fish camps and a lack of knowledge among fish traders about available services. "They are aware but the knowledge levels are low due to distance. The nearest health facility and poor road network…services don't reach them."

How Services Are Offered to Fish Traders

Most health workers noted that health services are offered at health centers and through outreach at fishing camps. Health workers reported that they camped near the fishing camps for a few days to provide services. However, it is unclear whether they were specifically providing general health or MHPSS.

Community members felt that fish traders were aware of their right to access free health care services.

> All community members are free to access/ obtain free medication without any payment and all fisherfolk have been made aware of these rights for obtaining free services at the health post. Yes, we have a community health worker in the community and he helps the community members as well as the fishermen.

As with the health workers, community members did not specify whether the community health worker was providing MHPSS, except in one case when it was noted that "we have no mental health and psychosocial services provided in the community."

Community leaders indicated that health services, in general, are free of charge. In contradiction to the findings from community members, one leader stated that "most of the community members don't know their rights, only a few know."

How Can Health Services Be Improved for Fish Traders?

Health workers needed more support and coordination of services from the Ministry of Health. Health workers suggested that the Ministry of Health should provide more MHPSS training and ensure a specialized counselor at each facility. Health workers also noted that an increase in community awareness and outreach could improve the uptake of MHPSS. Most health workers indicated the importance of working with community leaders such as headmen and church leaders. One participant stated there should be "community sensitization involving local leaders since people tend to believe more and follow their local leaders."

Findings from community members aligned with health workers' sentiments about sensitization and outreach. Further, community members voiced the need for the Ministry of Health to improve the local road infrastructure to make health clinics more accessible. One community member stated, "We need a clinic in our community so that it is easy to access health care at any time of the day." Further, the "Ministry of Health should provide more health posts and mobile health posts and deploy more community health workers." Another participant noted that "the workers at the nearest clinic should start outreach programs, especially for people living with HIV because these are the ones who are more vulnerable to mental health illnesses in my community."

Community leaders aligned with community members on the need for health education, mobile clinics, MHPSS, and outreach services. One leader noted that the "challenges can be addressed by providing mobile clinics nearby where the fish folk can easily access."

Current MHPSS Training

Many health workers noted that they have received minimal training related to MHPSS. Most health workers indicated that they have some knowledge related to mental health but that most services are related to HIV counseling.

Community members and community leaders reported a lack of education related to MHPSS among health workers. One participant stated, "The quality of services is very poor due to … low knowledge levels among the community hence they don't see it being important."

Barriers and Challenges Related to MHPSS

Health workers highlighted stigma, discrimination, lack of MHPSS staff, and a lack of education as contributing factors related to barriers to MHPSS. Health workers also noted that MHPSS is not a priority. "We have no mental health officer at all, you will find that a psychosocial counselor are the ones providing the services of a mental health officer, hence they may not fully effectively execute the work." Another participant noted that "It is a big challenge for someone to access MHPSS because one must travel to Lusaka."

In addressing the stigma that creates a barrier to MHPSS, one health worker stated, "most mental health victims are perceived as black magic - they have been bewitched..." To emphasize the lack of resources, one health worker stated, "We do not have an annex in Sinazongwe for mental health

conditions where patients can be observed before they are referred to U.T.H [University Teaching Hospital]."

Community members noted that a lack of education about MHPSS was a significant barrier preventing fish traders from accessing services. One community member stated, "Some think of it as an illness. Others think it's witchcraft; others think it's because of drug abuse." Additionally, seeking help from traditional healers was identified as the standard approach to treating mental health problems. A community member stated, "Most of them believe in rituals so they prefer going for traditional healers." Distance to the health clinics was an added barrier. For example, a community member noted:

> ...long distance from the community to the clinic, bad road network during rain season, wind on the lake. They do not move during the rainy season because of the bad roads and bad weather…most of the community members shun services for fear of being laughed at.

What Does Mental Health Mean?

Most fish traders who participated in the study generally understood mental health as being related to how people think, feel, and act. One fish trader stated, "Health is basically the well-being of an individual, whereas mental health is well-being well-being in terms of an individual's memory and mind."

Availability of MHPSS

Fish traders reported that MHPSS is not available at the fishing camps. One trader shared that "apart from the community health worker who mainly focus on people living with HIV, we don't have." Rather than using the health clinics to address mental health problems, fish traders preferred to rely on family, friends, village elders, or traditional healers. For example, one trader reported that "they go for traditional healers because sometimes they feel it has issues to do with witchcraft." Similarly, another trader noted, "No, they do not have, they go to Chiyabi clinic for any health problem, and others go for traditional healers, especially who have mental health problems."

MHPSS Community Needs

Fish traders identified the need for awareness, education, outreach, facilities, and training for community health workers. One participant stated, "People around the community need to be made aware of what mental health is, most of them lack knowledge about mental health services." The need for outreach in the camps was also significant. "We request to have outreach in the fishing camp every few weeks, door-to-door campaign(s) or sensitization about mental health." Further, MHPSS facilities within the camp were a noted need for fish traders, "I think the people in the community need a clinic. They also need more community caregivers; the clinic should be built nearby." Finally, traders noted that training more community health workers on MHPSS would be helpful. "(We need) a community health worker to help us before we go to the clinic."

Accessibility of Health Services

Fish traders amplified the distance between health clinics and fishing camps, indicating that most health clinics are challenging to get to and require between an hour and ninety minutes of travel time. Environmental factors can exacerbate the time it takes to travel to a health clinic. "It's very far. The shortest way is by using water transport, which is very challenging especially at night or when it becomes windy, causing waves on the lake."

Discussion

Findings revealed significant challenges in the demand for, accessibility, and availability of MHPSS for fish traders in the Sinazongwe district of southern Zambia. Important themes were analyzed across the participant subgroups: health workers, community members, community leaders, and fish traders. The themes that emerged during this study highlight systemic issues and community perceptions that impact the accessibility and utilization of MHPSS.

While health services are available in the Sinazongwe district, findings revealed a significant gap in MHPSS. Participants noted a predominant focus on HIV and other physical health concerns. However, the absence of specialized mental health professionals represented a critical barrier for individuals with higher levels of mental health needs. Inconsistencies emerged across groups regarding awareness of available services. Some participants reported limited access, while others perceived a complete absence of MHPSS. This inconsistency suggests a breakdown in communication and information dissemination about available services. Clear and consistent messaging about culturally relevant MHPSS, available through community channels, may help bridge the awareness gap.

These findings align with global patterns identified in fishing communities, where health services predominantly address physical health, occupational hazards, and behavioral factors, while mental health issues remain underemphasized (Woodhead et al., 2018). Disparities in healthcare provision leave these communities underserved in mental health support, a gap compounded by intersecting issues like alcoholism and domestic violence. In many fishing communities, these problems exacerbate mental health challenges. They are often worsened by policies restricting access to marine resources, which undermine traditional coping mechanisms, particularly for women who act as independent income earners (Coulthard et al., 2020). Our findings align with these patterns, suggesting the importance of MHPSS interventions to address multiple stressors faced by women at the intersection of these issues.

Furthermore, in fishing communities like Sinazongwe, structural and social determinants of health, such as employment, depression, and physical inactivity, can create additional barriers to well-being. For instance, Vancampfort et al. (2019) highlighted how depression and lack of employment were predictors of physical inactivity in a Ugandan fishing community, underscoring the interconnectedness of mental and physical health challenges. These findings emphasize the critical need for holistic approaches to health in fishing communities, integrating mental health support alongside physical health services. Addressing the low awareness regarding MHPSS availability is essential and requires improved communication strategies to ensure stakeholders can access the care they need.

Findings revealed a shared perspective among health workers and community members regarding the low demand for MHPSS among fish traders, who often prioritize traditional healing practices. Cultural beliefs in this context perceive mental illness as a spiritual or moral issue, influencing fish traders to seek help from traditional and faith healers rather than formal mental health services. Community members frequently highlighted the role of traditional healers, emphasizing cultural significance and accessibility; This aligns with findings from Ghana, where the widespread use of traditional and faith healers for mental health care is driven by cultural perceptions, affordability, accessibility, and the psychosocial support the healers provide (Ae-Ngibise et al., 2010). The ingrained cultural reliance on traditional health likely reinforces a reluctance to seek alternative care, including conventional mental health services (Ae-Ngibise et al., 2010). Expanding public awareness-raising efforts that help reframe spiritual and moral interpretations of mental health may help to reduce stigma and improve the likelihood of seeking care.

Similarly, practical considerations such as proximity, cost, and wait times influence healthcare-seeking behavior. In Zambia, for example, traditional healers are often preferred because they are more accessible and have shorter wait times than hospitals, with treatment costs frequently contingent on successful outcomes (Stekelenburg et al., 2005). Despite the low demand for MHPSS, community members, leaders, and health workers acknowledged the high levels of stress among fish traders, driven by economic pressures and the demanding nature of their work. This indicates an unmet need for interventions targeting stress-related dysfunction, which could provide a culturally acceptable entry point for addressing broader mental health concerns. Collaborative approaches that integrate traditional healers with formal mental health services, rooted in mutual respect and understanding, may offer a way to bridge these gaps and expand access to care.

The stakeholder groups (i.e., community members, leaders, and health workers) aligned with suggestions for improving health services for fish traders, including enhanced outreach, increased training, and support from the Ministry of Health. Health workers emphasized the need for MHPSS training. Collaboration with local leaders could promote trust in the community and among the fish traders. Community leaders agreed with increased access to MHPSS by reducing the time needed to travel to services through co-locating services in the fish camps, improving road infrastructure, and more resources to mitigate transportation barriers. The finding highlighted a clear need for a coordinated approach to making MHPSS available in fishing camps or much closer to them, thereby reducing some significant barriers to access.

Health workers, community members, and leaders reported insufficient training in MHPSS, with existing training for health workers focused primarily on people living with HIV. This limited training creates a critical gap in specialized mental health services, reducing the availability and quality of care. These deficiencies are compounded by infrastructure barriers that hinder access to MHPSS. Adopting culturally and faith-sensitive approaches to MHPSS interventions is essential to address these challenges effectively. Integrating cultural norms and practices into MHPSS programming can enhance interventions' cultural relevance and efficacy while reducing the stigmatization of mental illness (Amigues, 2022). Collaboration with faith-based and traditional community leaders is a key strategy for successful implementation. Faith and culture significantly influence coping mechanisms and recovery processes in many communities, making their inclusion vital for strengthening local capacities. MHPSS efforts can address stigma and build more resilient and sustainable support systems by

involving faith-based actors and aligning interventions with cultural norms. Amigues (2022) underscores the potential for such approaches to bridge mental health care gaps, particularly in under-resourced settings, and highlights the importance of capacity-building with faith-based and traditional structures.

Stigma and Discrimination

Stigma and discrimination are widespread in Zambian society, impacting individuals with mental illness within their families, communities, healthcare settings, and government institutions (Kapungwe et al., 2010). Social barriers like culturally rooted mistrust and stigma compound the existing limitations in service availability, further isolating those in need. This hinders healthcare-seeking behavior and exacerbates challenges faced by those living with mental illness. Thus, stigma and discrimination present significant barriers to accessing MHPSS in the community. Misunderstandings of mental illness, fears of contagion, and the perceived dangerousness of individuals with mental illness fuel these negative perceptions.

Additionally, the association between mental illness and HIV/AIDS introduces another layer of complexity, amplifying the risk of further marginalization and discrimination. Addressing these barriers requires culturally sensitive interventions, education campaigns to dispel myths, and systemic policy reforms to reduce stigma and promote mental health. Community-designed and mental health awareness campaigns could reduce stereotypes and improve MHPSS uptake. Furthermore, integrating traditional and faith healers into mental health initiatives can leverage their trusted status in the community to bridge cultural divides and increase service acceptability. Training health workers in culturally appropriate stigma reduction techniques is critical to improving the quality of care and encouraging positive attitudes within healthcare settings. To incorporate cultural competence and traditional healing, training programs may include education on local cultural beliefs and mental health explanatory models, integrating traditional healing perspectives to reduce stigma and improve acceptance. Training modules adapted from WHO's mhGAP guide with additional content on collaborating with traditional healers could be applied (Molebatsi et al., 2021). By linking the study's findings on stigma and discrimination with these practical, evidence-informed interventions, there is potential to enhance MHPSS access and acceptance among fish traders, ultimately fostering more inclusive and supportive community environments.

Conclusion

While fish traders demonstrate a basic understanding of mental health, they predominantly rely on community-based support networks and traditional methods to address mental health challenges. As such, health workers and community members reported that mental health issues are often attributed to dark witchcraft or substance abuse. This reliance is compounded by limited awareness of formal MHPSS, which remains underutilized even when available due to significant accessibility barriers (Munakampe, 2020). The findings highlight an urgent need for expanded outreach initiatives to raise awareness about MHPSS, alongside targeted training for health workers to enhance service delivery. By ensuring reliable access to high-quality, culturally sensitive mental health services, demand for MHPSS within the fish trader community could be stimulated and sustained. There is an urgent need to address the logistical and social barriers to MHPSS for fish traders in the Sinazongwe district. Targeted

training for healthcare workers in MHPSS is essential, focusing on bridging the gap between clinical practices and the traditional healing methods preferred by the fish trader community. Enhanced community outreach and awareness initiatives, led by trusted local leaders, are crucial for fostering greater engagement. Increasing the mobility of MHPSS services through enhanced visibility could stimulate demand and facilitate access to care in fish camps. This could be achieved through task shifting, which has been deemed a practical approach to mental health delivery (Murray et al., 2011).

Additionally, addressing infrastructure deficiencies, particularly local road conditions, and expanding the number of health posts near or within fish camps would help overcome logistical challenges and improve the reliability and availability of services. Furthermore, reducing the stigma associated with mental health care through educational campaigns and community outreach could encourage greater utilization of MHPSS services by fish traders. Therefore, a culturally sensitive, collaborative, and community-centered approach is imperative for the effective expansion and uptake of MHPSS services in the Sinazongwe district. This study supports the development of policy, in collaboration with the Ministry of Health and complementary to local traditional systems, that will prioritize community integration of MHPSS and enhance delivery systems and health worker capacity to respond to the needs of the fisherwomen of Sinazongwe.

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The Experiences of Parents in South Africa During the COVID-19 Pandemic: An Ecological Systems Perspective

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Abstract

COVID-19 has caused havoc on the stability of families in South Africa. Although researchers have explored the impacts of the pandemic worldwide, no studies have been done to explore the COVID-19 experiences of parents in South Africa. The exploration of parents' lived experiences from an ecological perspective can provide insight to researchers and policy makers on how best to empower parents. Furthermore, it can provide a comprehensive understanding about parents' lived experiences during a pandemic in a developing country. The research question was: 'What are the lived experiences of parents during the COVID-19 pandemic in South Africa?'. The study was qualitative in nature, participants were recruited from four provinces in South Africa using non-probability, purposive sampling methods. Data was gathered using one-on-one, semi-structured interviews and subsequently analysed using Creswell's (2014) model of thematic analysis. The findings from the study indicate both negative and positive experiences around the following issues: COVID-19 perceptions, relationships and spouse relationships, connections and lost connections, changes in routine, financial status, education, and positive experiences. The article concludes that comprehensive interventions for empowering parents during pandemics should be developed.

Keywords: Ecological systems, Parents, Lived experiences, South Africa, COVID-19

Introduction

COVID-19 has caused massive suffering and a severe disruption of family life. Most parents struggled to cope with the consequences of the pandemic that attacked them abruptly and found them unprepared. The pandemic upset bio-ecological systems, resulting in reduced health, relationships, and financial outcomes. This has crippled and undermined the capacity of parents to guarantee the livelihoods of family members, especially children. Whilst several researchers have highlighted the impact of the pandemic, there has been no study that has explored and described the lived experiences of parents in South Africa during the COVID-19 pandemic using the ecological systems framework.

The impacts of COVID-19 have been globally experienced and widely researched with researchers identifying biological, psychological, social, and socioeconomic effects of the pandemic.

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Received 13 November 2024 Revised 13 February 2025 Accepted 13 June 2025

Several researchers have explored the impacts of the COVID-19 on parents, children, and families. However, few research studies have explored the lived experiences of parents during the COVID-19 pandemic in low-income countries like South Africa (Weaver & Swank, 2021). Most studies have been conducted in developed countries. Consequently, little is known about the lived experiences of parents within a developing country like South Africa (Alonzo et al., 2021).

The pandemic management strategies implemented by the government of South Africa, which included lock-down, and quarantine, put families under strain. Due to social distance measures, parents were distanced from their support structures, increasing their distress and lowering their parenting capabilities (Weaver & Swank, 2021). Although parents may have retained a virtual connection with others, they lost physical assistance. Family interaction, including routines, rituals, and rules, may have been disrupted by pandemic-related changes (Weaver & Swank, 2021). The stay-at-home orders shifted family schedules, with children virtually attending school and parents working from home. Routines were disrupted by social distance restrictions, prompting families to adjust.

The Ecological System Theory

The study was guided by Bronfenbrenner's ecological systems theory (1979), which states that an individual's development occurs within several interrelated systems. The four ecological systems are: the microsystem, mesosystem, ecosystem, and macrosystem, which are interrelated, interact with, and influence an individual (Bronfenbrenner, 1979). The ecological perspective is influenced by the theory that no individual lives in isolation, acknowledging that individuals interact with their environments and are shaped by them. The COVID-19 pandemic has posed a threat to supporting systems and environments and evidence suggests that this may have detrimental effects on individuals and children's development (Haleemunnissa et al., 2021).

According to Barrow (2017), it is a parent's capacity to support their child that either enhances or diminishes their development. Research has indicated that parents have been faced with major pandemic related stressors which, consequently, has impacted their overall wellbeing and their capacities to support their children's development (Kerr et al., 2021). The pandemic related stressors are evident throughout the various ecological systems and will be unpacked throughout the paper. This ecological systems framework allowed the researchers to understand how COVID-19 has influenced and shaped parents, and how parents have responded to a pandemic impacted environment.

The Impacts of COVID-19 on Families

Increased Exacerbated Stressors, Burnout and Mental Health

COVID-19 has exacerbated stressors for families around the globe (Kerr et al., 2021). Stressors such as job instability, fear of infection, and food insecurity have led to an increase in parental distress and reports of mental health problems (Kerr et al., 2021). Researchers have indicated an increase in reported psychological problems such as depression, anxiety, insomnia, and an increased tendency to worry (Mortazavi & Ghardashi, 2021). The measures implemented to mitigate the spread of the virus led to an erosion of family connections, support, routines and heightened stressors (Cuartas, 2020). According to Kerr et al., (2021), the pandemic has magnified parental stress and burnout which directly impacts child stress and psychopathology. Researchers have found that parents with anxiety were seven

times more likely to report that their children were experiencing emotional problems (Saddik et al., 2021).

Impacts on Families from Low-Income Countries

Research has indicated that mental health symptoms were significantly higher in low-income countries due to their pre-pandemic risk of mental health challenges that are associated with exposure to poverty, crime, abuse, lack of food security, and resources (Alonzo et al., 2021). Kerr et al., (2021), identified that ethnic minority and low-income families are at a higher risk of experiencing psychological symptoms. Despite this, the only study that has been conducted in a low-income country that explored the mental health impact of COVID-19 on parents was in Guatemala (Alonzo et al., 2021). The study stressed the importance of addressing parental stress in high-risk communities to alleviate parental psychological distress because it has a direct correlation to child maltreatment (Alonzo et al., 2021). Similar to Guatemala, South Africa's population has a higher prevalence of depression, anxiety, and insomnia compared to other countries (Chen et al., 2021). Therefore, it is crucial that studies explore parental stress in high-risk contexts to provide support to parents and prevent possible child maltreatment.

The Socio-economic Impacts on Families

The stay-at-home lockdowns and social distancing regulations had a rippling effect on family relationships and social interactions (Kerr et al., 2021). Previous research has indicated that parental support and perceived control are resilient factors that assist parents and families in managing the stressors associated with COVID-19. Socialization is considered to be a protective factor for individuals' well-being, however, the social distancing and the closing of institutions such as churches and schools have eroded support systems (Cheng, Moon & Artman, 2020). With little support, parents have had to take on the role of educator to their children who were learning remotely whilst managing their full-time occupations (Haleemunnissa et al., 2021). In some instances, this dual role has caused negative interactions to occur between parents and their children as a result of burnout and parental distress (Russell et al., 2021). Furthermore, it is evident that parents have had to adapt to the ongoing changes during lockdown which have included adapting their work schedule, finances, routines, and their social lives (Vanderhout et al., 2020).

The pandemic has exacerbated current hardship for parents, revealing entrenched socioeconomic inequalities of access to healthcare, education, food security, and service delivery, complicated by the additional challenges of a co-existing global pandemic (Mlambo & Khuzwayo, 2021). The closure of educational institutions and non-essential work created mass disruption in families (Ishmael et al., 2020). Parents from low-come households who relied on informal sectors experienced temporary suspension in work, for some, this meant a loss in their livelihoods (Achuo et al., 2020).

Method

This section focuses on describing and explaining the research methodology and process. It discusses the research design and approach selected for this study. It also focuses on the selection of participants and the procedures used to collect and analyses data. Ethical considerations pertinent to the study are also discussed in this section.

The Research Goal and Aim

The purpose of the study was to provide a detailed description of the lived experiences of parents within a South African context during the COVID-19 pandemic. Therefore, the goal of this study was to explore and describe the lived experiences of parents in South Africa during the COVID-19 pandemic. The main research aim was to contextualise and conceptualise the lived experiences of parents from an ecological systems approach.

Research Questions

The main research question was: What are the lived experiences of parents during the COVID-19 pandemic in South Africa? The sub-questions that assisted the researchers in answering the main research question are as follows:

1. How to contextualize and conceptualize parents' lived experiences during the COVID-19 pandemic from an Ecological Systems Theory?
2. What are the positive experiences of parents in South Africa during the pandemic?
3. What coping strategies did parents utilize during the course of the pandemic?
4. What were the concerns and challenges that South African parents experienced during the pandemic?
5. What meanings have parents constructed from their experiences during the pandemic?
6. How may parents' lived experiences during the pandemic assist policy makers and researchers in the future?

Research Design

The study was qualitative in nature, specifically, a phenomenological research design was utilised. Qualitative research enabled the researchers to explore lived experiences of parents during the COVID-19 pandemic. A phenomenological research design was used to explore and gain a comprehensive understanding of the subjective experiences of the participants (Creswell & Poth, 2018). The phenomenological research design enabled the researchers to explore, describe, contextualise, and interpret the phenomenon of the lived experiences of parents in South Africa during a pandemic (Creswell & Poth, 2018).

Participants

The population for the study was all parents in South Africa. However, it was not feasible to include all parents in the study. Therefore, a non-probability, the purposive sampling method was used to select and recruit participants for the study (Babbie, 2016). Purposive sampling enabled the researchers to intentionally select individuals who could provide an abundance of information suited for the study (Babbie, 2016). The following sampling criteria was used: participants older than the age of 25; South African citizen; proficiency in English; the child's biological or legally adopted parent/s; parent to one or more children younger than 18 years of age; has been residing in South Africa during the pandemic.

A sample of 8 parents residing in the four highlighted provinces in South Africa was recruited. Data became saturated after the eighth interview. The study was approved by the Ethics Committee at the South African College of Applied Psychology (reference number: MSCL010322).

Data Collection Procedure

The participants were recruited via the following social media platforms: Instagram, Facebook, and WhatsApp. The advertisement was uploaded onto these platforms which highlighted the nature of the study, the eligibility criteria, and the researchers' contact details. Individuals who were interested in participating in the study contacted the researchers via the social media platform or directly using their listed contact details. Then the participants were screened by the researchers to ensure that they met the eligibility criteria, thereafter they received an email containing a consent form, as well given an opportunity to ask any further questions regarding the study.

Once the participants sent their signed consent forms to the researchers, the researchers responded with an email giving the participants a one-week period where they were able to choose a time slot for an interview to be conducted with one of the respective researchers. Thereafter, a follow-up email containing the Zoom meeting link was sent a few days before the scheduled meeting. A day before the scheduled meeting, the participants were sent a reminder email about the scheduled meeting. On the day of the meetings, the researchers logged into the Zoom meetings 15 minutes before the scheduled time and once the participant joined, the data collection procedure began. The zoom meetings varied between 30 minutes to 60 minutes, allowing the participants sufficient time to answer the semi-structured interview questions.

The interviews were recorded with the consent of the participants and later transcribed into a Microsoft Word document. At the conclusion of each interview, the interview recording and the informed consent forms were uploaded to a secure Google Drive. Furthermore, the researchers uploaded their field notes that are written prior to the data collection procedure, during, and after the interviews. Once the interviews were transcribed by the researchers, they were uploaded to Google Drive. The Google Drive was only accessed through an authorised link which only the researchers had access to.

Data Collection Method: Semi-structured Interviews

Data was collected using one-on-one virtual semi-structured interviews. The interview schedule was used to guide a systematic method of data collection, whilst accommodating a flexible approach to encourage the exploration of South African parents' lived experiences during the pandemic. Semi-structured interviews enabled the researchers to facilitate the elaboration of these experiences and possible meanings that have been constructed while allowing for a holistic conceptualization of the 'lived experiences of parents during the COVID-19 pandemic in South Africa'. The interview guides were formulated based on a literature review and sought to accomplish the aim of the study and answer the research questions. The open-ended questions mostly focused on the parents' experiences during the COVID-19 pandemic.

Data Analysis

Creswell's (2014) six-step model of thematic analysis was utilised to analyse the data. This model utilises systems of identification, formulation, and classification to perform a thematic analysis through which we can consolidate the empirical data into worked descriptions encompassing the

phenomena under investigation (Creswell, 2014). The following steps outline a systematic process toward thematic analysis that was used to process the data obtained from the 8 participants.

Step 1. The collected data was organized by the researchers for analysis by means of transcribing the Zoom meeting interview data, as well as the field notes.

Step 2. The researchers read through the data in order to gain an initial understanding of the data. Noting a preliminary sense of the general ideas, their tones, and the credibility of these ideas

Step 3. The data were then coded using a Program called MAXQDA 2022. The data was then organized into relevant and meaningful pieces and placed into categories that were labeled with a single word.

Step 4. The following setting, people, categories, and themes were described in the data analysis.

Step 5. The researchers considered the best way of representing the themes and descriptions in the findings. Therefore, involving a detailed discussion of the themes.

Step 6. A comprehensive interpretation of the findings was therefore presented, highlighting the conclusions and future recommendations from the study.

For confirming and verifying the results of qualitative analysis and ensuring that the provided findings are trustworthy, the researchers used transferability and reflectivity. To maintain a valid and rigorous study, the researcher presented their identified themes to one of the participants as part of a member-checking strategy. A bracketing strategy was also employed by writing in a diary about researchers' preconceptions, feelings, and field notes. In addition, the researchers had to re-read the interviews and transcripts and reflect on the possible meanings and biases of the participants and themselves (Barrow, 2017). Two types of triangulations were employed in the study, a) data triangulation (i.e., semi-structured interviews) and b) theory triangulation (i.e., phenomenology and Ecological Systems Theory).

Complementary to the bracketing strategy is the practice of reflectivity, in which it is the responsibility of the researcher to be cognisant of their position as a facilitator of knowledge and how the phenomena being investigated are presented. Reflexivity requires a process of critical examination of the judgments and interpretations made during the research process, which assesses the researchers' inherent and preconceived ideas, thoughts, and emotions that can influence the findings of the researcher and their interactions with research participants (Creswell, 2014). By documenting the preconceptions, feelings, thoughts, and fieldnotes in a diary, transparency can be emphasized, and further enhance the credibility and trustworthiness of the research report and deepen the understanding of the phenomena.

Ethical Considerations

Throughout the entire research process, the researchers adhered to ethical considerations. The researchers respected the dignity and worth of each participant and stakeholders involved in the research study and strived to preserve and protect their human rights in a professional manner. The researchers respected the participants' right to hold different opinions, values or beliefs from their own.

The following steps were taken to ensure that participants' identities were kept anonymous throughout the research process and the reporting of the findings. During the one-on-one interviews, the researchers allowed the participants to keep their camera off if they preferred doing so. In addition,

the participants' anonymity was concealed by providing the participants with pseudonyms which ensured that no one will be able to identify the participants after the study. This measure ensured that the participants' identities and personal information was safeguarded.

The researchers upheld the principle of confidentiality by handling information in a confidential manner. This includes the collection and storing of data from the participants, therefore, the researchers could under no circumstances interview participants or record interviews without the participants written and verbal consent. Permission was granted from participants to record interview sessions for transcription purposes. The audio and/or video recording was uploaded to a google drive that only the researchers had access to and was secured using a password. This was done promptly after the interview had been recorded. Once all the interviews had been transcribed into a written document, the researchers permanently deleted the audios and/or videos from the google drive. The transcribed interview and additional interview notes were uploaded and stored on a restricted Google Drive that only the researchers will have access to for the next five years, thereafter it will be destroyed.

To respect the participants' right to autonomy and to protect their welfare, the researchers provided all participants with a consent form at the beginning of the study. During the data collection procedure, the researchers ensured that written consent was received from the participants before any interview was scheduled. The researchers also asked the participants for their verbal consent to record the semi-structured interviews and for their permission to store the data. In addition, the participants were given the opportunity to ask any questions before the commencement of the study and during the investigation.

Each participant received a consent form that informed them a) on the nature of the research, b) their voluntary participation c) their right to decline participation, and d) withdrawing from the research.

The researchers valued the participants' rights and therefore, were candid with the participants about the research process and how it might have potentially affected them. The researchers ensured that they were transparent about the purpose and objectives of the study, and avoided any forms of deception. The potential risks to participants in the study may have included feelings of discomfort as a result of discussing sensitive topics. However, the foreseeable risks in this study were very minimal. Should participants have experienced any distress and required debriefing sessions, the researchers were accordingly going to refer them to organisations that could have assisted them in debriefing. However, no participant needed any form of debriefing.

Biographic Details of Participants

The biographical information of the participants related to this study is shown in Table 1 below.

Table 1 A Presentation of the Biographical Information of Participants

Participants	Gender	Race	Location	Highest Education	Occupation	No. of Children
Participant 1	Female	White	Pretoria	University Degree	Housewife	2
Participant 2	Female	White	Cape Town	University Degree	Communications	2

Participant 3	Male	White	Pretoria	University Degree	Compliance office	1
Participant 4	Female	White	Cape Town	University Degree	Administrator	2
Participant 5	Female	White	Bloemfontein	University Degree	Own business	2
Participant 6	Female	White	Western Cape	University Degree	Teacher	1
Participant 7	Male	White	Pretoria	High School	Engineer	2
Participant 8	Female	Indian	Cape Town	University Degree	Designer	1

In this study, there were a total of 8 participants, with females accounting for 80 percent of the overall population and males accounting for just 20 percent. There was only one Indian participant among the entire group of white Caucasians. The majority of the participants already had two children, while a small number of participants only had one. They all had some level of higher education background, with seven of eight obtaining a university degree.

Findings

Seven themes were identified among the 8 participants with additionally, two subthemes. The themes were: perceptions of COVID-19; relationships and with a sub theme spouse relationship; connections and lost connections; routine changes; financial changes and education; positive experiences. The findings of the study are discussed below. Pseudonyms were used in this section to guarantee participant confidentiality.

Theme 1: Perceptions of COVID-19

The majority of participants were concerned about the COVID-19 outbreak; they were worried about being infected. However, just a handful thought it would be life-threatening or serious. Participants reported significant levels of concern when it came to explaining the virus to their children, and thought the lockdown was necessary in some ways but that it was exaggerated. After learning about the virus, most participants increased their use of hygiene techniques and social distancing.

The participants talked about how they would inform their children about COVID-19, and talked about their emotional reactions to Covid-19 and their early emotions about it. Jane clearly stated that they told the truth to the children: "*They knew what was going on. We told them from the start what was happening in the world and my husband's best friend actually stays in China. So, we knew about COVID a bit before everyone started talking about it here. So, we talked about COVID with them before the pandemic actually started in our country".* Nadine also said being honest was a good approach for their family. However, Christine said that having a medical understanding made it much easier for her to explain the pandemic to her children. She said, *"Yes …. explain to them from a medical side or health side what it is [referring to the virus] that they are looking at and why we do what we do, to just break it down a bit, so it doesn't feel like we're on a different planet".*

Others tried to explain it in a sense that an 8-year-old would understand, Lily explained by saying *"I told him that there is a big … type of germs out there and is very bad. It's very, very bad, so we're not allowed to go in front of our house"*. They however made sure he was aware that he would be safe around them, whilst still telling him where one cannot go. Parents also stated that their children

were first terrified by what was said at school or outside their houses, and that the children did not always comprehend what was going on in the world until it was explained to them. Nadine also said, *"Bad connection that everybody with COVID is going to pass away, I think that frightened my little girl."*

The majority of participants stated that they implemented small changes at first, such as sanitising and mask wearing. Sharon shared, *"We've made a lot of changes, whether it be just the normal or like sanitizing all the time or things like that. But we're more cautious just physically, you know about what we touch".*

Theme 2: Relationships

Participants indicated that COVID-19 has affected relationships. These ranged from spouses and partners to co-workers, friends, and acquaintances. The relationships were affected in a variety of ways, including frequency of contact and emotional closeness. Face-to-face connections were generally limited to primary network members, such as partners and family members, during the peak of COVID-19 restrictions such as the Lockdown. Some 'weak' links were lost, and interactions began growing more limited to those closest.

Changes in relationships with family members, notably spouses, were reported by the participants. Jane commented; *"So we still have a normal relationship with them. Friends wise, yeah, like I said, we had a few friends that we haven't seen now since COVID started … we miss them."* However, Lily commented, *"I guess a lot of relationships actually grew closer because everybody was in the same boat and everybody could relate to what was going on, so I guess that forced us a lot to chat and reach out virtually, so, a lot of the relationships actually grew closer and deeper".*

Participants also stated that their relationships with the children was affected. However, there were many positive sides. Parents struggled with adjusting how to engage or communicate with their children. Mandi stated, *"I had to navigate how to communicate with the children and teach myself how to approach each child differently in order to get a positive outcome."*

Sub-theme 2.1: Spouse Relationships

Parents shared different perceptions of the effects on their spousal relationship. Sharon remarked, *"It wasn't all easy, but our relationship was stronger and better, so for me it was all good in the end."* Josh commented, "*As a married couple it was difficult because the way in which you coped was different. She would like to avoid where you would like to engage..."* Additionally, Chris stated, *"So, luckily my wife and I bounce each other off with regards to that, which really helped."* Sharon mentioned, *"I think it was definitely a positive impact because we definitely started relying on each other a lot more".* The fact that needing to now rely on just one another was beneficial for their relationships.

Theme 3: Connections

Social support and social interaction is an important method by which social ties improve health. In fact, one of the most crucial resilience components in the aftermath of stressful events has been found to be social support. The normal ways in which people connected and got social support

have been substantially disrupted in the specific instance of COVID-19 and the Lockdown in South Africa.

Parents discussed their connections with others and the different changes. Christine mentioned, *"Connections changed, there was a shift in who you like to surround yourself with, true friends, people that matter…quality relationships*. In pandemic times, participants started realising who their true friends are and who is willing to put in the effort to remain connected and in touch. Participants also had to select which ties to pursue and preserve and which ones to let go of. Josh also shared, "*But if you actually just focus for a bit. You see this…everybody is just selfish, you know. And this just brought it out. And you know the friendships we have? That's good, went deeper and we lost a lot of them … now we can see that there's no value to this and we just walk away."*

Sub-theme 3.1: Lost Connections

Participants voiced their concerns with their lack of connection and support. Jane shared: *"We've lost a few people…that were closely connected to us but I think when we started hearing about people that passed away from COVID, then it really hit home".* Josh said, *"The major challenge was the loss of emotional and physical connection that you used to have with family and friends."*

Participants also mentioned that children felt the biggest connection loss of friends and interactions. Sharon stated, *"The children need interaction with children their own age".* Some participants mentioned that they lost contact with other parents due to the closing of schools; this was a negative experience because these are the people who used to provide them with a support system. Nadine stated, *"…I mean also as a parent I guess that you lose that interaction with another fellow parent."*

Theme 4: Routine Changes

The participants shared how their lifestyle, routines, roles, and responsibilities had changed because of the pandemic. Chris said, *"I cope with this with this new environment, working with my wife at home. You know which we've never done. So, I think that first few weeks was quiet, I think it was an easy, easy three weeks for me."* Some challenges with regards to routine changes began when after school care closed whilst their jobs continued. This made participants to struggle balancing their everyday routines. Lily stated, *"All of a sudden there was no aftercare whilst me and my husband were still going to work, well, work goes on."*

Theme 5: Financial Status

Parents shared their different financial changes, struggles and privileges. Christine stated, *"My husband did not survive the pandemic, there were financial concerns with his business."*

Not all participants had negative financial experience, Nadine voiced, *"We were blessed, we didn't have any financial implications."* She stated that they were lucky enough to have benefited from the pandemic by means of owning a cleaning company that did sanitising during the lockdown. Other participants used the pandemic to sensitise their children to recognise their privileges. Lily shared an example of a play station that their son desired, but he had to earn it and was not simply allowed to just

get it, she mentioned, *"So he understood his privileges, his circumstances were better than of other kids during the pandemic."*

Theme 6: Education

The transition from in-person to virtual education was viewed by participants as being of a significant impact to them. Although there were two participants who either already did home schooling or considered it long before the pandemic and lockdown, most participants had children in public schools and found the adaption from face-to-face to online easy with minor difficulties. Parents expressed their thankfulness towards teachers and emphasised the extra mile that most teachers did to make the transition to online learning much easier for parents. Jane stated, *"I am a stay-at-home mom, and we also homeschool our kids."* The following are positive comments, as well as a few challenges that the parents faced during the pandemic and lockdown with regards to their children transitioning to online education. Christine commented, "*So now your day is not concentrating only on your work because you need to complete the schoolwork as well with the kids. So, your lunch hour is now a school hour and after hours you need to make sure everything is fine."* However, Mandi had a different experience, she stated, *"Teachers and schools really went the extra mile during the pandemic, uhm, structuring, …resources, lessons…resources for the little ones, making it so practical as possible for them."*

Because most of the participants had very young children, the responses regarding school adaptation were rather favorable, and not many struggled to help their children adapt to online learning, many stated that it was simpler to track their children's development online. Mandi stated, *"Because a lot of the schools had to throw stuff on the Internet, so it was a real cool way for us to measure where we are because especially when they small there's not a real syllabus that you're following and exams and stuff."*

It is clear from the findings that having to home school children during the pandemic had both positive and negative consequences.

Theme 7: Positive Experiences

During the pandemic, parents recounted their positive experiences and special occasions. Christine reflected on her positive experiences as follows, *"I had very much more quality family time."* Josh claimed, *"I never realised how strong you (woman) actually are and how much you can endure, you know and uhm, I guess that was such a heart-warming experience for me."* Lily added that the pandemic had a positive outcome of realising who is important in life, she said, *"The pandemic also made you realise that uhm, the people that matters are the people at home. And, and that is so, that's just so nice knowing that you don't have to go out, the pandemic also showed you who are the people who really matter to you".*

Other positive experiences were related to flexibility of work, Chris mentioned that he now has the opportunity to work virtually for a company internationally in the UK and believes that he does not think that it would have happened if it was not for the pandemic and lockdowns forcing people to use online platform, he reflected, "*It's quite cool, so I think the world has changed for the better".* For most participants, positive experiences were the extra time they got to spend with loved ones' and what they learned from one another in this time. Sharon shared that they had an opportunity to spend quality time

with their newborn baby without needing to share her with the world for a short while, she said, *"Being able to just sort of be home with the baby, and to do all of that. That was also, you know, quite good."*

Discussion of Findings

The study explored parents' lived experiences during the pandemic in South Africa. Seven themes and two subthemes were discovered by the researchers. The experiences ranged from social support groups and relationships with spouses and children, to positive experiences and adjustment to online education for children. There are clear links to past study literature; nevertheless, socioeconomic stresses were not as prevalent as projected in earlier research done in other countries. According to Vanderhout et al., (2020), the COVID-19 epidemic has had a particularly negative impact on children and families. While children appear to have milder impacts from COVID-19 than adults, abrupt changes in routines, resources, and relationships because of limits on physical engagement have had significant consequences for families with young children.

Children's social and support networks have been severely disrupted due to a lack of school, childcare, extracurricular activities, and family gatherings. Additional duties for parents as they adjust to their new roles as instructors and playmates while managing full-time caregiving with their own difficult shifts in job, financial, and social situations have added to the stress caused by COVID-19. The shifting emotional states were the subject of the first theme found in the study. This aligns to the findings of a study by Golberstein et al., (2020), who found that during the pandemic, both parents and children experienced increased levels of emotional anguish. When it came to explaining the matter to their children, the parents struggled and discussed how they would do it. Some parents went right to the point and told it like it was, while others attempted to explain things in a way that their children could comprehend.

During the early phases of the pandemic, many participants thought the lockdown had been prolonged unnecessarily and may have been implemented too soon, but they also exhibited a high level of adoption of preventive measures, as well as a willingness and perceived ability to self-isolate. To attain high adherence to these preventive actions in these groups, tailored public health messaging and interventions are required.

Participants expressed concern about future adult-child relationships. The ramifications of this unprecedented reliance on virtual connections are unknown. The sensation of emotional connection and closeness with other people is referred to as intimacy. Emotional connection, whether through sexual, friendship, or familial interactions, satisfies a basic human need while also providing significant health benefits, such as less stress, enhanced mental health, lower blood pressure, and a lower risk of heart disease. Companionship and proximity provide essential intimacy for mental health. Positively, the COVID-19 pandemic has provided opportunity for participants to (re)connect and (re)strengthen intimate relationships inside their families by spending quality time together when many common external social activities were put on hold. According to research, the first full lockdown period resulted in a significant improvement in the quality of stable relationships across the community (Greyling et al., 2021). During the lockdown, most parents said their relationships with their partners and children improved, though they did encounter small barriers and problems.

Infectious disease pandemics, such as COVID-19, necessitate intrapersonal behaviour changes and pose highly complicated public health concerns. A pandemic of an airborne sickness spreads rapidly through social contact, causing chaos in human relationships by significantly altering how people interact (Long et al., 2022). Participants described strengthening their bonds with their close family in the third theme, connections, which could be a benefit of the pandemic (Fegert et al., 2020). Researchers discovered an inverse association between parental intimacy and sadness, anxiety, and stress levels in their offspring (Wu et al., 2020).

Participants reported a deeper level of connection with others, as well as a loss of connection, as social distancing affects connecting with others outside the home. Connection and support are nevertheless vital in the face of this loss (Fegert et al., 2020). The study found that participants lost contact with other parents at school who could have assisted them with their children's difficulties. This also hindered their ability to communicate with people outside of their core connections. Meanwhile, online forms of social support are not geographically limited, allowing for interactions and social support from a larger group of people. Formal online social support spaces (e.g., support groups) existed long before COVID-19, but their popularity has skyrocketed since then. While online contacts can boost social support perceptions, it's uncertain whether distant communication technologies can replace in-person engagement during times of social isolation (Long et al., 2022). Therefore, some parents kept in contact with connections outside of their core relationships and they did not lose all connections with others. It is all too simple to flick on the TV or surf through social media while self-isolating. Trying to connect with people and exhibit compassion and solidarity, on the other hand, makes one to feel better and benefits everyone.

In the Fourth theme, participants talked about taking on new roles that came with their own set of obstacles (e.g., teaching) that is discussed in more detail in the 6th theme. Some participants discussed the advantages of spending more time at home and developing a new routine with their partner to combine work and childcare. Participants acknowledged the need for more structure at home in terms of family routine. Routines are vital in times of uncertainty because they provide a sense of normalcy and can help people cope (Harrist et al., 2019). Morning meetings, to-do lists, and teaching "life lessons" are all part of routines. The slower ~~the~~ pace and fewer activities allows parents to spend more time with their families. This is seen as a benefit of the epidemic by some (Fegert et al., 2020). Researchers have reported the consequences of the pandemic on work–family balance, as well as an inverse link between marital satisfaction and levels of sadness, anxiety, and stress (Craig & Churchill, 2021).

Participants talked about their financial status, their capacity to work/stay at home, and their health. Individuals in specific work sectors (e.g., restaurants, transportation) have been identified as being the most affected by social distancing practices (Vavra, 2020). In this study, most parents had professional careers and were not financially affected by the pandemic.

As a result of the COVID-19 epidemic, educational institutions have collapsed, and instruction has shifted drastically to distance learning. Students from low-income households and those who live in rural areas, on the other hand, have restricted access to the technology required for online learning. The study found that some participants had previously done home schooling and that it was not difficult; however, some participants struggled with the phenomenon of home schooling, which meant that they were actively required to assist the children with schoolwork. Therefore, a large part of routine changes was where parents now had to take on the roles as educators in the household. On a lighter note, the participants recognised the benefits of the new learning setup because it assures the protection of their

children while also strengthening family relationships. This links with the positive experiences of participants as well as child-adult relationships.

Lastly, the high and low experiences that the participants and their families experienced reflect reactions to the pandemic's negative (social isolation) and positive (more family time) effects. Positive experiences were however mentioned by participants, which should not be disregarded. Many parents, for example, reported feeling connected to their children than before the pandemic. This is relevant since the quality of parent–child relationships can safeguard the negative effects of stress and negative behaviours on both parents and children (Kerr et al., 2021).

Limitations

The findings of this study should be viewed in light of their limitations. Firstly, because this study used non-random sampling and a small sample size, the participants are not representative of the entire South African population of parents. Secondly, there was a limited amount of participant diversity due to most participants being White and female. Furthermore, most participants were in the professional fields and were able to work from home. Parents of primary school-aged children who had access to virtual learning or children who did not require online learning made up the majority of participants. Parents of high school students who needed daily online learning, for example, could be included in future studies.

Conclusion

The pandemic necessitates research about how parents feel and negotiate this experience. The COVID-19 epidemic has posed significant hurdles to the parents and families. The pandemic forced the closure of schools and a major shift in educational methods to online learning epidemic. The COVID-19 epidemic has had a particularly negative impact on children and families, interrupting routines, affecting relationships and roles, and causing changes to normal childcare, school, and leisure activities.

Parents who are learning to adapt to this new way of living by facing distinct problems along with positive experiences. Parents may manage the pandemic with the help of resources and assistance, developing positive coping skills and family interactions.

Recommendations

Due to the small number of participants, the findings of this study cannot be generalised to all South African parents. Future research could include a broader geographic scope, particularly in rural regions, as well as a combination of survey methods to accommodate parents of different races and income levels. A follow-up study may be conducted to investigate the pandemic's long-term effects.

The findings of the study underline the importance of parents being supported during a global pandemic. Future interventions that assist parents in navigating the demands of day-to-day life should be designed from an ecological systems perspective to be comprehensive, efficient, and effective in supporting parents during future times of crisis. The interventions should aim to promote parents to a) have positive outlooks b) seek support, c) maintain the family systems through utilising planning strategies, and d) conflict resolution.

Policy makers should development policies aimed at supporting parents during pandemics in collaboration with parents, giving them a voice. Such policies should be drawn from an ecological systems perspective and take into consideration the micro, macro, mezzo, and chrono impacts of the pandemic.

Social workers and social service providers should be trained on crisis intervention and disaster management to raise their competency in supporting families during pandemics.

Implications and Significance

Covid-19 has caused various impacts on the socio-economic, psychological, social, and physical aspects of parents' and children's lives. Therefore, the study contributes to the literature and provide insight into the lived experiences of South African parents during the Covid-19 pandemic, which will assist professionals and policy makers in formulating policies geared towards the establishment of interventions and programmes for supporting parents and children during pandemics, disasters, and other times of disruption.

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Examining The Prevalence of Postnatal Depression and Associated Factors Among Women: A Case of Women Delivering at Levy Hospital

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Abstract

This study examined the prevalence of postnatal depression (PND) and its associated factors among women who delivered at Levy Mwanawasa Hospital in Zambia. The cross-sectional study surveyed postpartum women using standardized questionnaires to assess PND prevalence and identify related socio-demographic, obstetric, psychological, and biological factors. The findings revealed that most respondents were between 26-30 years old, married, and had primary-level education. Despite a high unemployment rate of 76.1%, most respondents reported household incomes above K2,000. The study found that 54.8% of participants experienced post-birth sadness, while 48.6% reported anxiety. The overall PND prevalence was 18.2%, aligning with previous research findings. Financial stress emerged as the most significant contributing factor to PND, with 94.3% of respondents identifying it as a concern. Relationship difficulties (77.9%) and lack of social support (75.8%) were also major factors. Notably, childcare-related stress was not perceived as a significant contributor by most respondents, contrasting with existing literature. The study recommended integrating routine mental health assessments into postnatal care and developing culturally sensitive interventions at the hospital.

Keywords: Antenatal, Postpartum, Postpartum depression, Postnatal, Pregnancy

Introduction

1.1 Background

Postnatal depression (PND) has emerged as a growing public health concern in Zambia, affecting the well-being of mothers and their newborns. Evidence from various regions of the country indicates that a significant proportion of women experience depressive symptoms following childbirth. For instance, Mwape et al. (2012) reported a PND prevalence rate of 48% among postpartum women in Lusaka Province within six weeks of delivery. Similarly, Ng'oma et al. (2019) found that 30.3% of mothers in Choma screened positive for PND, with socio-economic and relational factors such as financial stress, limited social support, and marital problems contributing to increased vulnerability. Despite these findings, current research remains limited in its ability to offer localized, facility-specific data that can inform targeted interventions. Most existing studies have focused on broader regional or district-level prevalence, with only a few exploring the influence of contextual factors such as healthcare access, traditional practices, HIV status, and maternal socio-economic characteristics. For example,

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Received 27 February 2025 Revised 16 May 2025 Accepted 13 June 2025

Chibanda et al. (2011) and Pollard and Howard (2021) have emphasized disparities between rural and urban settings and the role of education and employment in influencing mental health outcomes. However, these studies do not fully capture the lived realities of women giving birth at specific institutions such as Levy Mwanawasa Hospital, a key referral facility in Lusaka. While there is emerging evidence on the effectiveness of interventions such as peer support groups and mental health screening integration, the extent to which these are implemented or effective in particular healthcare settings remains unclear. As a result, there is a critical gap in understanding the specific factors associated with PND among women delivering at Levy Mwanawasa Hospital.

This study therefore seeks to examine the prevalence and associated factors of postnatal depression among women delivering at Levy Mwanawasa Hospital. Researchers affirmed that by generating facility-specific data, the research aims to inform more targeted and context-relevant interventions, contributing to improved maternal mental health outcomes in Zambia. The study's findings will be particularly valuable for healthcare providers and policymakers seeking to integrate mental health support into postnatal care services.

1.2 Statement of the Problem

The prevalence of postnatal depression among women delivering at Levy Hospital, along with its associated factors, remains poorly understood. Postnatal depression affects approximately 10-15% of women globally within the first year after childbirth (O'Hara & McCabe, 2013) and can reach rates as high as 20-25% in developing countries (Gelaye et al., 2016). Despite the significant impact of postnatal depression on maternal and child well-being, including impaired mother-infant bonding (Slomian et al., 2019) and delayed cognitive development in children (Stein et al., 2014), there exists a gap in comprehensive examination and understanding of its occurrence within this specific demographic. Untreated postnatal depression can have long-lasting effects on both mother and child, including increased risk of chronic depression in mothers and behavioral problems in children (Netsi et al., 2018). Therefore, elucidating the prevalence and identifying associated factors are imperative to inform targeted interventions and support strategies (Howard et al., 2015) to mitigate the adverse effects of postnatal depression on mothers and infants in the local context.

1.3 Objectives of the Study

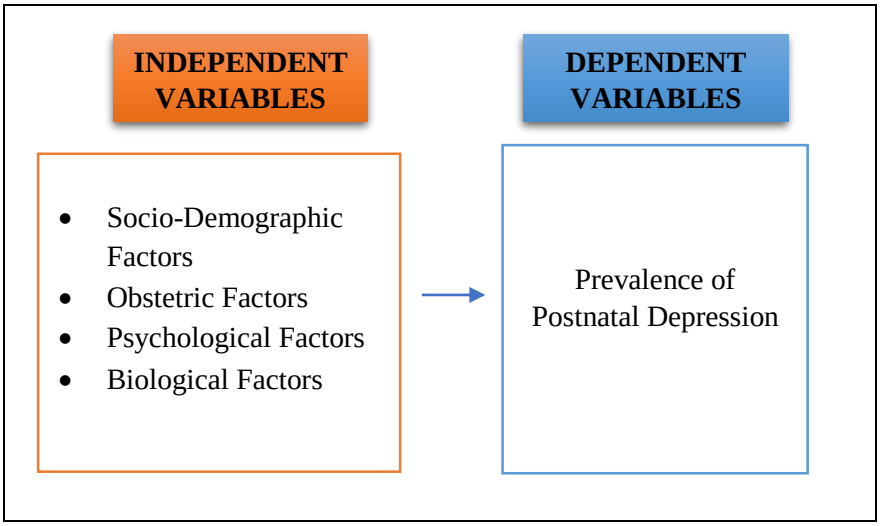
The following were the objectives of the research: To determine the prevalence of postnatal depression among women delivering at Levy Hospital, to assess the socio-demographic factors associated with postnatal depression among these women; to investigate the factors contributing to postnatal depression among women in this population and to explore coping mechanisms utilized by women experiencing postnatal depression at Levy Hospital.

1.4 Research Questions

The following were the questions guiding the study: What is the prevalence of postnatal depression among women delivering at Levy Hospital?, What are the socio-demographic factors associated with postnatal depression among these women?, What are the factors contributing to postnatal depression among women in this population?, What coping mechanisms do women with postnatal depression employ to manage their symptoms and navigate their experiences at Levy Hospital?

1.5 Conceptual Framework

The conceptual framework offered a structured approach to analyzing postnatal depression (PND) among women at Levy Mwanawasa Hospital by examining several key variables. The independent variables included socio-demographic factors, where younger age, lower education levels, single marital status, and lower socio-economic status correlated with increased PND risk. Obstetric factors such as cesarean deliveries, and pregnancy complications contributed to elevated PND risk. Psychological factors, including previous mental health issues and stressful life events, significantly influenced PND development, while strong social support served as a protective factor. The dependent variable was PND prevalence, which manifested through symptoms like persistent sadness, worthlessness, and difficulty bonding with infants. Early identification and intervention were crucial for maternal and infant well-being.



Literature Review

Postnatal depression (PND) is a growing public health concern that affects a significant number of women globally. Numerous studies have been conducted across various countries to understand its prevalence and associated risk factors. This section reviews literature thematically, focusing on global, regional, and national contexts, and highlights critical gaps that justify the present study.

2.1 Global Perspectives on Postnatal Depression

Globally, studies have consistently shown that PND affects 10–20% of new mothers. Gavin et al. (2005), through a systematic review and meta-analysis in North America and Europe, estimated that 10–15% of women experience PND, utilizing standardized tools such as the Edinburgh Postnatal Depression Scale (EPDS). O'Hara and McCabe (2013) further noted that up to 80% of women experience transient “baby blues” within the first two weeks postpartum, though this is distinct from clinical depression.

In China, Pan et al. (2024) conducted a meta-analysis and reported a 16.3% prevalence rate of PND in 2020. Another study by Wang et al. (2017) observed disparities in depression prevalence based on demographic and geographical differences. Similarly, Goyal et al. (2010) found that low income and financial stress significantly predicted PND among young urban mothers in the United States. Chang et

al (2024) highlighted that American women adopted various coping mechanisms, including therapy and self-care activities, to manage PND.

Studies have also explored interventions. Milgrom et al. (2016) in Australia found that a self-help workbook based on cognitive behavioral therapy, combined with minimal telephone support, was effective in reducing depressive symptoms in PND patients.

2.2 Socio-Demographic and Cultural Influences on PND

Socio-demographic risk factors are strongly linked to PND. Robertson et al. (2004) identified poor marital relationships as moderate risk factors through a meta-analysis. Schobel et al. (2018), in a German context, found a higher PND prevalence among women from low socio-economic backgrounds. In India, Alam et al. (2021) revealed that marital conflict, cultural stigma, and financial stress exacerbated depressive symptoms among postpartum women. Yim et al. (2015) emphasized that the availability and quality of social support play a critical protective role in preventing PND.

2.3 Postnatal Depression in Africa

In Africa, PND remains under-researched despite growing concerns. A study by Gowon et al (2024) in Nigeria used a systematic literature review and found considerable variation in PND prevalence due to socio-economic and healthcare disparities. In Ghana, Osei et al. (2014) found that 23% of postpartum women had PND symptoms, with significant associations to unplanned pregnancies, youth, unemployment, and low education levels.

In East Africa, Doe (2023) conducted a mixed-methods study in Kenya and found higher PND prevalence in urban (25%) compared to rural areas (15%). In Rwanda, Umuziga et al. (2023) explored the qualitative dimensions of PND and identified economic instability, poor healthcare access, and lack of social support as major contributors to maternal depression.

2.4 Postnatal Depression in Zambia

Zambia has also witnessed increased attention to PND. In a more targeted study, Kabwe et al (2022) found that younger mothers, those with low education, single or unhappily married women, and those from low-income households were more likely to develop PND. These findings emphasized the influence of socio-demographic vulnerabilities on maternal mental health.

At the national level, Mwansa (2024) conducted a mixed-method study and found that 65% of women attributed their PND to lack of social support, 52% to economic stress, and 40% to cultural beliefs. Furthermore, only 25% of the respondents were aware of available mental health services, highlighting a significant service gap.

2.5 Research Gaps

Although existing studies have highlighted the prevalence and risk factors associated with PND in Zambia and other regions, there is limited research specifically targeting institutional-level data. For example, while national and district-level studies provide general insights, they do not capture the specific socio-cultural, demographic, and clinical variables unique to particular healthcare facilities like Levy Mwanawasa Hospital.

This gap presents a critical opportunity for localized research to inform policy and tailor interventions. The current study, therefore, aims to examine the prevalence and associated factors of PND among women delivering at Levy Mwanawasa Hospital. Focusing on this institution, the study

will provide evidence-based insights that can guide hospital-level screening, early detection, and mental health service integration within postnatal care programs.

Research Methodology

This study employed a cross-sectional design to investigate the prevalence of postnatal depression and its associated factors among women delivering at Levy Mwanawasa University Teaching Hospital in Lusaka, Zambia. The cross-sectional approach allowed for the simultaneous examination of multiple variables at a single point in time, making it particularly suited for estimating prevalence and identifying correlates in a cost-effective manner.

3.1 Target Population and Sampling

The target population comprised postnatal women who had recently delivered at Levy Hospital. The hospital, a tertiary referral and teaching facility, records approximately 3,480 deliveries annually. The study employed systematic random sampling to ensure unbiased selection of participants from the hospital's maternity records. The sample size was determined using a 95% confidence level, a 5% margin of error, and an assumed prevalence rate of 50% to ensure maximum variability. Based on this calculation, the final sample size was 385 respondents.

3.2 Data Collection Tools and Procedures

Data were collected through structured interviews using a pre-tested questionnaire composed of three sections. The first section gathered socio-demographic data, the second focused on obstetric and medical history, and the third employed the Edinburgh Postnatal Depression Scale (EPDS), a validated screening tool for assessing postnatal depression. The EPDS uses a cutoff score (commonly ≥13) to identify likely cases of postnatal depression. This instrument was selected for its reliability and global applicability in postnatal mental health studies.

3.3 Data Analysis

All data were analyzed using the Statistical Package for the Social Sciences (SPSS) Version 22.0. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize participants' demographic characteristics and determine the prevalence of postnatal depression. Bivariate analysis was conducted using Chi-square tests to assess associations between categorical independent variables, such as marital status, education level, and employment status, and the presence of postnatal depression. In addition, independent t-tests were used to compare mean EPDS scores across two-group variables, for example, comparing employed versus unemployed women. Furthermore, multivariate analysis was carried out using binary logistic regression to identify independent predictors of postnatal depression while controlling for potential confounders. Odds ratios (OR) with 95% confidence intervals (CI) were calculated to assess the strength and significance of these associations. This multi-layered analytical approach enabled the identification of both statistically significant bivariate associations and independent predictors of postnatal depression.

3.4 Validity and Reliability

To ensure the quality of the measurement tools, content validity was established through expert review and alignment with existing literature on postnatal depression. Construct validity was assessed using factor analysis to confirm the underlying structure of the EPDS. Reliability was verified through Cronbach's alpha, with a coefficient of 0.70 or above considered acceptable for internal consistency.

These steps ensured that the data collection instruments were both valid and reliable for the study context.

3.5 Ethical Considerations

Ethical approval for the study was obtained from the National Health Research Authority (NHRA). Informed consent was secured from all participants prior to data collection. Confidentiality and anonymity were maintained by coding responses and securely storing data. Participation in the study was voluntary, and respondents were informed of their right to withdraw at any stage without consequence. Participants who were identified as being at risk for postnatal depression, based on their EPDS scores, were referred to mental health professionals for further evaluation and support. The study prioritized the rights, dignity, and well-being of all participants throughout the research process.

Findings

4.1 Demographics

This section provided an overview of the respondents' demographic profile. The age distribution of respondents indicated that 8.1% (n = 31) were under 20 years, 26.2% (n = 101) were between 20–25 years, 46.5% (n = 179) fell within the 26–30 age group, 15.1% (n = 58) were aged 31–35 years, and 4.2% (n = 16) were between 36–40 years. In terms of marital status, 16.4% (n = 63) of participants were single, while the majority, 83.6% (n = 322), were married. The valid and cumulative percentages were consistent, with singles accounting for 16.4% cumulatively, and married individuals comprising the remainder of the sample. Educational attainment showed that 45.7% (n = 176) of respondents had completed primary education, followed by 42.1% (n = 162) with secondary education, and 12.2% (n = 47) with tertiary education. Thus, nearly half of the participants had attained only primary-level education. With regard to employment status, 76.1% of the respondents reported being unemployed, representing the largest proportion. Full-time employment accounted for 16.1%, part-time employment for 5.7%, while students represented the smallest category at 2.1%.

Table 1 Demographic profile

Variable	***n***	***%***
Age		
Under 20	31	8.1
20-25	101	26.2
26-30	179	46.5
31-35	58	15.1
36-40	16	4.2
Marital status		
Single	63	16.4
Married	322	83.6
Education		
Primary Level	176	45.7
Secondary Level	162	17.8
Tertiary Level	47	12.2
Employment status		
Employed full-time	62	16.1
Employed part-time	22	5.7

Unemployed	293	76.1
Student	8	2.1
Household income		
Less than k1,000	14	3.6
k1,001 to k2,000	77	20.0
k2,001 to k4,000	140	36.4
Above k4,001	154	40.0

4.1.1 Postpartum emotional experiences

Table 1.1 Postpartum emotional experiences

Questions	Frequency			
	Yes		No	
Have you experienced feelings of sadness after giving birth	n	%	N	%
	211	54.8	174	45.2
Have you experienced feelings of anxiety after giving birth?	187	48.6	198	51.4
Have you experienced feelings of depression after giving birth?	70	18.2	315	81.8

The distribution of postpartum emotional responses among women delivering at Levy Hospital revealed a notable prevalence of emotional disturbances following childbirth. Specifically, 54.8% (n = 211) of respondents reported experiencing sadness postpartum, while 45.2% (n = 174) did not. Similarly, 48.6% (n = 187) indicated experiencing anxiety after delivery, with 51.4% (n = 198) denying such experiences. Notably, a smaller proportion, 18.2% (n = 70), reported symptoms consistent with postnatal depression, whereas a significant majority of 81.8% (n = 315) did not report depressive symptoms.

Statistical Inference

To assess whether the observed prevalence of postpartum depression significantly deviates from a known or hypothesized population rate of 20%, a binomial test was conducted. The result yielded a p-value = 0.408, suggesting no statistically significant difference from the 20% reference prevalence ($p > 0.05$).

Additionally, the Shapiro-Wilk test for normality was applied to assess the distributional assumptions of the depression variable (coded as 0 = No, 1 = Yes). The result indicated $p < 0.001$, implying a violation of the normality assumption. Given the binary nature of the dependent variable and the non-normal distribution, non-parametric statistical methods or logistic regression are recommended for further inferential analysis of associations between depression and independent variables.

4.1.2 Postpartum depression and related symptoms

In this postpartum depression survey, 36.9% of participants reported experiencing depression after giving birth, while 63.1% did not. When asked about their mood in the previous two weeks, 39.2% felt down on several days, while 60.8% did not experience such feelings. Additionally, 47% reported

feeling depressed on several days, while 53% did not feel depressed at all. Regarding hopelessness, 21.8% experienced these feelings on several days, while 78.2% did not. Loss of interest in activities was reported by 38.4% of respondents, while 61.6% experienced a loss of pleasure. Sleep issues affected 31.2% of participants on several days. Feelings of tiredness were prevalent, with 87% of respondents experiencing fatigue to some degree: 31.9% on several days, 40% on more than half the days, and 15.1% nearly every day. Appetite changes affected 77.4% of participants, with 67.8% experiencing this on several days. While 7.8% reported feelings of worthlessness, no participants indicated thoughts of self-harm or harming their baby. Only 1.8% reported concentration difficulties, suggesting this was not a widespread issue.

Table 1.2 Postpartum depression and related symptoms

Postpartum depression and related symptoms	Not at all	Several days	More than half the days	A Nearly every day
How often have you felt down in the past two weeks?	60.8%	39.2%	0.0	0.0
How often have you felt depressed in the past two weeks?	53.0%	47.0%	0.0	0.0
How often have you felt hopeless in the past two weeks?	78.2%	21.8%	0.0	0.0
Have you experienced a loss of interest in activities you used to enjoy?	61.6%	38.4%	0.0	0.0
Have you had trouble sleeping?	68.8%	31.2%	0.0	0.0
Do you often feel tired or have little energy?	13.0%	31.9%	40.0%	15.1%
Have you experienced changes in appetite?	22.6%	67.8%	9.6%	0.0
Have you experienced feelings of worthlessness?	92.2%	7.8%	0.0	0.0
Have you had thoughts of harming yourself or your baby?	100.00%	0.0	0.0	0.0
Have you experienced feelings of guilt?	100.0%	0.0	0.0	0.0
Have you had trouble concentrating on things such as reading or watching TV?	98.2%	1.8%	0.0	0.0

4.1.3 Association between Age and Depression

Table 1.3 Crosstab of Age Group and Postnatal Depression (Hypothetical Data)

Age Group	Depressed (n)	Not Depressed (n)
18–24	10	40
25–29	20	60
30–34	15	50
35–39	13	45
40+	12	55

The Chi-Square test for independence was conducted to assess the association between age group and the presence of postnatal depression among the 385 respondents. The result, $\chi^2(4, N = 385) = 1.24$, $p = 0.871$, indicates that there was no statistically significant relationship between a mother's age category and the likelihood of experiencing postnatal depression. This suggests that postnatal depression was uniformly distributed across different age groups within the sample.

4.1.4 Logistic Regression on Employment Status and Depression

Table 1.4 Model Summary: Logistic Regression Predicting Depression (N=385)

Predictor	Coefficient	Std. Error	z	p-value	95% CI
Intercept (Reference: Employed)	≈ 0	0.204	≈ 0	1.000	[-0.400, 0.400]
Part-time	-22.87	9439.62	-0.0024	0.998	[-18524.2, 18478.4]
Student	+22.87	9437.29	0.0024	0.998	[-18473.9, 18519.6]
Unemployed	+0.021	0.288	0.072	0.943	[-0.544, 0.585]

The findings revealed that none of the employment categories demonstrated a statistically significant association with postnatal depression. All the p-values obtained were greater than 0.05, indicating weak evidence to support the hypothesis that employment status is a significant predictor of postnatal depression among the respondents. This suggests that, within this sample, whether a woman was unemployed, part-time employed, full-time employed, or a student had no meaningful impact on the likelihood of experiencing postnatal depression.

4.1.5 Factors contributing to postnatal depression

Table 1.5 Summary of Agreement on Contributing Factors (N = 385)

Factor	Agreement (%)	Neutral (%)	Disagreement (%)
Lack of social support	75.8%	11.7%	12.5%
Financial stress	94.3%	3.9%	1.8%
Relationship difficulties	77.9%	14.0%	8.1%
Stress related to childcare responsibilities	11.9%	30.1%	57.9%

Statistical analysis using chi-square tests revealed that *lack of social support* ($\chi^2 = 198.64$, $p < 0.001$), *financial stress* ($\chi^2 = 322.08$, $p < 0.001$), and *relationship difficulties* ($\chi^2 = 216.15$, $p < 0.001$) were significantly associated with postnatal depression. In contrast, *childcare responsibilities* did not show a statistically significant association ($\chi^2 = 3.42$, $p = 0.064$), indicating weak evidence for its role.

A binary logistic regression was conducted with postnatal depression (Yes/No) as the dependent variable. Financial stress ($p = 0.001$), lack of social support ($p = 0.003$), and relationship difficulties ($p = 0.009$) were statistically significant predictors. Childcare-related stress did not significantly predict depression ($p = 0.234$).

4.1.6 Coping Mechanisms for Postnatal Depression

The table below summarizes the frequency of coping mechanisms adopted by respondents.

Table 1.6 Frequency of Coping Strategies Reported by Respondents (%)

Coping Mechanism	Not at all	Several days	> Half the days	Nearly every day
Physical exercise	79.5	20.5	0.0	0.0
Relaxation techniques (e.g., breathing, yoga)	26.5	40.8	25.2	7.5
Talking to a supportive person	0.0	92.7	7.3	0.0
Participating in hobbies	18.4	69.1	12.5	0.0
Self-help resources (books, apps)	40.8	59.2	0.0	0.0
Spiritual practices	17.9	82.1	0.0	0.0
Creative activities (drawing, painting, writing)	45.7	54.3	0.0	0.0
Mindfulness practices	52.7	47.3	0.0	0.0
Self-care activities (e.g., bath, massage)	7.8	56.4	31.9	3.9

The most widely adopted strategies included talking to supportive individuals (92.7%), spiritual practices (82.1%), and engaging in hobbies (69.1%). Physical exercise was the least used (only 20.5%). These findings suggest a reliance on informal psychosocial support and spirituality rather than structured physical or psychological interventions.

4.1.7 Effectiveness of Various Coping Mechanisms for Postnatal Depression

Table 1.7 Effectiveness of Coping Mechanisms for Postnatal Depression (%)

Coping Mechanism	Not Effective	Slightly Effective	Moderately Effective	Very Effective
Physical exercise	7.8%	39.2%	32.2%	20.8%
Relaxation techniques (e.g., breathing, yoga)	13.0%	24.9%	38.2%	23.9%
Social activities with family/friends	2.1%	4.4%	27.8%	65.7%
Hobbies or enjoyable activities	6.2%	4.2%	18.7%	70.9%
Talking to a supportive person	0.0%	2.1%	40.3%	57.7%
Self-help resources (books, apps, articles)	36.9%	28.3%	20.5%	14.3%

The study assessed how women delivering at Levy Mwanawasa Hospital rated the effectiveness of six coping mechanisms for postnatal depression. Table 1.8 below presents frequencies as percentages

across four categories: not effective, slightly effective, moderately effective, and very effective. To determine the appropriateness of using parametric statistical methods, a Shapiro-Wilk test was conducted on the composite scores derived from the respondents' ratings of coping mechanism effectiveness. The results showed that for all six coping mechanisms, the Shapiro-Wilk p-values were greater than 0.05. This indicated that the data did not significantly deviate from a normal distribution and met the assumption of normality, thereby justifying the application of parametric tests for further analysis.

In order to examine whether there were statistically significant differences in perceived effectiveness among the six coping mechanisms, a one-way Analysis of Variance (ANOVA) was performed. The null hypothesis (H_0) for this analysis stated that there is no significant difference in effectiveness ratings among the six coping mechanisms, while the alternative hypothesis (H_1) proposed that at least one coping mechanism differs significantly in effectiveness. The results of the ANOVA indicated a statistically significant difference, with an F-value of 28.43 and a p-value less than 0.001. These findings suggest that participants did not view all coping mechanisms as equally effective. Further post-hoc analysis using Tukey's Honest Significant Difference (HSD) test revealed that hobbies, talking to a supportive person, and engaging in social activities were significantly more effective compared to self-help resources and physical exercise.

To further understand which coping mechanisms significantly predicted a reduction in postnatal depression symptoms, a multiple linear regression analysis was carried out. The dependent variable in this analysis was the self-reported reduction in depressive symptoms, scored from 1 (not effective) to 4 (very effective). Independent variables included the six coping mechanisms. The regression model was statistically significant, with an R-squared value of 0.45 and an adjusted R-squared of 0.43, indicating that approximately 43% of the variance in depression symptom reduction could be explained by the model. The regression coefficients showed that hobbies ($\beta = 0.237$, $p < 0.001$), social activities ($\beta = 0.222$, $p < 0.001$), and talking to a supportive person ($\beta = 0.210$, $p < 0.001$) were the strongest positive predictors of symptom reduction. Relaxation techniques and physical exercise also had statistically significant but weaker effects. Self-help resources, on the other hand, were not found to be a significant predictor ($p = 0.449$).

Table 1.8 ANOVA Test – Comparison of Coping Mechanisms

Source of Variation	SS	df	MS	F	p-value
Between Groups	314.52	5	62.90	28.43	**<0.001**
Within Groups	849.78	379	2.24		
Total	1164.30	384			

The p-value (< 0.001) indicates a statistically significant difference in effectiveness ratings among the coping mechanisms. Post-hoc comparisons (Tukey's HSD) showed that *hobbies*, *talking to someone supportive*, and *social activities* were significantly more effective than *self-help resources* and *physical exercise*.

4.1.9. Regression Analysis – Predicting Reduction in Postnatal Depression Symptoms

To identify which coping mechanisms best predict a reduction in postnatal depression symptoms, a **multiple linear regression** was conducted.

Dependent Variable: Self-reported reduction in postnatal depression symptoms (scored from 1 = Not effective to 4 = Very effective)

Independent Variables: Physical exercise, relaxation, social activities, hobbies, talking to someone, self-help resources.

Table 1.9 Multiple Linear Regression Output

Predictor	B (Unstandardized Coeff.)	SE	β (Standardized)	t	p-value
(Constant)	1.028	0.129	-	7.97	<0.001
Physical exercise	0.142	0.053	0.118	2.68	0.008
Relaxation techniques	0.198	0.049	0.171	4.04	<0.001
Social activities	0.278	0.061	0.222	4.56	<0.001
Hobbies	0.303	0.064	0.237	4.73	<0.001
Talking to someone	0.259	0.058	0.210	4.47	<0.001
Self-help resources	0.042	0.055	0.037	0.76	0.449

A multiple linear regression analysis was conducted to assess the predictive power of six coping mechanisms physical exercise, relaxation techniques, social activities, hobbies, talking to someone, and self-help resources on the overall perceived effectiveness in managing postnatal depression symptoms. The model's constant (intercept) was statistically significant (B = 1.028, $p < 0.001$), indicating a baseline level of coping effectiveness when all predictor values are zero.

Among the coping strategies, **hobbies** showed the strongest standardized predictive effect (β = 0.237, $p < 0.001$), suggesting that increased engagement in hobbies or enjoyable activities significantly predicted higher perceived effectiveness in managing postnatal depression. Similarly, **social activities** (β = 0.222, $p < 0.001$) and **talking to someone supportive** (β = 0.210, $p < 0.001$) also demonstrated strong, statistically significant contributions to the overall coping outcome.

Relaxation techniques (β = 0.171, $p < 0.001$) and **physical exercise** (β = 0.118, $p = 0.008$) were also statistically significant predictors, though their effects were weaker compared to hobbies and social strategies. This implies that while they are beneficial, their impact may be more modest in comparison.

In contrast, **self-help resources** (β = 0.037, $p = 0.449$) were not a significant predictor of perceived coping effectiveness. This suggests that materials such as books, articles, or apps did not substantially influence how effectively participants felt they managed postnatal depression symptoms.

Discussion

The discussion explored the findings on financial inclusion and postpartum emotional experiences, presenting key demographic insights and the prevalence of mood disturbances. The demographic profile of respondents revealed that the majority were young women aged between 26–30

years, with a significant proportion being married. Marital status, as a key social determinant, influences access to financial resources and emotional support, making it an essential factor in both financial inclusion and postpartum mental health (Zins & Weill, 2016).

Despite educational and employment limitations 76.1% of respondents were unemployed the study found that a substantial proportion (76.4%) earned above K2,000 monthly, mainly from informal income-generating activities. This reflects the resilience of women in low-income urban settings who leverage informal markets for financial survival. The findings suggest that financial inclusion initiatives must acknowledge and integrate the realities of informal economic activity. As argued by Demirgüç-Kunt et al. (2018), digital financial services, microloan access, and tailored savings products can bridge the gap for marginalized groups excluded from formal banking. Furthermore, given the high unemployment rate, policy interventions focusing on vocational training, small business development, and inclusive labor market strategies would significantly enhance women's financial stability and well-being during and after childbirth.

Financial literacy emerged as a critical area for intervention. With low levels of formal education among participants, financial literacy programs designed in local languages and simplified formats could empower women to better manage their income, prepare for childbirth expenses, and access appropriate health and financial services. Importantly, the role of marital status and household composition in influencing financial decisions suggests that family-oriented financial products such as joint savings accounts or maternal insurance policies could promote greater financial security.

Turning to postpartum emotional experiences, the findings revealed a concerningly high prevalence of mood disturbances. Sadness (54.8%) and anxiety (48.6%) were reported by nearly half of the respondents, while 18.2% experienced symptoms indicative of postnatal depression. These findings are consistent with global patterns and highlight the significant psychological burden of the postpartum period. According to O'Hara and McCabe (2013), while transient mood fluctuations or "baby blues" are common and usually self-resolving, persistent symptoms may evolve into clinical depression if unaddressed. The identified rate of postpartum depression aligns closely with the findings of Norhayati et al. (2015), who reported rates between 10–20% in similar socio-economic contexts.

Several contextual stressors contributed to the onset and severity of postpartum depression. Financial stress (94.3%) emerged as the most frequently cited factor, underscoring the critical intersection between economic insecurity and maternal mental health. Relationship difficulties (77.9%) and lack of social support (75.8%) were also prominently reported. These findings reinforce the biopsychosocial model of postpartum depression, where psychological vulnerability, socio-economic constraints, and relational stress converge to increase the risk of depressive symptoms (Beck, 2001). Interventions should therefore adopt a holistic framework that incorporates psychosocial support, partner involvement, and targeted economic empowerment for new mothers.

The evaluation of coping strategies revealed important insights into what women found most and least helpful in managing postpartum symptoms. Hobbies and enjoyable activities were rated as highly effective by 70.9% of respondents, followed closely by social interactions (65.7%) and supportive conversations (57.7%). These coping strategies align with literature emphasizing the protective role of positive engagement, social bonding, and leisure in mental health recovery (Dennis & Chung-Lee, 2006). The high rating of these strategies suggests the importance of community-based interventions, such as peer support groups, recreational programs, and maternal social networks, which can provide accessible and culturally relevant emotional support.

Conversely, self-help resources such as books, articles, and apps were perceived as least effective, with 36.9% of respondents rating them as not effective at all. This finding highlights a gap in accessibility, relevance, or usability of such resources in the local context. Digital literacy limitations, cultural perceptions of mental health, and language barriers could have contributed to the low effectiveness of these tools. It suggests that while self-help tools may be effective in high-resource settings, they require contextual adaptation to be beneficial in lower-income environments.

The application of inferential statistics further strengthened the validity of the findings. The one-way ANOVA test revealed statistically significant differences in the perceived effectiveness among the six coping mechanisms. Regression analysis confirmed that hobbies ($\beta = 0.237$), social activities ($\beta = 0.222$), and talking to someone supportive ($\beta = 0.210$) were the strongest predictors of coping effectiveness, all with p-values < 0.001. These results underscore the critical importance of interpersonal and activity-based coping strategies in postnatal mental health management. In contrast, self-help resources showed no statistically significant effect ($p = 0.449$), reinforcing the need to reevaluate their application in this demographic.

Conclusion

This study investigated the prevalence of postnatal depression and associated factors among women delivering at Levy Mwanawasa Hospital. The findings revealed that 18.2% of the respondents reported experiencing postnatal depression, a rate consistent with global estimates, though not statistically different from the hypothesized 20% threshold. Emotional disturbances such as sadness, anxiety, fatigue, and appetite changes were also notably common, suggesting that while not all respondents met the threshold for clinical depression, many experienced distressing postpartum emotional symptoms.

Crucially, the study identified financial stress, lack of social support, and relationship difficulties as significant predictors of postnatal depression through both chi-square tests and logistic regression analysis. In contrast, age, employment status, and stress from childcare responsibilities showed no significant association. These findings underscore the importance of social and economic context in understanding maternal mental health.

From a methodological standpoint, the study's use of both descriptive and inferential statistical analyses provides a reliable picture of the mental health status of postpartum women in an urban Zambian context. However, the Shapiro-Wilk test confirmed the non-normality of the depression variable, suggesting the need for more tailored non-parametric or logistic models in future research.

The results highlight an urgent need to strengthen maternal mental health services as part of postpartum care in Zambia. Policies and interventions that target social support systems, improve access to mental health counseling, and address financial vulnerabilities are essential. Given the lack of significant association with demographic factors such as age and employment, interventions should not be limited to specific socioeconomic groups but rather universally integrated into maternal care packages.

Future research should adopt longitudinal designs to examine the persistence and progression of postnatal depression beyond the early postpartum period. Additionally, qualitative studies exploring women's lived experiences would provide a deeper understanding of contextual factors influencing emotional well-being after childbirth. There is also scope to validate culturally appropriate screening tools for early detection of postpartum depression in hospital and community settings in Zambia.

Recommendations

The researcher hopes that the following recommendations will be taken and will aid in the fight against underage drinking not only in Misisi complex but across the country.

The study developed the following recommendations:

- Screening and early intervention protocols were enhanced to identify postpartum emotional issues, including sadness and anxiety, not just depression, for timely support.
- Financial stress for new mothers was addressed through programs such as extended paid maternity leave, childcare subsidies, and financial counseling.
- Social support networks were strengthened by establishing community-based support groups for mothers and promoting partner involvement in postpartum care.
- Education about effective coping strategies emphasized social activities, enjoyable hobbies, and emotional support to improve maternal well-being.
- Interventions were tailored to accommodate the varying effectiveness of coping strategies, offering diverse options for individual needs.
- Accessibility to mental health services was improved by increasing the availability and affordability of counseling and therapy for new mothers.
- Education and awareness campaigns informed expectant mothers, partners, and families about postnatal depression, its symptoms, and support options.
- Interdisciplinary collaboration was fostered among healthcare providers, mental health professionals, social workers, and community organizations to deliver holistic maternal support.

The researcher anticipated that implementing these recommendations would help stakeholders reduce the prevalence and impact of postnatal depression, enhancing the overall well-being of mothers and their families.

Acknowledgments

I extend my heartfelt appreciation to Dr. Felix Chibesa, my thesis supervisor, whose guidance and assistance have been instrumental. Without his support, this dissertation would not have reached its current form. My profound gratitude goes to my family for their unwavering support, care, encouragement, and inspiration throughout my university studies.

Lastly but not the least, I would like to acknowledge the help that was given to me by the National Health Research Authority with the clearance to conduct the study and Levy Mwanawasa University Teaching Hospital for facilitating my data collection.

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Determinants of Community Based Mental Health Services Utilization among War Survivor Communities of Gondar and Wollo Zones, Amhara region

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Abstract

The world faces serious challenges from mental health issues, with untreated illnesses often leading to increased morbidity and mortality. Lack of treatment for mental Illnesses comes from both accesses for the services and patients' preference for the services. World Health Organization (WHO) recommended the Strength based and recovery oriented model called community-based health service (CBMHS) which even though h the response of people to CBMHS use varies across countries and communities. In addition, Ethiopia as a country and war prone communities in the country have their own unique dynamics of context which in turn determines patients' intention to CBMHS. This study aimed at investigating the associated factors of CBMHS use intention among civil war affected zones of north Ethiopia. Absence of studies specifically on people's responses for CBMHS was the rationale for choosing this study and the site.

Quantitative approach with a cross sectional community survey design and questionnaire were used. The study used SPSS version 24 to analyze descriptive and inferential statistics designed to show the characteristics of the data and explain the association between the factors and CBMHS use intention.

CBMHS use intention could be predicted by CMD, self-efficacy and self-concept, attitude, knowledge and expectancy, social norms and social constraints. People with common mental disorders have difficulty to develop intention of using CBMHS. Self-efficacy, self-concept, attitude towards CBMHS and expectancy contributes for the good intention of using CBMHS while knowledge has nothing to do with the intention of people to use CBMHS. Social norms and social constraints are found to be the barriers for the intention of people to consider CBMHS.

With the absence of intention of people survived in the civil war to use CBMHS, it is meaningless to invest in any form of mental health services. It is invaluable to enhance self-efficacy, self-concept, attitude, and expectancy of people, and prevent the prevalence CMD, control social norms and social constraints through health and life skill education. Public health policies are imperative for the better utilization and intention of CBMHS in the war survivor community members. Social work services of all kind are important for the better utilization and intention of CBMHS in the war survivor community members.

Keywords: Community based mental health, Service utilization, Intention, War survivor community

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Received 24 March 2025 Revised 29 May 2025 Accepted 13 June 2025

Introduction

The World Health Organization (WHO) proposed that world countries adopt the model of community based mental health care so as to effectively address the mental health services. Accordingly, many developed countries have turned their face towards it (WHO, 2006). They are expected to exert effort on reorganizing to respond most effectively to the recommendation given by the world health organization. Western countries well-recognized the different elements of a community-based service and started closing down or down-sizing mental health hospitals, integrate psychiatric units in general hospitals and the formation of community-based mental health teams as it requires a new way of arrangement of service system (Alem et al., 2008).

Unfortunately, most of African countries including Ethiopia have not yet utilized either the traditional model of hospital based mental health care nor moved to community based care (Alem et al., 2008). The fact that Ethiopia has its own unique dynamics of socio-cultural and mental health system arrangement determines patients' intention and behavioral response to use it. For several reasons, many of the Ethiopian population with different mental health issues have been reported to prefer traditional healing methods rather than a traditional hospital-based mental health services delivery mode. One of the multiple factors for their preference of traditional healing methods over hospital based service is the fact that many believe all mental illnesses are of spiritual origin and accessibility of traditional healing. Fees charged by traditional healers and costs of prescribed items are usually cheaper than that of the modern services. People feel more at ease and at home with the traditional healers because there is symbolism and meaning to what traditional healers prescribe which matches cultural and religious beliefs (Alem et al., 1995).

In addition to the recommendation of WHO to CBMHS, the preference of Ethiopian population with different mental health issues for traditional healing methods over institutional hospital-based mental health services indicates the tendency of the country's population towards the community based mental health service. However, before conforming to the proposal of WHO and adopt community based mental health care model in Ethiopia, it is critical to conduct research to identify the intention and behavior of people with CMD on the recommended model.

There are several research projects that have contributed to our understanding of mental health issues. For example, Atalay Alem conducted a study on community based mental health in 2003. Galmessa (2005) also examined a cross sectional study to explain the prevalence, causes and effects of mental illness among Alemaya University students. In addition, Deribew and Tesfaye (2005) conducted a study on assessment of knowledge, attitude and practice of nursing staff towards mental health problems in Jimma zone, south western Ethiopia. Moreover, the qualitative study of Shiferaw and Derbew in 2005 focused on how mental health problems are perceived by a community in Agaro town. (Mekonnen & Esayas, 2003) again conducted a study on the correlates of mental distress in Jima town, Ethiopia.

Many other studies were conducted on mental health issues in Ethiopia. But, the most relevant studies listed above and others revolve around; assessing the availability of health services for mentally ill individuals, assessing the attitude of the community towards mental illness by relating with stigma and discrimination and explaining causes and effects of mental illness. In addition, most of the research was limited to specific areas, usually the southern part of Ethiopia only. This might be related to the proximity of the area to research centers and universities. War prone communities are also expected to be different with regard to the prevalence and mental health service utilization. Currently there are no

published studies exploring community based mental health services utilization intention and behaviors and the associated factors and prevalence of common mental disorders among war survivor communities in Ethiopia which is the focus of this study.

This study aimed at investigating Factors Associated with Community Based Mental Health Services Utilization Intention and Behaviors in the civil war Survivor Communities of Gondar and Wollo Zones. Specifically, the study wanted to respond to the research questions such as What the Relationship between Self efficacy, Self-concept and Common Mental Disorder and the Behavior of Community Mental Health Services Survivor Communities of Gondar and Wollo Zones? What is the relationship between intention of people to use CBMHS and attitude, knowledge and expectancy in the war survivor communities of Gondar and Wollo Zones? What is the relationship between behavior of people to use CBMHS and attitude, knowledge and expectancy in the war survivor communities of Gondar and Wollo Zones? What is the relationship between intention of people to use CBMHS and social constraints and social norms? And what is the relationship between behavior of people to use CBMHS and social constraints and social norms?

The study intended to provide data for a policy makers determined to community based mental health service (CBMHS) initiation. Evidence about the community based service use behavior of war prone communities for relevant stakeholders (policy makers, practitioners, researchers and teachers) could be documented. It specifically informed concerned bodies on issues such as the context, accessibility, acceptability and determinants of community based mental health service use. The study also provided evidences to health community workers and researchers working in the area about the existing challenges and the respective improvement areas in the health care system.

Review of Related Literature

The first comprehensive view of mental wellbeing was proposed by Jahoda as it is composed of the capacities to acknowledge one's unique self, to feel right towards others, to fulfill life's tasks, maintain adequate contact with reality, control thoughts and imagination, be efficient in work and play, and achieve social acceptance, positive self-respect, and a healthy emotional life (Jahoda, 1959). A positive demeanor towards self, the capacity for self-actualization, integration, independence, discernment of reality and natural dominance are the six additional indicators of mental wellbeing recognized by Jahoda.

The World Health Organization (WHO) also emphasized the indicators of mental health in 2006 as a whole package of health with a complete physical, mental and social well-being beyond the absence of disease or infirmity. In the same year, WHO specifically defined mental health as a state or condition whereby persons are resilient with normal life stressors, have awareness of one's potential and an ability to be productive in a society (WHO, 2006). Garland and his associate also defined mental health in 2000 as a state of mind which enables individuals to realize and choose their own life goals including subjective expectations unique to their culture (Garland et. al., 2000).

When one or more mental health qualities mentioned in the above definitions are compromised for some reason, the mental health condition can be considered as a problem. Any mental health problem arises when a person experiences a range of emotional and behavioral problems that are outside the normal range for their age. The common ones among several mental health problems are the group of distress states manifesting with anxiety, depression, and somatic symptoms. These problems usually manifest with shifting combination of symptoms over time indicating emotional or mental abnormality (Mechanic, 1999).

No community/group is immune to mental disorders except that the risk is higher among the poor, homeless, the unemployed, uneducated, victims of violence, migrants and refugees, indigenous populations, children, and adolescents, abused women and the neglected elderly communities. Studies have documented that untreated mental illness in turn results in several adverse consequences including poverty and mortality (Garland et al., 2005).

The world is seriously challenged by mental health disorders regardless of geographic location or income level (Luitel et al., 2015). Mental diseases account for a significant portion of the worldwide burden of disease, accounting for 13% of it till 2000 and anticipated to climb to 15% by 2020. Mental illness accounts for 7.4% of disability adjusted life years (Luitel et al., 2015).

In both industrialized and developing countries, mental illness is recognized as a public health concern. The idea that mental illness is less widespread in low-income countries than in high-income countries has long been debunked. The national mental health strategy indicates that Ethiopia (one of the low-income countries) also has a high rate of mental illnesses. In fact, mental illness is the leading non-communicable disease in Ethiopia with high psychological, physical, and economical burdens.

However, compared to physical health, specialty disparities in research and service practice on mental health is observable in many parts of the world (Garland et. al., 2000). A disparity in access to mental health doesn't only affect the access to treatment but also the health service use behavior of patients. One study reported that even in countries where there are effective treatments, many community members did not seek professional help (adults with diagnosable mental disorders was shown to be only one third). Health service utilization is an active and adaptive process of attempting to cope with health problems or symptoms by using external resources for assistance both formally and informally. Unfortunately institutionalized mental health services do not allow the adaptive process of attempting to get assistance both formally and informally like community based mental health service does (Kerebih, H., et al., 2017). It is important to understand the barriers to seeking out and receiving health care services including mental health assistance.

Community based mental health service is defined as care to promote mental health for a community by entertaining community needs in an accessible and acceptable manner based on the goals and strengths of people with mental illnesses using a wide network of supports, services and resources of adequate capacity; and emphasizing services that are both evidence-based and recovery-oriented (Thornicroft, G. et al., 2016). However, community based mental health service access and utility is different across countries with different development level and population type. There is also considerable difference between developing and developed countries regarding access due to low number of trained mental health professionals and mental health facilities (WHO, 2006). Even though there are differences among different population groups in their service use behavior perceived barriers to usual care, perceived difficulties in accessing care specialists were identified as reasons for avoiding mental health services use at all. (Zeber, et.al., 2009).

The response of community based health service use could also vary according to the cultural, social, economic, sex and demographic situation (Amente & Kebede, 2016). Studies in many countries consistently mention some common factors associated with low professional treatment seeking behaviors such as fear of being stigmatized for having mental illness, believing in informal help sources, lack of mental health literacy, negative experience of past help seeking and being unaware of services among others.

Studies on war survivor communities in different parts of the world evidenced that there are high prevalence (38.5% depression, 51.8% anxiety and 20.4% PTSD) and need for mental health services (Murthy & Lakshminarayana, 2006). Despite the findings reviewed above, there is no evidence specific to the incidence/ prevalence and the response of community members on common mental disorders in a war survivor community in Ethiopia. The response of a war survivor community for community based mental health services and barriers are not yet studied in Ethiopia.

Theoretical and Conceptual Framework

Theoretical frame work; Unified theory of Behavior

This study is concerned with explaining health service use intention and the behavioral concepts and constructs in general community based mental health service use. Specific to this research, The Unified Theory of Behavior (UTB) is chosen to be the most ideal comprehensive theoretical framework as it represents the accumulation of knowledge about human intention which is necessary to inform our use of constructs for research practice as it facilitates the understanding of key behavioral variables in the context of mental health service utilization.

Since health seeking and service use behavior is all about a choice of patients as to which practice and service to use, rational choice theory (*health belief model*, *the theory of reasoned action*, and the *theory of planned behavior*), *social network theory* and *social action theory* are the three major versions of unified theory of behavior (UBT) which provide a theoretical framework. In addition to that, the behavioral model of health service use and unified theory of health service use are directly related to the study to be conducted. Finally, the theory is the unification of the other models which is empirically tested to encompass theoretical predictor variables like self-concept, self-efficacy, emotion, attitude about mental health, knowledge on mental health, social constraints, expectancy on mental health service, social norm on mental health and predicted variables like mental health behaviors and mental health intention.

The UTB articulates the important behavioral determinants most amenable to change. The UTB is a comprehensive, multivariate framework that incorporates micro- and macro-level constructs from several evidence-based theories of health behaviors and health-related decision-making. This framework emerged out of a week-long meeting convened by the National Institute of Mental Health (NIMH) in 1991 with leading human behavior theorists aiming to summarize theories of social and developmental psychology under a unifying framework based on their core construct. Although there was no consensus among the theorists, Jaccard and colleagues subsequently summarized a general framework, along with their specific modifications, into what is now the UTB. Specifically, UTB integrates Social Learning Theory (Bandura & Walters, 1963), the Theory of Reasoned Action (Ajzen & Fishbein, 1980) the Theory of Subjective Culture (Triandis, 1994), and self-regulation theories (Kanfer, 1987) into a unified theory of behavior decision-making and performance.

Justification of the Unified theory of Behavior as a framework

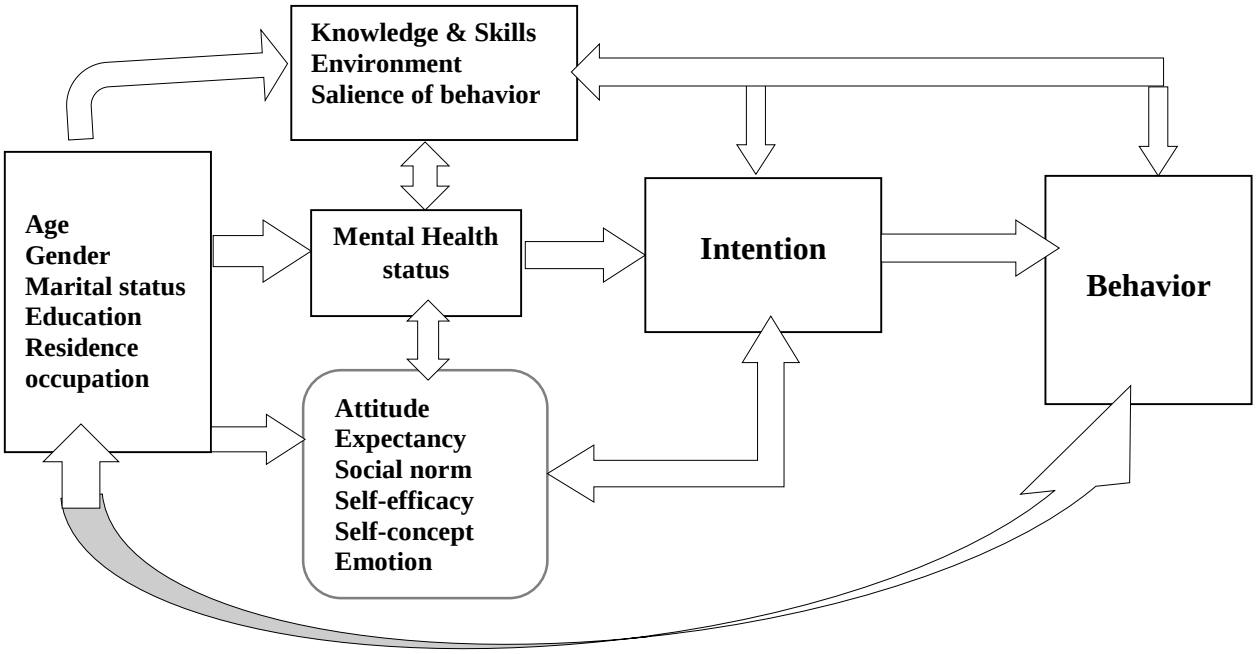
Among its many applications, the UTB offers a powerful framework for understanding behavioral determinants to help-seeking and formal mental health services use for both patients and their caregivers. UTB can facilitate the targeting of core processes and underlying behaviors regarding youth and family engagement, and other family contextual factors influencing service use, including relationships between families and clinicians, and families' sense of self-efficacy, expectations, and

attributions regarding mental health services (Lindsey et al., 2013). The study may systematically assess how structural factors influence people's intention and behavior to use CBMH services with is theory. The UTB has been successfully applied in prior research to evaluate service use intentions and behaviors across various healthcare settings. (Onwujekwe et al., 2010).

Conceptual framework

The conceptual framework includes demographic variables (e.g., age, gender, marital status, education, residence, occupation), as well as psychological and social predictors (e.g., CMDs, self-concept, attitude, social norms, and intention).

Figure 1 Unified Theory of Behavior.



A framework for understanding mental health service use. The above pictorial representation of the theoretical framework is developed by the author based on the relationship between variables explained in the unified theory of behavior.

Approach and Methods

Quantitative research approaches assume that it is possible to generalize about the general population based on the observed pattern of sample respondents under study. This research assumes that the behavioral pattern of sample respondents towards community based mental health service is generalizable (Marlow et al., 2003). The position of the researcher here is that it is possible to achieve the most attainable objectivity if researchers critically reflect on the intersection between the known and (the knowers) themselves and deliberately controlling with standardized and rigorous process.

Study Design

The study used a design of cross-sectional community survey on community based mental health service utilization intentions. This design was selected for this study because the research

objective about barriers/facilitators of community based mental health service intention was incorporated in the specific research objectives mentioned above.

The population of the study is all adult community members in selected war survivor zones of North Ethiopia. North and south Wollo are zones found in the Amhara National Regional State (ANRS) of Ethiopia. The zones are composed of 40 woredas. The woredas directly affected by the Ethio-TPLF war are 25 in number which is estimated to have more than 400,000 adult individuals. Therefore, only those woredas of the four zones (North & South Wollo & Gondar) were selected as cluster of sampling. Multi stage sampling procedure is used to select the study participants. First, woredas directly affected by the war are identified purposively. The population is clustered based on their wareda of residence and proportion is calculated againist the 400,000 adult populations. Then systematic random sampling is applied for each woreda.

Probability sampling technique specifically multistage sampling was employed. An attempt was made to cluster the population based on Woredas. Long lists of adult inhabitants in all woredas were prepared as a population frame and the proportion of sample for each cluster woredas was calculated and then after, systematic random sampling was employed. Given the above population, the sample size determination formula adopted from Kalavalli, 2022, the sample size is 384 for community-based survey (Kalavalli et al.,2022).

$$n = \frac{\frac{Z^2 * P(1-P)}{e^2}}{1 + \left(\frac{Z^2 * P(1-P)}{e^2 N}\right)} \quad n = \frac{\frac{1.96^2 * 0.5(1-0.5)}{0.05^2}}{1 + \left(\frac{1.96^2 * 0.5(1-0.5)}{0.05^2 400000}\right)}$$

n = sample size
P = proportion picking a choice n=384
N = population number
e = margin of error
Z = standard score

Since some of the research objectives in this study demanded different instruments to better determine results, data collection instruments were developed and adapted as necessary. Variables to measure the mental health status, determinants of behavior and intentions of residents displayed in the conceptual model of this study and socio demographic information were used to collect the data. Common mental disorder Checklist with Cronbach alpha value of 0.952 was used to assess the mental health conditions of participants. Scales of related variables mentioned in the conceptual model and the service seeking intention and behavior are tested and it was used as survey instrument in the study. The Cronbach's alpha value for the scales Self-concept, Self-efficacy, Emotion, Attitude, Knowledge, Social constraints, Expectancy, Social norms and MHSU Intention were tested after a pilot data and the alpha values are 0.788, 0.843, 0.794, 0.888, 0.750, 0.940, 0.769, 0.800 and 0.872 respectively.

Table 1 Reliability index of scales used

S.No	Scale	Number of items	Original scale's r (If any)	Pilot r	Main study r
1	Common mental disorders	17	.703	.932	.952
2	Self-concept	29	.700	.789	.752
3	Self-efficacy	10	.802	.843	.843
4	Emotion	9	.811	.859	.839
5	Attitude about mental health	7	.845	.943	.940
6	Knowledge on mental health	19	.705	.710	.722
7	Social constraints	15	.952	.940	.940
8	Expectancy on mental health service	11	.828	.821	.821
9	Social norm on mental health	14	.801	.858	.858
10	Mental health Intention	3	.761	.819	.819

Source: Own survey result, 2025.

Note: Items deletion and/or substitution were taken to improve the reliability value.

The data (mental health survey, community based mental health service utilization intention was analyzed by SPSS version 24. Both descriptive and inferential statistics were applied. The descriptive statistics included mean frequencies, Std. Deviation, Variance, Skewness, and Kurtosis and cross tab. whereas inferential statistics like Pearson correlation, multiple regressions, ANOVA and MANOVA were utilized. Appropriate measures on statistical procedures of data cleaning for parametric statistic tests were followed; there was not an issue of missing data, univariate outliers were checked using z value distribution of continuous variables, and multivariate outliers were checked with mahalanobis distance. All the assumptions of multiple regressions were tested as the quantitative analysis was conducted by those analysis models.

The model of multiple regressions were used to measure the relationship between Self efficacy, Self-concept and Common Mental Disorder and the intention of people to community based mental health services use, $\text{IPCBMHSU} = \beta_0 + \beta_1 Se + \beta_2 Sc + \beta_3 CMD + \varepsilon_{ij}$, to explain the relationship between intention of people to use CBMHS and attitude, knowledge and expectancy, $\text{IPCBMHSU} = \beta_0 + \beta_1 Atti + \beta_2 Kn + \beta_3 Exp + \varepsilon_{ij}$ and explain the relationship between intention of people to use CBMHS and social constraints and social norms;

$$\text{IPCBMHSU} = \beta_0 + \beta_1 Sn + \beta_2 Sc + \varepsilon_{ij}$$

Where, β_1, β_2 & β_3 are coefficients of Self efficacy, Self-concept and Common Mental Disorder (Se_1, Sc_2 and CMD_3) respectively.

βo: ……. constant parameter (intercepts of the intention of people to community based mental health services use (IPCBMHSU))

Se_1, Sc_2 and CMD_3: 3 explanatory variables

ϵ_{ij}: ……..Error term

$Atti, Kn$ & Exp : are the 3 explanatory variables

Sc & Sn: are the 2 explanatory variables

Research ethics is an integral aspect of any research activity; each and every activity of the research should be embedded with the research ethical considerations. The researchers in this project enthusiastically strived to respect all the ethical issues expected in this study and secured IRB from the University of Gondar.

Findings

Introduction

This section presents findings of the research objectives introduced above. The barriers to the intention and utilization of community based mental health services, the difference between people with and without CMDs in their behavior and intention to community based mental health services, the relationship between self-efficacy, self-concept, CMD attitude, knowledge, expectancy, social constraints, social norms and the intention and behavior are reported below.

Demographic Information about the Study Participants

Table 1 The Demographic Characteristics war survivor community members of Gondar and Wollo Zones in Ethiopia, 2023 (N= 384)

Demographic Varibles	Categories	Frequency	Percent
Age	young	163	42.44
	Adult	193	50.26
	Senior	28	7.3
	Total	384	100
Gendar	Male	224	58.2
	Female	160	41.6
	Total	384	100
Educational status	Illiterate	46	11.9
	Non-formally Literate	18	4.7
	Grade 1-4	76	19.7
	Grade 5-8	72	18.7
	Grade 9-12	50	13.0
	Diploma	65	16.9
	Degree & above	57	14.8
	Total	384	99.7
Marital status	Single	54	14.0
	Married	195	50.6
	Separated	59	15.3
	Divorced	76	19.7
	Total	384	99.7
Residence	Rural	119	30.9
	Urban	265	68.8
	Total	384	99.7
Occupation	Farmer	51	13.2
	Merchant	68	17.7
	Civil Servant	115	29.9
	Entrepreneur	36	9.4
	Housewife	52	13.5

Demographic Varibles	Categories	Frequency	Percent
	Student	7	1.8
	Unemployed	16	4.2
	Retired	39	10.1
	Total	384	99.7

Source: Researcher own questionnaire

The gender of the respondents is composed of 224 (58.2%) male and 160 (41.6%) female out of 384 sample participants. Table 4.4 shows that educational status of the respondent proportionally distributed across the ordinal category of academic status. Grade 1-4 is the leading frequency (76) which is (19.7%) of all the respondents followed by Grade 5-8 who are 72 participants which covers (18.7%) of 384 sample respondents. Even though the sample was systematically randomized across urban and rural residents, table 4.6 depicts that more than half (68.8%) of the respondents in the sample are urban residents. This might be related to the internal displacement of rural people to IDP (internally displaced persons) centers which are located in semi urban areas during and following war. The above table is a frequency composition of occupation about the sample respondents and shows that students are the least number of respondents whereas the civil servants comprises of the highest one. Table 4.5 indicates that 50.6 % of 384 respondents are married. Separated marital status was not common in Ethiopia however the table above shows a significantly high percent (15.3%) of the marital status. Again, this may be related to the war held in the study area as internal displacement is prevalent in areas where there is conflict.

The Relationship between Self efficacies, Self-concept and CMD and the Intention of CBMHS in War Survivor Communities

The intention of this research objective is to know how well the intention of people to community based mental health services can be predicted from a combination of three variables: common mental disorders, self-concept and self-efficacy. It also wanted to know which of these three predictors contribute significantly to the multiple regressions.

Table 2 Means, Standard Deviations, And Inter-correlations for Intention to CBMHSU and Predictor Variables (N=384)

Variables	M	SD	1	2	3	4
MHSU intention	15.9696	3.38411	1	.314	-.073	.441
Predictors variables						
CMDs	8.2072	6.16070		1	.678	-.371
Self-concept	121.8923	19.04935		.678	1	-.159
Self-efficacy	50.2735	7.14083		-.371	-.159	1

First, the output provides the useful description of all the three predictor variables and it showed that the correlations of the Common Mental Disorder (CMD) with Self-concept and Self efficacy are all significantly correlated. But Self efficacy is negatively correlated with the rest two variables.

The Model Summary table shows that the multiple correlation coefficient (R) is statistically significant, using all the predictors simultaneously, (R=.884 which means 88% of the variance in community based mental health service use intention can be predicted by common mental disorders,

self-efficacy, and self-concept. Note that the adjusted (jR^2 = .779) is lower than the unadjusted $R^{2=}$.781 which is in part related to the number of variables in the equation. The adjustment is also affected by the magnitude of the effect size and the sample size. As it can be seen from the coefficients table, common mental disorders *(B*=.576, P<.05), self-concept. (B=937, P<.05) and self-efficacy (B=-.415, P<.05) are all significant.

The ANOVA table shows that F (3,1062) =6.51 and is significant. This indicates that the combination of the predictors (common mental disorders, self-concept self and efficacy) significantly predict community based mental health service use intention. Common mental disorders, self-concept self and efficacy are the only variables that are significantly adding anything to the prediction.

Table 3 Simultaneous multiple regression analysis summary for Common Mental Disorder, Self-concept and Self efficacy predicting CBMHSU Intention (N =384)

Variable	B	SEB	β	Sig
CBMHSU Intention				
Common Mental Disorder	.314	.020	.576	.000
Self-concept	-.073	.006	-.415	.000
Self-efficacy	.441	.013	.937	.000
Constant	.136	.873		.876

The Coefficients table indicates the standardized beta coefficients, which are interpreted similarly to correlation coefficients or factor weights. As you can see from the coefficients table, CMD (β=.576, P<.05), self-concept (β=-.415, P<.05) and self-efficacy (β=.937, P<.05) are all significant for the predicted variable (community based mental health service use intention).

The Relationship between Intention of People to Use CBMHS and Attitude, Knowledge and expectancy in the War Survivor Communities

The intention of this research objective is to know how intention of people to community based mental health services is predicted from a combination of three variables: attitude, knowledge, and expectancy and which of these three predictors contribute significantly to the multiple correlation/regression.

Table 4 Means, Standard Deviations, And Inter correlations for CBMHSU Intention and Predictor Variables (N=384)

Variables	M	SD	1	2	3	4
CBMHSU intention	15.9696	3.26412	1	.025**	.215**	.040**
Predictors						
Attitude	54.4558	5.88040	.025**	1	.613**	.535**
Knowledge	92.7431	11.30668	.215**	.613**	1	.161**
Expectancy	61.9365	7.97901	.040**	.535**	.161**	1

The first row shows the correlations of Knowledge and Expectancy with Attitude are all significantly correlated with it. But, when we see the strength of correlation with each other, Attitude is highly correlated with Knowledge and Expectancy whereas Knowledge is less correlated with Expectancy. The Model Summary table shows that the multiple correlation coefficient (R) is

statistically significant, using all the predictors simultaneously, (R=.965) which means 96.5% of the variance in community based mental health service use intention can be predicted by Attitude, Knowledge and Expectancy. Note that the adjusted (jR^2 = .931) is lower than the unadjusted (R^2=.932) which is in part related to the number of variables in the equation. The adjustment is also affected by the magnitude of the effect size and the sample size.

The ANOVA table shows the F Value F (3, 1267.048, P<.05) =1722.508 that the variance between the means of predictors is statistically significant. It also indicates that the combination of the predictors (Attitude, Knowledge and Expectancy) significantly predict community based mental health service use intention.

Table 5 Simultaneous multiple regression analysis summary for Common Mental Disorder, Self-concept and Self efficacy predicting CBMHSU Intention (N =384)

Variable	**B**	**SEB**	**β**	**Sig**
CBMHSU Intention				
Attitude	.025	.114	.617	.000
Knowledge	.215	.035	.400	.000
Expectancy	.040	.073	.028	.583
Constant	27.012	5.026		.000

The Coefficients table indicates the standardized beta coefficients, which are interpreted similarly to correlation coefficients or factor weights. As you can see from the coefficients table, Attitude (β=.272, P<.05), and Expectancy (β=.795, P<.05) are all significant whereas Knowledge (β=-.010, P>.05) is not statistically significant predictor for the predicted variable (community based mental health service use intention). Attitude and Expectancy are the only variables that are significantly adding anything to the prediction. It is important to note that all the variables related to Community based mental health service used intention are being considered together when these values are computed.

Over the years, many studies of mental disorders reported that attitudes of people with mental illness towards mental health services and treatment have consistently shown negative attitudes. A study explored communities' attitudes towards mentally ill and psychiatric patients as well as perceptions of community members towards psychiatric treatment and reported compared to 24% in 1976. 88% advise people with mental health problems to see a psychiatrist, but 26% still do not want to be referred to a psychiatrist (Ineland et al., 2008).

A study of mental health help-seeking intention and organizational environment among a population of military service members reported similar finding that mental health help-seeking attitude is an important predictor of intention to seek mental health help (Cuyler, 2016).

Amelia Gulliver and her associates (2012) conducted a systematic review of six published randomized controlled trials investigating eight different help-seeking interventions for depression, anxiety, and general anxiety disorder and found mental health literacy content to be effective (i.e. = 0.12 to 0.53). Most post-intervention studies improved help-seeking attitudes but did not affect help-seeking behavior (d = -.01, .02). Finally, although this review recommends that interventions to promote mental health literacy are promising ways to promote positive attitudes toward help-seeking, there are no significant differences in their impact on help-seeking behavior. The review recommended further research to examine the effects of interventions on attitudes, intentions and behaviors (Gulliveret al., 2012).

The Relationship between Intention of People to Use CBMHS and Social Constraints and Social Norms

This specific objective deals with relationship between intentions of people to community based mental health services and social constraints and social norms.

Table 6 Means, Standard Deviations, And Inter correlations for CBMHSU Intention and Predictor Variables (N=384)

Variables	M	SD	1	2	3
CBMHSU intention	15.9696	3.26412	1	-.099**	.317**
Predictors					
Social constraints	60.5663	26.14126	-.099**	1	.799**
Social norms	56.4254	9.67871	.317**	.799**	1

First, the descriptive statistics table displayed that the correlations between Social norms and Social constraints is significantly correlated with each other (r=.799, P<.05). The correlations between Social norms and CBMHS Use intention (r=.304, P<.05) is also significantly correlated (r=.799, P<.05) and Social constraints and CBMHS Use intention is not significantly correlated (r=-.044, P>.05).

The Model Summary table shows that the multiple correlation coefficient (R) is statistically significant, using all the predictors simultaneously, (R=.566) which means 56.6% of the variance in community based mental health service use behavior can be predicted by common mental disorders, self-efficacy and self-concept. Note that the adjusted (jR^2 = .317) is lower than the unadjusted R^2=.320 which is in part related to the number of variables in the equation. The adjustment is also affected by the magnitude of the effect size and the sample size. As you can see from the coefficients table, Social norms (β=.939, P<.05) and Social constraints (β=-.794, P<.05) are all significant.

The ANOVA table shows that F (2, 653.359, P<.05) =89.739 and is significant. This indicates that the combination of the predictors (Social norms and Social constraints) significantly predict community based mental health service use intention.

Table 7 Simultaneous multiple regression analysis summary for Social constraints and Social norms predicting CBMHSU Intention (N =384)

Variable	B	SEB	β	Sig
Social constraints	-.099	.009	-.794	.000
Social norms	.317	.024	.939	.000
Constant	4.115	.977		.000

The Coefficients table indicates the standardized beta coefficients, which are interpreted similarly to correlation coefficients or factor weights. The t value and the P value of each independent variable indicates whether that variable is significantly contributing to the equation for predicting community based mental health service use behavior from the whole set of predictors. Social norms and Social constraints are significantly adding something to the prediction.

Stecker et al., 2010 has similar finding consistent with this finding. Whereas Cuyler reported contrary to the finding of this research that neither the social norms of mental health help seeking nor the perceived control of mental health help seeking behavior were significant predictors for intention to seek mental health help (Cuyler, 2016). This paper is different to previous research of leadership support climate as a social constraint and social norms contributing to a community member's decision to seek mental health care were regressed and found that they are not significant on whether community members will seek mental health care or not (Cuyler, 2016).

The only research closer to social constraint (social pressure) demonstrates that organizational climate can affect a service member's intention to seek mental health care. The relationship between the leaders and non-leaders should have been supportive because influence that leaders have on individuals can affect individual's attitudes and intentions (Cuyler, 2016).

There is a large gap between relatively high help-seeking intentions and significantly low knowledge of helpful resources. Predictors of help-seeking intentions for mental health problems in the current study are consistent with previous studies. (Yu et al., 2015).

Conclusion

This study was conducted with the aim of investigating factors associated with CBMHS utilization intention in the Civil war survivor communities of Gondar and Wollo zones having three specific objectives. The results are precisely presented as followed.

The intention of this research objective was to know how well can intention of people to community based mental health services be predicted from variables: common mental disorders, self-concept and self-efficacy, attitude, knowledge, expectancy, social norm and social constraints and which of these predictors contribute significantly to the multiple regression models. The result shows that each model was significant. This indicates that the combination of the predictors (common mental disorders, self-concept and self-efficacy, attitude, knowledge, expectancy, social norm and social constraints) significantly predict community based mental health service use intention.

Therefore, public health services are imperative for the better utilization and intention of CBMHS in the war survivor community members. Access for the services and mental health education can alter the situation in the study area.

The study showed that there is statistically significant relationship between common mental disorder and community based mental health service use intention. Therefore, some other agent is mandatory to help those mentally challenged people to come for the treatment of community based mental health service use intention and behavior. The combination of the predictors (common mental disorders, self-concept self and efficacy) significantly predict community based mental health service use intention. Providing life skills education that enhances self-concept, self-efficacy, positive attitudes, expectancy, and addresses social norms and constraints may help prevent CMDs and improve service uptake. We argue that improving treatment is as important as changing attitudes through accurate information.

In addition to access and availability of CBMHS or other modality of services, intention of people with the mental health issue for the service offered is supposed to be positive. Therefore, social work services of all kind are imperative for the better utilization and intention of CBMHS in the war

survivor community members. Advocacy for the access of services and mental health outreach intervened by social workers can alter the situation in the study area.

The paper contributes to the literature by providing a new look at theoretical framework (UTB) to study CBMHSU intention and behavior or mental health help-seeking in war survivor community members. Unified theory of behavior explores every construct related to behavior and intention in general. This paper indicates that whatever specific study one wants to approach, UTB needs to be solicited to control the rest of variables and constructs as extraneous or intermediate variable. As far as the search for literature is concerned, there is no study used UTB to drive the formulation of hypothesis in mental health help-seeking research in general CBMHSU intention and behavior in particular. The incorporation of personal and environmental constructs together was not tried to study behavior and intention. Our society as a whole is challenged with encouraging people with mental health problems to seek mental health care. Efforts should focus on creating environments that minimize social constraints and encourage mental health help-seeking.

The finding confirmed that community based mental health service use intention and social norm are inversely related. This finding suggests that social workers should ensure they fully understand the influence social norm on the intentions of war survivors to mental health care. Social workers therefore, should take an active role in shaping the norm of CBMHSU environment. Social workers should also influence the policy of professional education and mental health training pedagogy in a way that social workers are not only trained to provide service but also actualize the latent demands of CBMHS and promote a positive environment mental health care.

Acknowledgement

First and foremost, I would like acknowledge the university of Gondar for financing this research work. I would like to express my deepest gratitude to study participants for the invaluable time they dedicated with this research. My heartfelt acknowledgement also goes to my professors for their kind support to help me better understand research. The support of study participants deserves a much esteemed acknowledgement as well. Finally, I would like to acknowledge all my friends for their kind and unreserved encouragement.

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Pathways to Access Center-Based Early Childhood Education and Care for Families of Foreign Origin in Japan: A Qualitative Analysis Using Levesque's Framework of Access

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Abstract

The number of foreign residents in Japan is increasing, and correspondingly so is the number of preschool-age children of foreign origin living in Japan on a mid- to long-term basis. Thus, it is increasingly important to ensure opportunities for early childhood education and care (ECEC) for these children with diverse origins. Although previous studies have shown a higher rate of non-enrollment in center-based ECEC in children of foreign-national parents compared with children of parents of Japanese nationality, only a limited body of research has comprehensively examined the details of the process through which children of foreign origin gain access to ECEC opportunities. In this study, semi-structured interviews were conducted with parents from 23 families to identify facilitating and inhibiting factors faced by families of foreign origin who wish to enroll their children in center-based ECEC in Japan. These interviews were analyzed with the aid of the theoretical framework by Levesque et al. As a result, facilitating and inhibiting factors for both service users (parents) and service providers (ECEC facilities and municipalities) were identified. The author found that access to ECEC for families of foreign origin is often a reversible process, with families potentially returning to earlier stages of the process—even after reaching the final stage. It was also confirmed that ECEC access for families of foreign origin is constrained by language and institutional barriers and is promoted by social support from diverse communities. These findings suggest that improved access to ECEC for children of foreign origin requires provision of appropriate enrollment information to the diverse communities that these families engage with, including communities of ethnic minorities, workplaces, and universities.

Keywords: Early childhood education and care, Access to services, Accessibility, Qualitative study

Introduction

In Japan, the number of foreign residents is increasing and so too is the number of preschool-age children of foreign origin living in Japan on a mid- to long-term basis. The number of foreign residents in Japan reached a record high of 3,588,956, up from 177,964 (5.2%) at the end of the previous year (Immigration Services Agency of Japan, 2024a). The number of preschool-age children of foreign origin living in Japan is 118,863, approximately 1.5 times the number from 10 years ago (author's calculation based on foreign resident statistics from 2013 and 2023, published by the Immigration Services Agency of Japan, 2024b). Thus, early childhood education for children of foreign origin in Japan is increasingly important.

In Japan, three primary types of facilities provide center-based early childhood education and care (ECEC): nursery schools (Hoikuen), kindergartens (Yochien), and children's centers (Kodomoen), which have both nursery school and kindergarten functions (Children and Families Agency, 2022). This

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Received 10 April 2025 Revised 22 May 2025 Accepted 13 June 2025

study collectively refers to these different types of institutions as "center-based ECEC facilities." When enrolling a child in an ECEC institution, the local government of the child's place of residence grants a "childcare certification" based on the reason for the childcare needs. Depending on the certification, the type of ECEC facility, the hours of care, and the financial burden borne by the family for ECEC will differ. Nursery schools provide care for children between the ages of 0 and 5 in place of parents who cannot care for their children at home due to work or other reasons. In addition to standard daycare hours from morning to evening, extended nighttime care is available as needed.

Kindergartens are regarded as facilities that provide early childhood education in preparation for school entry. Childcare hours are short, lasting until early afternoon. Although there are differences in the objectives and functions of nursery schools and kindergartens, both types of institutions provide ECEC for children before they enter elementary school. Nursery schools and kindergartens work to ensure the development of children in the preschool years, serving as institutions that support early childhood growth (Ministry of Education, Culture, Sports, Science and Technology, 2005). Although nursery school and kindergarten are not compulsory in Japan, approximately 99% of 5-year-old children attend nursery school, kindergarten, or a children's center as children aged 3 years or older are eligible for free preschool education (Children and Families Agency, 2023). Thus, most children enter elementary school after attending these center-based ECEC facilities. The internationally recognized term "early childhood education and care" encompasses all formal and informal systems and institutions that serve children before they enter primary education (OECD, 2001). Therefore, ECEC is not limited to what is provided by families, nursery schools, or kindergartens. However, for the sake of convenience, this research refers to institutions that provide ECEC as "ECEC facilities."

Kachi et al. (2020) reported that children with foreign national parents are about 1.5 times more likely not to be enrolled in center-based ECEC than are children with parents of Japanese nationality. Furthermore, in a survey conducted by Minato Ward, Tokyo (2023), 9.8% of children of foreign national parents do not attend center-based ECEC and are cared for at home, compared with 2% of families where both parents are Japanese nationals. Furthermore, a survey in Ayase City, Kanagawa Prefecture, found that 41% of foreign national children in the municipality were not enrolled in center-based ECEC (Kanagawa International Foundation, 2023). In a survey of 260 foreign national children of school-entry age registered in Hamamatsu City, Shizuoka Prefecture, the overall non-enrollment rate in ECEC was 11%. The rates varied by nationality: 24% for Filipino, 12% for Brazilian, and 8% for Peruvian children (Hamamatsu City, 2018). As described above, there are already clear disparities in access to education at the preschool stage. Other countries have promoted moves to make ECEC free or compulsory as well as more accessible to parents and children from ethnic and cultural minorities on the basis of research showing the positive impact of early intervention for preschool age children upon starting schooling and even over the entire lifespan. On the other hand, national policies in Japan have primarily focused on school adaptation and Japanese-as-a-second-language programs for children of foreign origin at the elementary school level and above. Furthermore, there is a lack of national and local government policies, systems, and measures to support children of foreign origin before they enter primary education (Mitsui, Han, Hayashi & Matsuyama, 2018). As a result, research on access to center-based ECEC for children of foreign origin remains in its nascent stages. Based on the above, the purpose of this study is to identify facilitating and inhibiting factors in the access of center-based ECEC opportunities for families of foreign origin in Japan who wish to enroll their children in center-based ECEC. To achieve this objective and clarify the current status of the ECEC enrollment process, semi-structured interviews were conducted with 23 parents from families of foreign origin who were raising

children in Japan. This study is structured as follows. First, the theoretical background is organized through a review of previous studies. Next, the research methodology is described, including the data collection and analysis procedures. Finally, interview results are presented, in order to clarify facilitating and inhibiting factors to center-based ECEC access for families of foreign origin in Japan.

Literature Review

Levesque et al. (2013) analyzed the definition of healthcare access based on previous studies and pointed out the polysemy of the term "access", and the broad scope it encompasses—from the perception of need to the eventual receipt of care benefits. For example, studies on center-based ECEC access are largely divided into three categories: (1) those related to availability (potential access), (2) those related to the process of reaching service utilization (utilization pathway), and (3) those related to the actual situation at the time of service (realized access). Table 1 summarizes existing studies on access to center-based ECEC in Japan, including those focusing on families of foreign origin as well as broader studies relevant to them.

Table 1 Studies on access to center-based ECEC in Japan relevant to families of foreign origin

Availability of ECEC (Potential access)	Process of reaching ECEC (Pathway to utilization)	Utilization of ECEC (Realized access)
Facility placement based on home–work–facility proximity and commute efficiency (e.g., Pred & Palm, 1978; Miyazawa, 1998). Factors behind regional disparities in childcare supply and demand (e.g., Wakabayashi, 2006; Wakabayashi et al., 2023).	Research that comprehensively examines the process through which families with foreign origin access and enroll in center-based ECEC remains limited.	Childcare practices in ECEC facilities and the experiences of caregivers and parents of foreign origin (e.g., Hotta et al., 2010; Uchida, 2017; Hori et al., 2017; Wadaue et al., 2017; Ashizawa, 2020; Mitsubishi UFJ Research and Consulting, 2020, 2021; Maeda, 2022; Tanaka et al., 2023; Nishimura & Omichi, 2024)

Source: Table generated by researcher

In Japan, with the advancement of women's participation in the workforce, the issue of childcare waiting lists has emerged as a significant challenge, with the demand for childcare services exceeding the available supply in local communities. Another issue is regional disparities in the distribution of childcare services. In order to solve the imbalance between supply and demand of childcare services, as represented by these unresolved issues, researchers, particularly in the field of human geography, are focusing on the "availability" of childcare facilities in order to analyze facility placement that would balance childcare and work by considering the proximity of homes, ECEC facilities, and workplaces and the time required for drop-off and pick-up (e.g., Pred & Palm, 1978; Miyazawa, 1998). Additionally, given that factors such as household composition, women's employment status, and regional differences in lifestyle and work patterns influence childcare demand, studies have examined factors contributing to regional disparities in the supply and demand of childcare services in response to local childcare needs (Wakabayashi, 2006; Wakabayashi et al., 2023).

There is also a large body of research on the actual use of center-based ECEC after access to ECEC is realized, including the relationship between caregivers and parents of foreign origin who use ECEC facilities. For example, studies have analyzed the status of multicultural childcare initiatives in nursery schools, caregivers' perceptions of parents and children of foreign origin (Hotta et al., 2010; Uchida, 2013; Hori et al., 2017; Wadaue et al., 2017; Ashizawa, 2020; Mitsubishi UFJ Research and Consulting, 2020; Mitsubishi UFJ Research and Consulting, 2021; Maeda, 2022), and the childcare practices of nursery school teachers of foreign origin (Sasaki, 2015; Ohsaka & Inaba, 2024). Other studies have interviewed foreign parents with children enrolled in center-based ECEC in order to

analyze the challenges faced after starting a preschool program (Tanaka et al., 2023; Nishimura & Omichi, 2024).

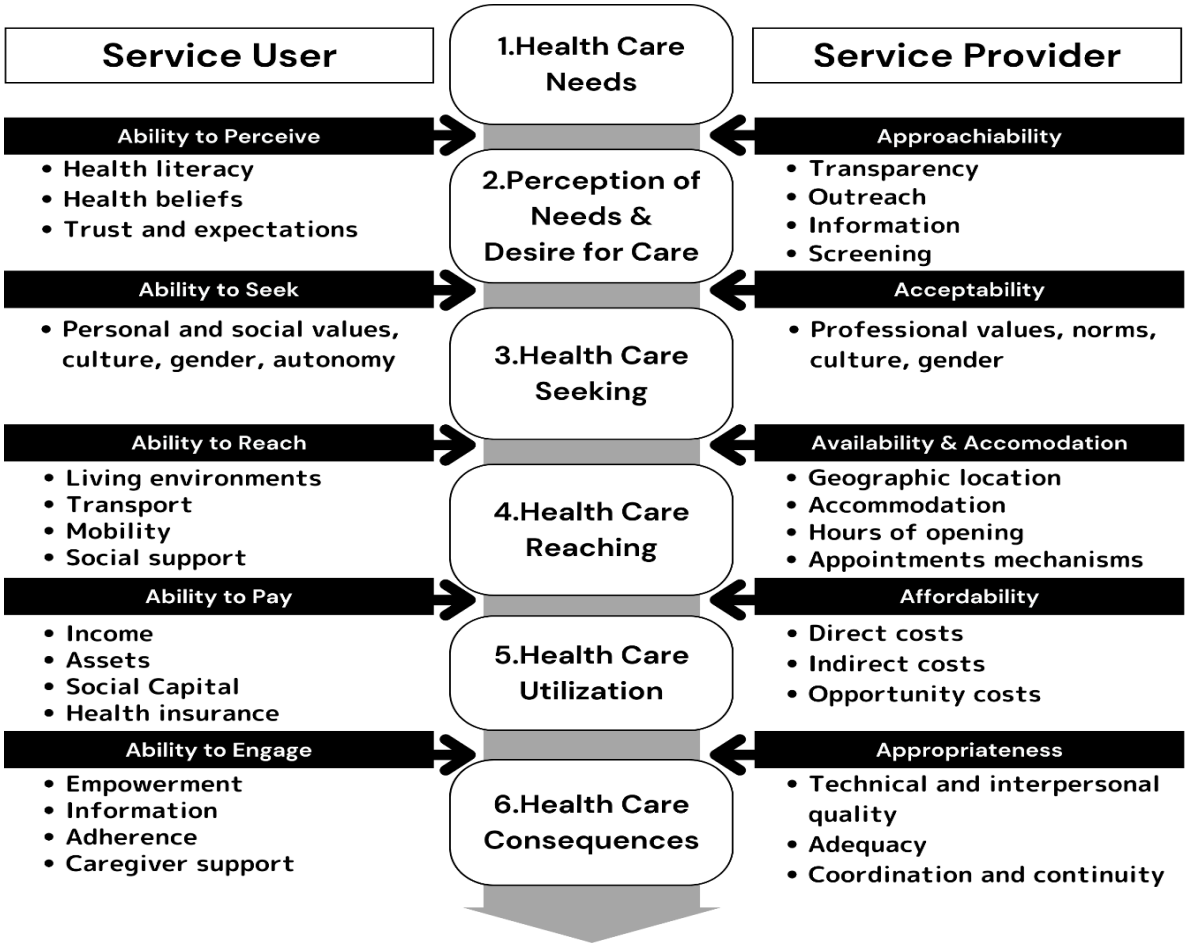
As mentioned above, children of foreign parents in Japan are less likely to attend center-based ECEC than those of Japanese families. Several studies have examined the prevalence and status of children of foreign origin without ECEC opportunities (Utsumi, 2021; Toriumi, 2021; Yamada, 2022; Miyama et al., 2019). Given that some parents and children do not have access ECEC opportunities, an essential focus is not only availability of center-based ECEC and the experience and quality of ECEC service providers once access is realized but also the pathway to access enrollment. Identifying factors that hinder access to center-based ECEC and considering strategies for improvement are critical. However, only a limited number of studies have comprehensively examined the process in which these families enroll and gain access to ECEC opportunities.

Theoretical Framework for Access to Care

There is an accumulation of domestic and international research on facilitators and inhibitors of access to medical and health services for foreign residents, such as a study analyzing the current status of access to medical and health services in a Filipino community in Japan (Yokota, 2016), a study analyzing access to medical and health services among Brazilian children with special medical needs (Motogi et al., 2016), a study examining characteristics of foreign residents with difficulties accessing medical care in terms of inhibiting factors and effective support measures (Morita et al., 2021), and an analysis of inhibiting factors of medical examination behavior among foreign HIV-positive people in Japan (Nakao & Yamamoto, 2013).

This study examined the process by which families of foreign origin access center-based ECEC opportunities with the aid of Levesque et al.'s (2013) theoretical framework for individuals accessing health care (see Figure 1). Levesque et al. (2013) define access to health care as "the opportunity to reach and obtain appropriate health care services in a situation of perceived need for care." The process can be organized into six steps: (1) the need for health care, (2) perception of needs and desire for care, (3) seeking health care services, (4) reaching services, (5) utilization of services, and (6) consequences. These steps also involve the abilities of service users to perceive, to seek, to reach, to pay, and to engage, whereas the attributes of the service provider includes approachability, acceptability, availability, accommodation, affordability, and appropriateness of services. The health care access framework of Levesque et al. (2013) has aided national and international research as a model that reveals complex factors in access to health care services, especially for people with certain attributes such as pregnant refugees in Germany (Henry et al., 2019), migrants residing near the Mexico-US border (Infante et al., 2022), and migrants of South Asian origin residing in Hong Kong (Vandan et al., 2019). Another study examined healthcare access during the COVID-19 pandemic among refugees living in Portugal (Portela et al., 2024) and among transgender persons infected with HIV (Fauk et al., 2019). The present study aims to identify facilitators and inhibitors of access to ECEC opportunities for families of foreign origin raising

Figure 1 Conceptual framework of access to health care by Levesque et al. (2013)



Source: Adapted from Levesque et al. (2013); layout changed from vertical to horizontal by the author.

children in Japan, with the model by Levesque et al. (2013) adopted as a framework to organize and examine the results extracted in the qualitative study.

Methodology

Between November 2023 and December 2024, semi-structured interviews lasting approximately 40 to 60 min each were conducted with 23 parents from families of foreign origin residing in Japan. Participants were selected using snowball sampling and theoretical sampling, with a focus on families in which the mother, father, or both parents were of foreign origin and are raising (or had raised) preschool-aged children in Japan.

In Japan, parents are not required to enroll their children in nursery school or kindergarten, so each family can decide whether or not to send their children to center-based ECEC depending on the family's educational policy. Therefore, this study excluded parents who did not wish to enroll their children in a center-based ECEC and sampled only those families who did.

The researcher recruited several participants from the researcher's network, with new subjects recruited to refine concepts and categories identified through data analysis. Furthermore, to ensure participation in the interviews by not only families who eventually enrolled their children in center-based ECEC but also families who were unable to do so for various reasons despite their wishes, this

study sought the cooperation of NPOs and other supporters who assist parents and children of foreign origin to gain broad experience of the target population.

In the interviews, participants were asked to speak freely, focusing on their family structure, time of arrival in Japan, current status of childcare-related support, reasons for wanting to enroll in center-based ECEC, and experiences in gathering information and procedures when selecting an ECEC facility. All interview data were assigned codes by semantic cohesion using qualitative data analysis software (MAXQDA). These codes were then organized to create subcategories. Subcategories were organized by process, from the point at which parents wished to enroll their children in center-based ECEC to the point at which they started the program.

This study adopted a qualitative research approach to elucidate the detailed process through which families of foreign origin attempt to enroll their children in nursery school and kindergarten—an aspect that is not fully captured by previous quantitative research. In particular, gaining an in-depth understanding of the realities faced by minority groups, such as parents of preschool-aged children of foreign origin seeking enrollment in Japanese ECEC facilities, is expected to contribute to the improvement of policies and support systems.

Ethical Considerations

A written explanation was provided regarding protection of personal information, the voluntary nature of participation, and the possibility that some of the provided information may be modified and published in academic conferences or scholarly papers. Consent was obtained before proceeding, and participants were asked to sign a consent form. Prior to the interviews, participants' preferred interview language was confirmed, and interpreters were arranged as needed. Participants were informed that they could withdraw from the interview at any time at their own discretion and that even after the interview, they had the right to revoke their participation and request deletion of their interview data. Interviews were conducted either in person or online via Zoom. For in-person interviews, a quiet location ensuring privacy was secured. The collected data were anonymized to protect participants' privacy and handled with strict consideration for confidentiality.

Results

Basic information about the families to be interviewed

A breakdown of the origin of parents participating in the interviews is shown in Table 2. Participants came from Vietnam (n=15, 33 %), Nepal (n=7, 15%), Japan (n=6, 13%), Indonesia (n=4, 9%), China (n=3, 7%), South Korea (n=3, 7%), the United States (n=2, 4%), Brazil (n=2, 4%), Egypt (n=2, 4%), Philippines (n=1, 2%), and Canada (n=1, 2%). Of the 23 families of foreign origin, 17 (74%) families had both parents from abroad. An asterisk (*) in the Table 2 indicates a parent who participated in the interview.

Table 2 Summary of interviewees

ID	Mother Country of Origin	Father Country of Origin	Number of Children	Mother Arrival in Japan	Father Arrival in Japan	Language used in Interview
1	USA*	USA	1	2022	2022	English
2	Nepal*	Nepal	2	2012	2008	Japanese
3	Indonesia*	Indonesia	2	2016	2016	English
4	China*	China*	1	2022	2019	Chinese
5	Brazil*	Brazil	2	1991	Not Specified	Japanese
6	Vietnam*	China	1	2012	2012	Japanese
7	Philippines	Japan*	2	2004	N/A	Japanese
8	Vietnam*	Vietnam	2	2023	2019	Vietnamese
9	Indonesia*	Indonesia	1	2018	2018	English
10	Vietnam*	Canada	2	2007	2009	Japanese
11	Japan*	Nepal	1	N/A	2013	Japanese
12	Korea*	Korea	2	2005	2005	Japanese
13	Nepal	Nepal*	1	2022	2014	Japanese
14	Vietnam*	Japan	2	2013	N/A	Japanese
15	Vietnam*	Vietnam	2	2018	2013	Vietnamese
16	Japan*	Korea	1	N/A	2008	Japanese
17	Vietnam*	Vietnam	3	2016	2014	Vietnamese
18	Vietnam*	Japan	3	2010	N/A	Japanese
19	Vietnam*	Japan	2	2017	N/A	Japanese
20	Nepal*	Nepal	2	2016	2014	Japanese
21	Vietnam*	Vietnam	1	2022	2023	English
22	Vietnam*	Vietnam	2	2023	2015	Vietnamese
23	Egypt	Egypt*	3	2019	2019	English

Source: Created by researcher. "Arrival in Japan" refers to the start of medium- to long-term residence, excluding travel and short-term study abroad. An asterisk (*) in the table indicates a parent who participated in the interview.

Results for each step of the enrollment process are presented in Figure 2.

The following section explains the process by which families of foreign origin access center-based ECEC based on interview findings. Text added by the author is shown in parentheses.

1. Needs for enrollment in center-based ECEC

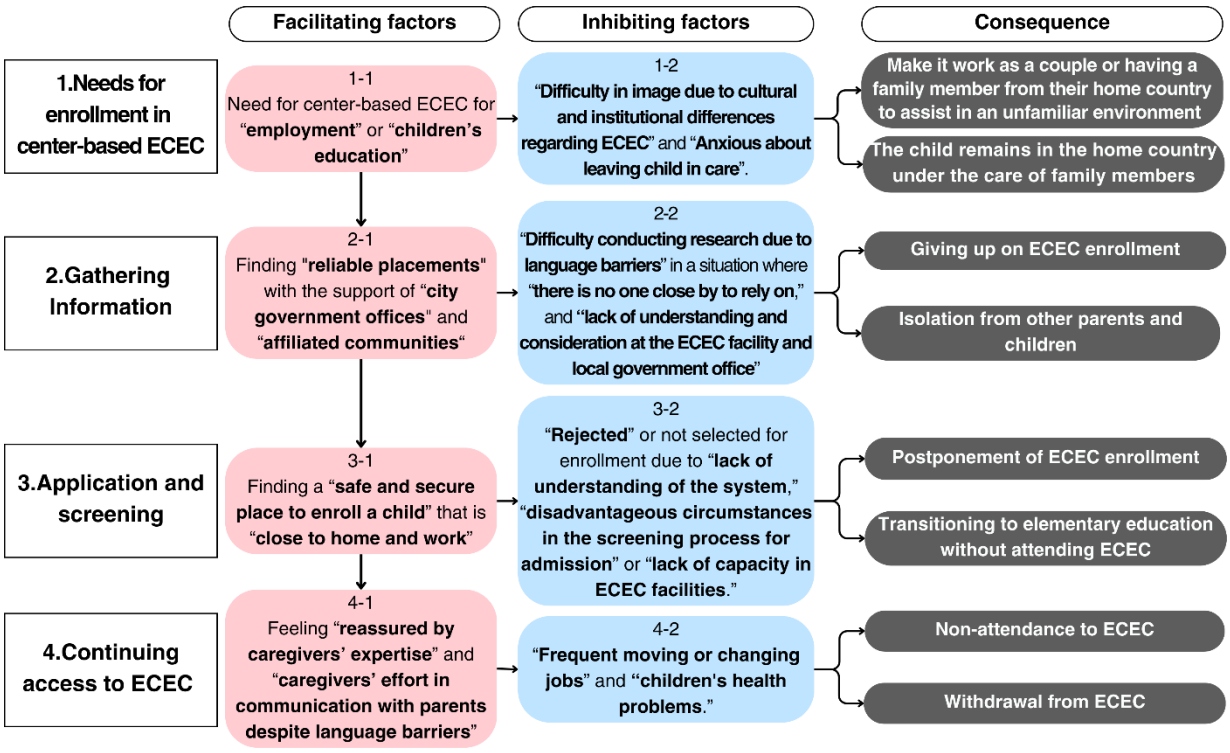
1.1 Facilitating factors: Need for center-based ECEC for "employment" or "children's education"

Most parents in this study were working in Japan and had medium to long-term plans to stay in Japan, whereas others who were currently studying abroad in Japan were considering returning to their home country after a certain period. However, the families wanted their children to "learn Japanese as soon as possible" and "become accustomed to the Japanese environment" in anticipation of "schooling" in Japan, indicating that they viewed enrollment in center-based ECEC as an experiential and educational opportunity for their children prior to primary education.

> *To engage with different cultures, different ideas, maybe. You know, Japan is very famous for technology. (…) So, I want my children to be, to experience the same, the same environment as Japanese children. (ID_3)*

> *Because I want to live in Japan for a long time in the future. I want them to go to nursery school and get used to Japanese life as soon as possible. (ID_8)*

Figure 2 Facilitating and inhibiting factors in access to center-based ECEC by families of foreign origin



Source: Created by researcher

Additionally, parents' ability to enroll their children in early childhood education is crucial for achieving their purpose of coming to Japan, especially when returning to work after parental leave, relocating to Japan for employment, or studying in Japan as an international student.

I came to Japan to earn a living, so if I can't leave my child in daycare, I can't work. (ID_22)

1.2 Inhibiting factors: "Difficulty in image due to cultural and institutional differences regarding ECEC" and "Anxious about leaving child in care"

It became clear that when parents wanted to enroll their children in center-based ECEC and began preparing for enrollment, they were confronted with cultural differences between their home country and Japan regarding the ECEC system. For example, parents from Nepal had no experience attending ECEC facilities themselves as children, given their upbringing in which children were cared for at home by their parents or grandparents.

Generally, everyone is at home with their families, so grandma and grandpa, my own mother, me, and my brothers are all together, so people don't go to nursery schools very often. (ID_2)

Parents from Indonesia also spoke about how they often used live-in babysitters in their home country.

But it was like in a small city... So usually working moms get support from their family, their parents. Grandparents take care of their grandchildren or (...) there's your babysitter. (...) who live together with you because labor is cheap in Indonesia. (ID_9)

In addition, parents from Vietnam said that, among parents who work, many leave their children with grandparents because the maternity leave period is shorter than in Japan and the safety of childcare facilities is not guaranteed.

> *In Vietnam, the maternity leave period is very short and they only give mothers 6 months off. (...) So people often ask family members to take care of children.*
>
> *Nursery schools and kindergartens in Vietnam are not all managed by the government like in Japan. That is why there are all kinds of problems. There are also places where violence occurs. So mothers are very worried about it and ask family members to take care of their children. (ID_18)*

As described above, the ECEC system and child-rearing environment in Japan often differ greatly from those in their home countries, and it is evident that they "cannot imagine (ID_11)" life in a Japanese ECEC facility or leaving their children in the care of strangers. Families of foreign origin raising children in Japan manage to "make it work as a couple (ID_1, 4, 7, 18, 20, 21)" in an unfamiliar environment, or they overcome challenges by having a family member from their home country, or in many cases, their mother, come to Japan to help raise their children (ID_6, 10, 13, 14, 15, 18, 19, 21). Lacking a clear picture of the enrollment process and the difficulties associated with enrolling their children, some families of foreign origin opted to have their children raised by relatives in their home country while the parents worked in Japan (ID_2, 21, 22). On the other hand, there were some families who, after securing a pathway to enrollment in Japan, decided to bring their children from their home country to join them (ID_21, 22).

2. Gathering information

In Japan, parents must select their desired ECEC facility and apply to the local government or kindergarten in their area of residence. Each ECEC facility has a different childcare/education policy, emphasis on activities, childcare hours, and capacity, and so parents must gather this information before selecting an ECEC. In Japan, the shortage of available slots in childcare facilities and the issue of childcare waiting lists remain significant challenges for families seeking enrollment. Finding a childcare facility that aligns with a family's needs while also having available spots is a highly demanding task, even for Japanese parents.

2.1 Facilitating factors: Finding "reliable placements" with the support of "city government ~~offices~~" and "affiliated communities"

When parents of foreign origin seek to enroll their children in center-based ECEC, municipal offices such as city or ward offices serve as important touchpoints. A certain level of awareness among parents was observed that, considering their lack of knowledge about enrollment systems and the types of ECEC facilities available in their area, the first step should be to inquire at the local government office (ID_4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 19, 20). In many cases, information is obtained from the city government offices on available ECEC facilities that are near the home or workplace. When applying for ECEC in Japan, applicants often rank five to eight ECEC facilities in order of priority. Given the limited number of available slots in childcare facilities, applicants are selected from a pool of candidates with a risk of not being accepted. Therefore, it is advisable to apply to multiple ECEC facilities to increase the chances of enrollment. However, interviews revealed that some families visited and applied to only the childcare center recommended by the ward office rather than exploring multiple options.

I don't really know the difference between nursery school and kindergarten. I just know that the city office told me that there are still open spots available, so I just sent her there. (ID_8)

I applied for that (ECEC facility) as my first choice. (At the ward office), I heard about that ECEC facility only. I was told that I would probably be able to enter the place. (ID_22)

In addition to ward offices, parents obtained necessary enrollment information and received support with the application process through their affiliated communities. This study identified the following four types of communities that played a role in supporting enrollment:

Community 1: People of foreign origin raising children in Japan

In some cases, parents can receive support for ECEC enrollment from a community of people from the same country who are raising children in Japan. Parents of foreign origin living in Japan or in the same area may also create an online community through social networking services where they can ask questions about preschool and child-rearing. This is reassuring when there is no social support close by, such as when parents are new to Japan or live in areas with few parents of the same origin.

I got a lot of information from the community of Chinese mothers who are raising their children in Japan. (ID_4)

I joined those groups by joining a Facebook community, a community of Vietnamese mothers in Japan. (ID_17)

We have an Indonesian community, so we can communicate via group chat in WhatsApp. So, we asked how to enroll our children in Hoikuen(nursery school), and then they gave us information that we have to go to the ward office. (ID_3)

Community 2: Japanese friends and neighbors

Parents of foreign origin also received support for ECEC enrollment from Japanese friends and local acquaintances. For families who had recently arrived in Japan or relocated, having someone nearby who could understand and explain information about local nursery schools and kindergartens, as well as assist with enrollment documents in Japanese, was crucial in overcoming language barriers.

Because the apartment manager knows English and Japanese.

(Author) Do they come to Hoikuen (nursery school) with you?

Yes. It's only in the beginning of the enrollment that we have to deliver everything. We have to deliver our concerns, everything at the beginning of the year. (ID_3)

Community 3: Religious groups

Parents in Japan who regularly attend religious community gatherings also receive information about ECEC and childcare from other parents in the same religious group.

I said that we want to enroll (child's name) in Yochien (kindergarten), but I have no idea what to do or which Yochiens are good, which ones are bad. And so a couple of them (in the religious group) gave me recommendations, and separately, they each both said the name of the Yochien that we are now enrolling (child's name) in. (ID_1)

Community 4: Workplace colleagues and university networks

Research participants residing in Japan for work or study obtained information about childcare enrollment through workplace colleagues and international student networks. Although the level of support from employers and the nature of colleague relationships varied, some participants received assistance from their workplaces with enrollment procedures, whereas others exchanged information with colleagues who were also raising children and received their recommendations on childcare facilities.

> *I shared and asked for various kinds of information from colleagues who also had children. (…) For example, how to handle situations when a child is sick, or about the sick-child daycare system, which allows parents to leave their child in care without taking time off work when they are too ill to attend daycare. (ID_10)*

> *My husband's company took care of all the (enrollment) procedures for us. (ID_17)*

2.2 Inhibiting factors: "Difficulty conducting research due to language barriers" in a situation where "there is no one close by to rely on," and "lack of understanding and consideration at the ECEC facility and local government office"

Participants revealed difficulty obtaining information about ECEC enrollment when not belonging to a community or when other parents in their community lacked experience with ECEC enrollment in Japan.

> *These two families (of foreign origin that I know) cannot distinguish between nursery schools and kindergartens, so I didn't ask them much. When I was choosing those nursery schools, I just chose those two that were closest to my house as my priority, if they were available there. (ID_8)*

> *There's no information among foreigners. (ID_12)*

Furthermore, even when families belonged to a community, some parents found differences in household circumstances, such as their child's age or their employment situation, —meant that others' experiences did not always apply to their own. Additionally, even when families found others in similar situations, they sometimes lost access to their support network due to factors such as relocation or returning to their home country.

> *Parenting is different for everyone. And in my case, it's a bit different too because my child is biracial. So that part is completely different. The food is different, and the language is different as well. (ID_6)*

> *At that time, I didn't have any acquaintances—neither Vietnamese nor Japanese. In my company, there was only one other person who was married. (ID_18)*

In Japan, most information related to ECEC enrollment is available only in the Japanese language. The extent to which enrollment documents are translated into multiple languages and interpreters are provided varies significantly between areas with high concentrations of foreign residents and those where they are more dispersed. Many local governments have machine translation functions that allow their websites to be displayed in multiple languages. However, information on ECEC enrollment is difficult to fully understand even with machine translation, as there are many systems and proper nouns that are unique to Japan. During the enrollment process, many situations require

communication in the Japanese language, such as nursery school visits and pre-enrollment interviews with caregivers or municipal office staff. In this context, acquaintances or friends who can serve as interpreters are valuable resources. However, finding such individuals and arranging for them to accompany parents is not always easy.

> *I can't do that by myself because again I don't have the language to be able to just do a Google search like I do in my home country really easily. (ID_1)*

> *There are disadvantages, such as when going to visit a daycare center, members (of the community who can interpret) are not always available, so there is a time lag before the visit. (ID_23)*

Additionally, there were cases where municipal offices and ECEC facilities provided insufficient information regarding the enrollment process for families of foreign origin. Instances of insensitivity toward the cultural, linguistic, and religious backgrounds of these families were also observed. In Japan, children of foreign nationality not attending school has become an issue, and the Japanese Ministry of Education, Culture, Sports, Science and Technology has issued its "Guidelines for the Promotion of School Enrollment of Foreign Children and the Monitoring of School Enrollment Status" (Ministry of Education, Culture, Sports, Science and Technology, 2020). On the other hand, the degree of information provision and procedural support at local government offices regarding ECEC enrollment varies widely.

> *When my child entered elementary school, the process went smoothly. But as I mentioned earlier, when it comes to nursery schools and kindergartens, there was hardly any support. It was pretty much just handing over an information booklet, and that was it. (ID_4)*

In some cases, parents were told to enroll their children in an international school even though they wanted to attend a local ECEC facility.

> *They told me, "there are no available spots."*

> *They said, "since there are no openings in nursery schools, why don't you send your child to a school for foreigners instead?" It felt like they were saying, "Because the parents don't speak Japanese, just go to a foreign school." (…)*

> *I was asked, "Why do you even need to work?" by the person in charge of nursery school applications at the city office. (ID_5)*

In some cases, parents must visit the ECEC facility for a tour or interview before applying for nursery school or kindergarten. At such times, some teachers spoke to parents of foreign origin in an inconsiderate manner.

> *If I tell them at daycare that I don't use Japanese at home, and they say, "that's not good for your child," or something like, "please use as much Japanese as possible at home," I won't go there. (ID_10)*

There were also children who were refused enrollment due to their parents' Japanese language skills, even when the parents wished to enroll their children. In addition, depending on the timing of their arrival in Japan, some parents were denied enrollment due to the short period of time between enrollment and entrance to elementary school.

> *So, I went there and then I asked, but I think we could not communicate so well (in Japanese), so they said my child cannot join the Yochien. (ID_9)*

> *I felt that some nursery schools didn't seem to be welcoming toward foreigners. They indirectly told me, "You may not be able to be admitted to the nursery school," which gave me the impression that they didn't really want foreign families to enroll. (ID_23)*

> *I had heard that in Japan, when a school refuses or rejects a request, they do so in a very gentle manner and without causing too much trouble. I was a little angry at the way they kept putting things off, even though we had clearly expressed our wish to enter the school. (ID_4)*

As a result, it became clear that children who are forced to be cared for at home spend their time "watching YouTube and drawing pictures (ID_7)" until they start school, and they are isolated from other parents and children.

> *A lot of times we go to the park all the time during the week, but I would say 80% of the time when we go to the park, there's no one else there. (ID_1)*

On the other hand, in cases where children entered elementary school without having first attended an ECEC facility, parental narratives revealed that local learning support programs for children of foreign origin played a crucial role. These programs provided opportunities for children to interact with peers and prepare for formal schooling.

3. Application and screening

Parents must apply for certification of their need for childcare based on factors such as child's age and parents' employment status before enrolling their child in their preferred nursery school or kindergarten. This certification is required to access center-based ECEC facilities. The process involves gathering the necessary documents for certification, completing enrollment application forms, assessing available spots at different facilities, and strategically selecting and applying to facilities with a higher likelihood of acceptance.

3.1 Promoting factor: Finding a "safe and secure place to enroll a child" that is "close to home and work"

Enrollment in ECEC involves entrusting one's child to someone else, and therefore trust between the service provider and parents is a crucial element. Families of foreign origin prioritized entrusting their child with a sense of security when visiting nursery schools and communicating with caregivers.

> *Of course, there's a lot of information out there, but for me, a nursery school is simply a place to leave my child. As long as my child is taken care of in a safe and secure environment, that's all that really matters to me. (ID_10)*

3.2 Inhibiting factors: "Rejected" or not selected for enrollment due to "lack of understanding of the system," "disadvantageous circumstances in the screening process for admission" or "lack of capacity in ECEC facilities"

In Japan, the largest number of center-based ECEC openings occur in April when the school year begins, and there is a high likelihood of enrollment. For this reason, many applicants wish to enroll their children in April, but parents must apply for enrollment in the fall of the previous year, which is

an early deadline. In some cases, ECEC enrollment was delayed due to insufficient understanding of the system, such as the application schedule.

> *With that April admission, the deadline was probably October or November before that fiscal year. I just didn't know about that opportunity. It was my first child, and it was my first experience, so I went to apply after the New Year, sometime in January or February. (ID_6)*

In the enrollment screening process, parents are assigned points based on their reasons for needing childcare, such as their employment situation, with selection prioritized by highest scores. Accounts from parents of foreign origin who came to Japan for work or study indicated that statuses such as "international student" or "currently seeking employment" tended to receive lower scores in the screening process, making it more likely for them to be rejected for enrollment.

> *Maybe at that time, maybe my husband was, you know, an international student, a graduate student (...) so that's why we didn't get in. (ID_10).*

> *I am planning to return to work this month or so, but the company I was working for has been slow to respond, so there is a chance that I may not be rehired, so I am currently doing another job search. (ID_15)*

In addition, most spaces are filled with children brought up from the 0- and 1-year-old classes, and depending on the child's age at the time of arrival in Japan, they are likely to be placed on a waiting list.

> *Enrolling in a class at the middle of the year at age 2 is extremely difficult. Everywhere is already full, or that's just how it feels. (ID_6)*

4. Continuing access to ECEC

The interviews in this study also identified findings related to continuity of childcare after enrollment had been secured.

4.1 Promoting factors: feeling "reassured by caregivers' expertise" and "caregivers' effort in communication with parents despite language barriers"

As a contributing factor to continued enrollment, some parents expressed a strong sense of reassurance in the professionalism of ECEC service providers and felt as though they were co-parenting with them.

> *The teachers noticed it—they recognized the changes in my child and what was different. I think that's a really great aspect. Since the teachers have received proper training, they also understand children's psychology. I truly feel that they are more capable than I am in that regard. (ID_18)*

Regardless of whether caregivers could speak a foreign language, the sense that they were trying to communicate and support parents of foreign origin played a crucial role in building trust. Their willingness to engage and accommodate the needs of these families fostered a stronger sense of connection between caregivers and parents.

> *The principal—she's very nice and she supports me and also gives me much information. So I think that this is good for my baby. So, I send him there. She does not speak English, but she tries to use an app for translation and explains to me how it is possible. (ID_21)*

4.2 Inhibiting factors: "Frequent moving or changing jobs" and "children's health problems"

However, even after an ECEC placement decision, the child might need to leave or change their ECEC facility due to frequent relocation or job changes. Then, parents must restart the enrollment process from the beginning to enroll their children at a new location. Clearly, ECEC enrollment might be impossible or postponed due to lack of capacity at other ECEC facilities or relocation timing.

> *I wanted to look for a job, but after three months, my husband got a new job here, so we moved. (ID_9)*

> *"(Child's name) has been transferring between schools a lot. We enrolled in (nursery school name) partway through, when they were one year old, or maybe even younger. Then, when my husband got a new job, I think around the age of two or three, we moved to (nursery school name). Then, we had to transfer again when we moved to (region name). When we arrived in (region name) at age four, we tried to enroll in (nursery school name), but we couldn't get in. (...) There have been many transfers—probably about four different places in total." (ID_10)*

Some parents temporarily returned to their home country to raise their child due to concerns about navigating unfamiliar parenting practices or giving birth to a second or subsequent child. Then, after a certain period, they returned to Japan. After enrollment, children also commonly contract various infectious diseases in daycare settings. Some parents shared experiences of repeated illnesses leading to prolonged absences from an ECEC program, which made them reconsider continued enrollment.

> *(With regard to the reason why she quit an ECEC facility and returned to Nepal) When my child was 8 months old, we enrolled in daycare, but then we left and stayed in Nepal for about 4 months. After that, when my child was around 1 year and 3 months old, we re-enrolled in nursery school. But since life in Nepal and Japan is quite different, I wasn't really accustomed to it at first. (ID_20).*

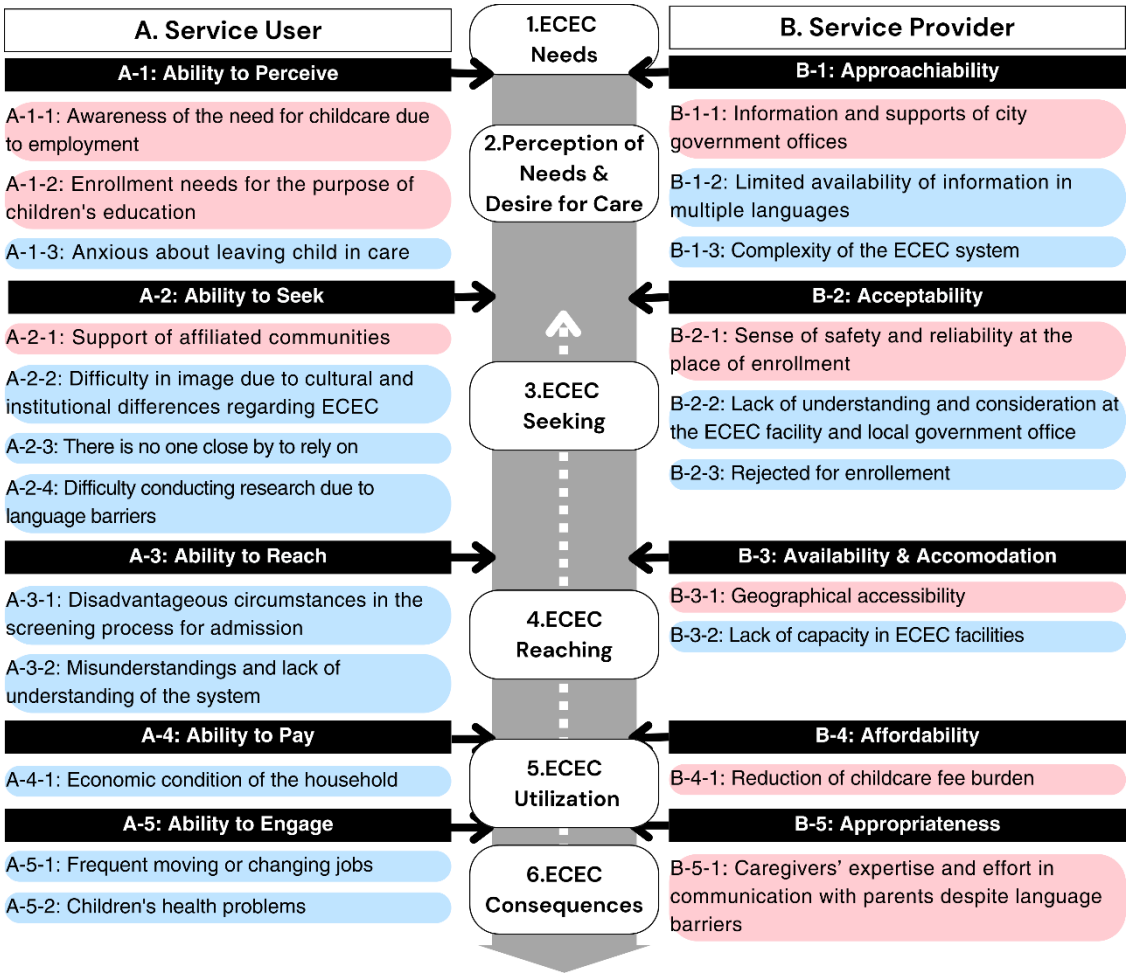
> *My child was in Japan until the age of four, then we went back to (home country) and stayed there for about a year and a half. We were in (home country) until my child was nearly 5 or 6 years old. When my child was a little over three, they were diagnosed with (child's disability), and I started feeling overwhelmed. I thought about returning to my family home for a while. (ID_5)*

Discussion

This study examined facilitating and inhibiting factors in the process of "recognizing needs for enrollment in center-based ECEC", "gathering information and selecting ECEC facilities to apply", "applying for placement" and "continuing access to center-based ECEC" for families of foreign origin in Japan who wished to enroll their children in center-based ECEC. These results were categorized by

ability on the part of service users and service providers with the help of Levesque et al.'s (2013) health care access model (see Figure 3).

Figure 3 Access to center-based ECEC organized within the framework of Levesque et al. (2013)



Source: Adapted from Levesque et al. (2013); the layout was modified from vertical to horizontal, and facilitating factors (pink) and inhibiting factors (blue) identified in this study were added by the author.

To a certain extent, concepts extracted from the interviews regarding the enrollment process for children of families of foreign origin in Japan fit into Levesque et al.'s (2013) framework. Levesque's framework illustrates that access to healthcare progresses through multiple stages, shaped by the complex interaction of user- and provider-side factors. When this framework is applied to access to ECEC, it becomes evident that families of foreign origin often experience disruptions or regressions along the way, as both user-related and provider-related factors can cause them to return to earlier stages in the process. (This reversibility is visually represented in the figure3 by white arrows indicating the possibility of returning to earlier stages.) In Japan, it is not the duty of parents to enroll their children in a nursery school or kindergarten. Therefore, nursery schools and kindergartens operate on an application basis, whereby local governments and kindergartens screen applications from parents, and parents must prove and sometimes negotiate their own family's need for childcare. Furthermore, a major issue in Japan is the "waiting child problem," involving a mismatch between demand for childcare services from families in need and supply of services available at ECEC facilities. It is not easy for parents to enroll their children in an ECEC facility of their choice. This study confirmed the existence

of situations where parents are easily disadvantaged in the screening process, such as with the statuses of "searching for employment opportunities" or "international student" or where parents are refused ECEC enrollment due to "timing of arrival in Japan," "status of residence of the family," or "inability to communicate in Japanese." Additionally, even when families successfully navigate every step and secure enrollment, characteristics of families in Japan—such as frequent relocations, job changes, and the need to travel between their home country and Japan for various reasons—often require them to withdraw from ECEC opportunities.

In such cases, it is crucial for service providers, including local governments and childcare facilities, to recognize barriers to enrollment faced by families of foreign origin as identified in this study. Proactive measures such as disseminating information in multiple languages and providing interpreters can play a significant role in ensuring that children of foreign origin gain access to and continue receiving ECEC opportunities. This study also revealed that communities of affiliation, such as groups of people who share the same national origin, religion, and place of employment, help overcome the lack of information as well as language and institutional barriers to ECEC enrollment. Therefore, providing appropriate information related to ECEC, not only to families of foreign origin but also to their ethnic minority communities, companies, and universities, would improve access to ECEC for children of foreign origin. Under the current system, barriers to enrollment identified in this study—such as frequent domestic and international relocations and residency status issues—have not been fully addressed, potentially leaving some children of foreign origin without access to center-based ECEC. To ensure that these children can access alternative ECEC opportunities and to prevent both them and their parents from becoming isolated within the community, it is essential to establish community-based support structures—such as culturally responsive preschool preparation programs and children's spaces—where children can interact with peers, learn, and develop school readiness.

Limitations of this study include having participants primarily from two-parent households with residency status, such as those with work or family stay visas. Thus, the study does not analyze the process of accessing center-based ECEC opportunities from the perspectives of refugee families, families with undocumented status, or single-parent households. Additionally, the sample might be biased toward specific groups as participants were recruited through the author's networks, including foreign communities and support organizations with which the author is affiliated. This study interviewed some parents who wanted to obtain an ECEC opportunity but whose children had reached school age before they could do so. However, it is necessary to continue tracking families who remain unable to secure access to ECEC and who are not connected to any communities or support organizations. In doing so, future research can further refine its understanding of factors that hinder access to ECEC for children of foreign origin in Japan. In addition, this study was a qualitative analysis of the processes involved in accessing center-based ECEC for the parents of 23 families, and a quantitative study is warranted to determine the status of access to preschool education for a broader population of foreign origin raising children in Japan.

Conclusion

In Japan, parents are not required to enroll their children in nursery school or kindergarten. However, given the Japanese government's active promotion to recruit foreign workers and international students, increasing numbers of people are coming to Japan for employment or education. Certainly, the ability to enroll their children in center-based ECEC plays a major role in their ability to achieve the purpose of their migration to Japan. For parents of foreign origin raising preschool-aged

children in Japan, which can be a brand-new environment, ECEC facilities such as nursery schools and kindergartens serve not only as spaces for children's growth, development, and school readiness but also as the first long-term formal support that many foreign parents engage with for over a year. As such, these institutions represent a crucial social resource in the lives of families of foreign origin in Japan. Given the growing severity of labor shortages in Japan, the government has been actively promoting employment of foreign workers. For Japan to remain a desirable destination for people from other countries, it is essential to establish a supportive environment where they can work and live with a sense of security. Moreover, further shifts in awareness and policies are needed to ensure the retention and active participation of these workers in Japanese society (Ministry of Land, Infrastructure, Transport and Tourism, 2024). The "Roadmap for Realization of a Society Coexisting with Foreign Residents" states the need for the national government, local governments, support groups, and other related organizations to cooperate and collaborate in understanding the support needs of foreign residents and to support their inclusion in society and ensure safe and secure living conditions (Immigration Services Agency of Japan, 2022). Essential components of fostering a more inclusive and supportive environment for foreign professionals in Japan include ensuring their equitable access to information about childcare and ECEC opportunities and creating an environment where all children can grow up safely and securely while reaching their full potential in society.

Acknowledgement

This research was supported by JST SPRING, Grant Number JPMJSP2136, and the FY2024 Academic Research Grant provided by the Japan Geographic Data Center. I would also like to express my sincere gratitude to the families of foreign origin raising children in Japan, as well as to the support organizations, for their valuable cooperation in this study.

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