

Psychological Distress Among Ethiopian Pregnant Women During COVID-19: Negative Correlation with Self-Efficacy

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Background: Since the onset of coronavirus disease 2019, the mental health of individuals has been negatively affected, especially among vulnerable groups.

Objective: The aim of this study was to explore the association of psychological distress with self-efficacy and other correlates among Ethiopian pregnant women.

Methods: A cross-sectional study was carried out among 384 pregnant women from August 1 to 15, 2020. Pandemic-related psychological distress was measured by the Impact of Event Scale Revised (IES-R). Hospital anxiety and depression scale (HADS), generalized self-efficacy scale (GSES), and fear of COVID-19 scale (FCoV-19S) were employed to examine independent variables. A consecutive sampling technique was employed and the data were analyzed by SPSS version 23.0. Categorical variables were presented in terms of frequencies and percentages; and mean with SD was employed to express continuous variables. Multiple regressions were performed; and for statistical significance, $p < 0.05$ and 95% CI were considered.

Results: The participants had 31.3 (SD \pm 7.7) mean age and those participants between the ages of 25–34 were dominant. The mean score of IES-R scale was 45.1 (\pm 17.4) indicating severe psychological distress. The IES-R mean score for primiparous women was significantly higher than the mean score of multiparous women. Psychological distress has a strong positive correlation with symptoms of anxiety, depression and fear of COVID-19. In contrast, a negative relationship was found between psychological distress and participants' self-efficacy.

Conclusion: The results indicate that the current pandemic has imposed severe psychological distress among pregnant women. The presence of anxiety, depressive symptoms, and pandemic-related fears were identified as positive predictors. In contrast, better self-efficacy of the pregnant women was linked to lower psychological distress. For health-care professionals, broadening the focus and collaboration among service-delivering units are important in halting undesirable outcomes of the pandemic.

Keywords: mental well-beings, anxiety, depression, COVID-19 fear, Ethiopia

Introduction

Since the onset of coronavirus disease 2019 (COVID-19), the mental health of individuals has been affected negatively. In regulating their lifestyles during this pandemic, many people are facing numerous challenges¹ and psychological distress has significantly elevated among the global population.²

Being a poor country, Ethiopia is also struggling to rescue its weak health-care system from collapse since the detection of the COVID-19 index case on March 13,

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2020.³ Stressed by the pandemic, the country has implemented defensive measures and had declared an emergency state by April 2020.⁴ In spite of this, the number of cases continues to increase and confirmed cases had reached 175,467 with 2,550 total deaths on March 17, 2021.⁵

As time has progressed, the pandemic has caused myriad psychosocial disruptions.⁶ Preventive measures of the pandemic have been connected to substantially increased stress,⁷ especially among young people and women.² Mainly, women have been exposed to significant psychological distress in the era of the current pandemic⁸ which is probably intensified during pregnancy. On the other hand, disturbances in mental well-being and psychological health are common at the time of pregnancy, which possibly deepen with the negative effects of the pandemic.⁹ Concerns about vulnerabilities, fear of virus transmission to the fetus and antenatal care service utilization could make pregnant mothers prone to psychological disruptions¹⁰ and the occurrence is high in poor communities.¹¹ For instance, previous studies have revealed the raised level of psychological distress among women¹² and mental wellbeing of pregnant mothers has decreased during the COVID-19 pandemic.¹³

In addition to psychological distress, the negative perceptions of the pandemic during pregnancy have caused prominently heightened anxiety and depressive symptoms in this population.¹⁴ Previous studies have indicated that the occurrence of depression has increased¹⁵ and the number of pregnant women with abnormal levels of anxiety symptoms have doubled during COVID-19.¹⁶ A supportive study has also identified highly increased anxiety and depression among pregnant mothers during the current pandemic and linked this to adverse pregnancy outcomes.¹⁷ In line with these observations, Kajdy et al. has reported elevated levels of perinatal anxiety and depression during the current pandemic.¹⁸ On the top of direct effects, pandemic-related relationship issues and financial difficulties have contributed to raised mental health and psychological problems.¹⁹ In line with this, lockdown and quarantine policies such as social isolation have driven the disturbances of mental wellbeing.²⁰

Beyond psychological distress and mental health instabilities, the unexpected COVID-19 outbreak has brought feelings of insecurity and fear globally. Particularly, the negative emotions during pregnancy concerning the disease have led pregnant women to anticipated panic and fear.²¹ On the top of worrying for

their own health, the concern about unforeseen impacts of the pandemic on the fetus and new coming baby have deepened the fear of the pandemic crisis among pregnant women.¹⁶ In addition to concerns for health issues, financial disruptions and instabilities due to home confinement were other crucial sources of fear among pregnant women that could affect their psychosocial and mental wellbeing.¹⁸ Elevated fear of the pandemic among this population has been associated with depression, perceived stress, lowered quality of life and could extend to suicidal behavior.²²

Reversing the negative emotions and boosting the level of self-efficacy could be helpful in promoting mental wellbeing and combating psychological distress. It has been found that raised self-efficacy is associated with lowered psychological distress and enhanced mental health.²³ Interestingly, better self-efficacy has negative impacts on anxiety, stress and depression, while being linked to improved sleep, which in turn could boost mental wellbeing.²⁴ Another supportive finding has reported the importance of heightened self-efficacy in combating anxiety and depression and improving interpersonal relationships which are crucial in maintaining mental health and psychological wellbeing.²⁵ Additionally, satisfying relationships and support from significant others were identified as positive enhancers of mental and psychological health during COVID-19.²⁶

The extensive and multidimensional impacts of the COVID-19 pandemic besides the preeminent fear of the illness could cause considerable psychological distress and mental health disruptions among pregnant women. Hence, identifying the level of psychological distress and mental well-being disturbance and emphasizing the prominence of self-efficacy are paramount in maintaining mental health and psychosocial wellbeing. Despite this, to the best of our knowledge, studies were deficient in Ethiopia to evaluate the mental wellbeing of pregnant women amidst COVID-19. In this regard, the main aim of this study was to assess the mental wellbeing of pregnant women during COVID-19. In light of this purpose, the findings of the current study could help as the baseline for future studies under similar themes. Moreover, it will provide an input for clinical experts to provide evidence-based services. Furthermore, the results of this study will support health-care planners and policy makers in the context of the current or future pandemic.

Hypotheses of the Study

H₀: Pregnant women with different characteristics had equally experienced psychological distress during COVID-19 pandemic.

H₁: Pregnant women with different characteristics had not equally experienced psychological distress during COVID-19 pandemic.

Materials and Methods

The current study was part of a previously published project²⁷ and the details of the methodologies were elaborated there.

Study area and Participants

The study was done among 384 pregnant women who were on follow-up for antenatal care (ANC) at health institutions of Mettu town, southwest Ethiopia. Mettu is a zonal town which has one referral hospital and two medium private clinics that provide antenatal care services from which the study participants were enrolled. In general, these institutions are serving the local residents, both from the town and nearby rural areas.

Study Design and Period

The cross-sectional study was conducted from August 1–15, 2020.

Participant Inclusion Criteria

Pregnant women who were on regular follow-up and had achieved at least basic ANC services were included. Those women with any condition that limits their communication and might impede them from responding to the interview and those identified with high-risk pregnancy were excluded from the study. Furthermore, those mothers with a medical registration book that has missed basic information were excluded from the study.

Sample Size Calculation and Sampling Procedures

The minimum sample needed for the study was obtained using the formula of single population proportion by assuming 95% confidence interval, 5% margin of error, and predicted proportion of 50%. Accordingly, calculated samples (384 pregnant women) were included by proportional allocation among the health institutions mentioned above in accordance with their follow-up flow. Then, those

participants who fulfilled the inclusion criteria were recruited by consecutive sampling technique.

Data Collection Instruments and Procedures

Data were collected by face-to-face interview technique while keeping the minimum distance (one meter) and using compulsory personal protective materials such as face masks. Original versions of questionnaires were interpreted into local languages (Amharic and Afan Oromo) and then back to English by experts for consistency. Socio-demographic and clinical characteristics (age [18–24, 25–34, 35–44], educational status [no formal education, primary, secondary, above secondary], occupation [government employee, self-employed, housewife], parity [primiparous, multiparous], trimester [first, second, third], residency [urban, rural], pregnancy-related complications [present, absent] and family size [Less than 5, Five and above]) of the participants were collected from themselves and respective medical record books and these categories were used in comparisons of mean difference among groups. Additionally, the status of psychological distress, level of anxiety and depression symptoms, level of self-efficacy and extent of pandemic fear of the participants were examined by the questionnaires. Direct reports from the participants and medical record review were used to obtain socio-demographic and clinical characteristics.

Psychological distress caused by the pandemic was measured by the Impact of Event Scale revised (IES-R).²⁸ The tool has 22 items which scored on a Likert scale of 5 points ranging from 0 (not at all) to 4 (extremely) to assess the participant's experience about the event during the past 7 days. It yields 0–88 total scores in which higher score indicates the higher distress. The tool can be sub-scaled into intrusion (8 items), avoidance (8 items) and hyperarousal (6 items) categories.²⁹ This tool divided the severity of psychological distress as mild (24–32), moderate (33–36) and severe (≥ 37)²⁸ although the mean of overall score was considered in the current study. Although not in Ethiopia, the tool has been validated among adult populations in different settings and was acceptable to good internal consistency (alpha coefficients = 0.75–0.94)^{30,31} and in this study, the Cronbach's alpha was 0.95.

The levels of anxiety and depression symptoms were evaluated by the hospital anxiety and depression scale (HADS). The tool contains 14 items (7 items for each)

and scored on Likert scale of 0–3 points to give a maximum of 21 points for each sub-scale¹⁷ and it specifies the severity of anxiety and depressive symptoms as normal (0–7), borderline (8–10) and abnormal/case (11–21).³² The tool was validated in Ethiopia³² and in this study, the values of Cronbach's alpha were 0.83 and 0.70 for anxiety and depression sub-scale, respectively.

Ten-item generalized self-efficacy scale (GSES) was employed to examine the strength of participants' self-efficacy. Each item was scored on the scale from 1 (not at all true) to 4 (exactly true) and the higher the score, the greater the sense of self-efficacy.³³ It is a widely used tool to assess self-efficacy and has been validated in more than 30 countries³⁴ and in the current study, it has shown excellent internal consistency (Cronbach's alpha = 0.96).

Pandemic-related fear was measured by the fear of COVID-19 scale (FCoV-19S) which was developed and validated for the general population. The tool has seven items which are scored on a Likert scale of 5 points that ranged from 1 (strongly disagree) to 5 (strongly agree) and the higher score specifies the greater fear from COVID-19.³⁵ Currently, the tool has been validated in Ethiopia (Cronbach's alpha = 0.87)³⁶ and the Cronbach's alpha was 0.90 in this specific study.

Statistical Analyses

All data were analyzed by SPSS version 23.0 (IBM, Armonk, NY, USA). Categorical variables were presented in terms of frequencies and percentages and mean with SD was employed to express continuous variables. The groups of dichotomized variables with normal distribution (mothers' parity, place of residence, family size and pregnancy-related complications) were compared by *t*-test. One way ANOVA was employed to compare the groups of normally distributed variables that have three or more categories (age, gestational age, occupation and educational status) and Tukey HSD test was performed for post-hoc group analysis. The strength and direction of relationships between variables were defined by a Pearson correlation coefficient (*r*). Multiple regressions were performed and model fitness was expressed by the coefficient of determination (R^2). Required preliminary analyses were conducted; all assumptions of the regressions were checked and no violation was detected. For statistical significance, $p < 0.05$ and 95% CI were considered.

Results

Socio-Demographic Characteristics of the Participants

The proposed number of participants was obtained during the study period without attrition rate and all data were analyzed. The participants had 31.3 (SD± 7.7) mean of age and those subjects between the ages of 25–34 were dominant in number (40.4%). The majority (59.4%) of the women were multiparous and about one-third of them were in the third trimester. More details about the demographic characteristics of the study participants were explained in our previous paper.²⁷

Mental WellBeing Status of the Participants

The mean score for overall items of IES-R scale was 45.1 ±17.4, indicating severe psychological distress among study participants. Considering individual sub-scales, the mean score for intrusion subscale (18.0±8.3) was higher compared with the mean score of avoidance (15.5±5.4) and hyperarousal (11.6±4.2) subscales. As measured by HADS, the overall mean scores for anxiety and depression subscales were 10.7±5.6 and 11.2±4.6, respectively, which are an indication of abnormal levels. Nearly half (48.2%) of the participants and more than two-fifths (43.8%) of them had reported an abnormal level (score >10) of anxiety and depression, respectively. Looking into the psychological strength of the study subjects, the mean score of GSES was 24.0±8.4. Unfortunately, only less than one-fifth (18%) of the women had reported that they can exactly manage difficult problems when they try hard enough. About 34.1% of the women had stated that they were moderately confident that they could deal efficiently with unexpected events like the current pandemic.

The Status of Pandemic-Related Fear Among Study Participants

Considering the fear of COVID-19, the mean score of FCoV-19S among pregnant women was 27.1±5.2. About 43.8% of the women agreed that they were afraid COVID-19 mostly and more than one-third (35.7%) of them strongly agreed that they feared that they could lose their life due to COVID-19. Similarly, about 33.6% of pregnant mothers strongly agreed that they had difficulty in sleeping due to worrying about contracting the illness. On the evaluation of mean differences, primiparous women had significantly [t

(382) = 9.82, $p < 0.001$] higher mean than multiparous mothers. Similarly, a having pregnancy-related complication was linked to higher mean score of FCoV-19S compared with their counterparts (mean difference = 4.15, $p < 0.001$). Further, those pregnant women in third trimester had significant ($p < 0.001$) highest mean ($M \pm SD = 30.30 \pm 4.36$) compared with those mothers in first ($M \pm SD = 27.48 \pm 3.81$) and second ($M \pm SD = 22.70 \pm 6.62$) trimesters. Apart from this, no socio-demographic factor has reached a significant level of difference.

Comparing the Mean of the Samples Between the Groups

Independent sample *t*-test was used to compare the mean of overall IES-R score against mothers' parity, residence, family size and pregnancy-associated complications. Consequently, the significant mean difference was observed in groups of mothers' parity and status of pregnancy complication. Thus, the IES-R mean score for primiparous women ($M = 63.1$, $SD = 4.4$) was significantly higher [$t(382) = 32.31$, $p < 0.001$] than the mean score of multiparous women ($M = 32.8$, $SD = 11.1$). Similarly, those women who had reported any type of pregnancy-related complication had shown a significantly [$t(382) = 11.11$, $p < 0.001$] higher IES-R mean score ($M = 67.3$, $SD = 2.7$) compared with those women without known complications during pregnancy. Although some differences were observed between the mean score of IES-R scale for current place of residency and number of families, neither of them reached a significant level (Table 1).

To explore the mean differences of IES-R scale among the groups of age, gestational age, occupation and educational status, one-way ANOVA was performed. Among these, only the mean scores of gestational age groups showed a significant difference [$F(2, 381) = 820.6$, $p < 0.001$]. Tukey HSD test post-hoc analysis revealed that the mean score of IES-R for those women in the third trimester ($M = 63.6$, $SD = 6.5$) was significantly highest from those women in first ($M = 44.3$, $SD = 9.7$, $MD = 19.3$) and second trimesters ($M = 23.3$, $SD = 5.0$, $MD = 40.3$). Also, the mean score for women at first trimester was significantly higher than the mean score of those women at second trimester ($MD = 21.0$) (Table 2).

Analysis of Correlation Among Variables

The relationship among continuous variables was assessed by a Pearson correlation coefficient (*r*). As a result, psychological distress revealed a strong positive correlation with symptoms of anxiety, depression and fear of COVID-19 (*r* ranged from 0.45 to 0.56, $p < 0.001$). In contrast, participants' self-efficacy has a very strong negative relationship with psychological distress ($r = -0.79$, $p < 0.001$) and strong negative correlation with fear of COVID-19 ($r = -0.52$, $p < 0.001$). (Table 3)

Multiple Regression Analysis

As a result, anxiety symptoms, fear of COVID-19 and the status of participants' sense of self-efficacy were significant predictors of psychological distress among pregnant women. Among these, the score on the general self-efficacy scale was the best predictor of all variables, which uniquely

Table 1 Independent-Samples *t*-Test for Overall Score of IES-R Against Dichotomized Predictors of Study Participants ($n = 384$)

Predictors	F	t-value	df	Sig.	M±SD for IES-R	Mean Difference	95% CI of MEAN DIFFERENCE
Parity Primiparous Multiparous	149.4	32.31	382	<0.001 [†]	63.1±4.4 32.8±11.1	30.32	28.5, 32.2
Residency Urban Rural	0.08	1.73	382	0.78	46.4±17.5 43.2±17.3	3.11	-0.4, 6.6
Complication Yes No	173.4	11.11	382	<0.001 [†]	67.3±2.7 41.8±16.2	25.56	21.0, 30.1
Family size < 5 ≥ 5	0.002	0.13	382	0.96	45.1±17.5 45.0±17.4	0.23	-3.3, 3.8

Note: [†]Significant values at $p < 0.05$ are in bold font.

Abbreviations: CI, confidence interval; M, mean; SD, standard deviation; IES-R, Impacts of Event Scale Revised; the higher the score, the worse the psychological distress is.

Table 2 One-Way Analysis of Variance for Overall Score of IES-R Against Participants' Age, Occupation, Educational Status and Gestational Age (n = 384)

Predictors		Sum of Squares	df	Mean Square	F	P-value
Age	Between groups	35.5	2	17.7	0.06	0.94
	Within groups	116,261.5	381	305.1		
	Total	116,297.0	383			
Educational status	Between groups	1025.9	3	342.0	1.13	0.34
	Within groups	115,271.1	380	303.3		
	Total	116,297.0	383			
Occupation	Between groups	525.0	2	262.5	0.86	0.42
	Within groups	115,272.0	381	303.9		
	Total	116,297.0	383			
Trimester	Between groups	94,385.1	2	47,192.5	820.6	<0.001[†]
	Within groups	21,912.0	381	57.5		
	Total	116,297.0	383			

Note: [†]Significant values at $p < 0.05$ are in bold font.

Abbreviations: df, degree of freedom; IES-R, Impacts of Event Scale Revised; the higher the score, the worse the psychological distress is.

accounted for a 29.16% variance in the IES-R. Overall, the model's ability of psychological distress prediction of the included variables (HADS-A, HADS-D, FCoV-19S and GSES) was about 67.3% (Table 4).

Discussion

In the current study, we tried to evaluate the status of psychological distress and its relationship with socio-demographic variables, status of anxiety and depressive symptoms, pandemic-related fear and strength of self-efficacy among Ethiopian pregnant women and it was thought to be the first study nationally.

As the results indicated, the current pandemic has imposed significant psychological effects on pregnant

women and nearly two-thirds of participants reported severe psychological distress (IES-R score ≥ 37). This finding was higher compared with the results of previous studies conducted in Italy³⁷ and Nepal³⁸ and lower than the finding of a study done in Spain.³⁹ The discrepancy between these results might be accounted for by the difference in the used tools, study period and the standards of the health-care system among the countries in which the studies were conducted. On the other hand, the difference in the educational status of the participants is also unavoidable, which could affect the level of pandemic awareness and related psychological disturbances.⁴⁰

Primiparous women had significantly higher mean score of IES-R than multiparous women. The fear of

Table 3 Analysis of Correlation (by Pearson's Correlation Coefficient) for the Scores of IES-R, HADS, FCoV-19S and GSES[†]

Predictors	1	2	3	4	5	M \pm SD	Sign.
1. Overall score of IES-R [†]	-					45.1 \pm 17.4	
2. Score of anxiety symptoms [‡]	0.47**	-				10.7 \pm 5.6	< 0.001
3. Score of depression symptoms [‡]	0.45**	0.72**	-			11.2 \pm 4.6	< 0.001
4. Overall score of FCoV-19S [§]	0.56**	0.42**	0.49**	-		27.1 \pm 5.2	< 0.001
5. Overall score of GSES	-0.79**	-0.32**	-0.37**	-0.52**	-	24.0 \pm 8.4	< 0.001

Note: **Correlation is significant at the 0.01 level (2-tailed).

Abbreviations: M, mean; SD, standard deviation; IES-R, Impacts of Event Scale Revised; higher score indicates higher psychological distress; HADS, measured by hospital anxiety and depression scale and the higher the score, the greater the anxiety and depression are; FCoV-19S, fear of COVID-19 scale; the highest score implies the worst fear; GSES, generalized self-efficacy scale; participants with higher self-efficacy had a higher score.

Table 4 Analysis of Multiple Regressions to Predict Psychological Distress^a from Total Score of HADS-A, HADS-D, FCoV-19S and GSES

Predictors	Standardized Estimation (β)	t	P-value	Accounted Variance (%)	95% CI
HADS-A	0.15	3.5	0.001	1.04	0.20, 0.72
HADS-D	0.04	0.9	0.39	0.06	-0.19, 0.47
FCoV-19S	0.14	3.8	< 0.001	1.23	0.21, 0.65
GSES	-0.65	-18.4	< 0.001	29.16	-1.47, -1.19
Model summary: $R^2 = 67.3\%$ $F = 195.2$ $df = 4$ $P < 0.001$					

^a**Note:** ^aMeasured by Impacts of Event Scale Revised; higher score indicates higher psychological distress. Statistical significance was considered at $p < 0.05$ and significant values are in bold font.

Abbreviations: CI, confidence interval; HADS-A, Hospital Anxiety and Depression-Anxiety subscale; HADS-D, Hospital Anxiety and Depression-Depression subscale; the higher the score, the greater the anxiety and depression are. FCoV-19S, fear of COVID-19 scale; the highest score implies the worst fear. GSES, generalized self-efficacy scale; participants with higher self-efficacy had a higher score.

attaining the new maternal role among primiparous women during the current pandemic probably escalates the psychological distress. Additionally, primiparous women may negatively perceive the body changes during pregnancy⁴¹ which could heighten the disturbances. Also, those women who had reported any type of pregnancy-related complication showed significantly higher IES-R mean scores compared with their counterparts. The presence of complications and comorbid physical comorbidities probably give way to high psychological distress.⁴²

The mean scores of IES-R for those women in third and first trimesters were significantly higher than those of women in the second trimester. This might be due to the fact that transient symptoms like nausea, vomiting and mood disturbances during the first trimester and the concern related to weight gain and fear of labor during the third trimester probably elevate psychological disruptions⁴³ with synergistic effect of the pandemic.

The current study revealed that the mean score of FCoV-19S for pregnant women was 27.1 ± 5.2 . This finding appeared higher than the previous result among non-pregnant subjects during this pandemic.⁴⁴ Primiparous women had significantly higher mean scores than multiparous mothers. There was a previous supportive finding in which primiparous mothers had reported higher worries than their counterparts.⁴⁵ This is probably due to the natural discomfort on the top of illness-related factors. Similarly, having pregnancy-related complications has been linked to higher mean score of FCoV-19S. A study conducted in Iran⁴⁶ has supportive findings in which women with any medical conditions reported greater mental health disturbances. Further, those pregnant women in third trimester had significant highest mean of FCoV-19S

score possibly due to the factors such as weight gain and increased concern about labor during this time.

In correlation analysis, psychological distress has revealed a strong positive correlation with symptoms of anxiety, depression and fear of COVID-19. As a matter of fact, the symptoms overlap between anxiety, depression and psychological distress could play a role in their strong correlation. The correlation of COVID-19 fear and psychological distress is perhaps supported by the fact of multidimensional impacts during the pandemic. Specifically, the result could be worsening in pregnant mothers due to additional disturbances during pregnancy. Furthermore, the current pandemic has brought multiple psychosocial disturbances, including mental health problems as supported by previous evidence,^{47,48} which could raise psychological distress.

Among continuous predictors, the score of general self-efficacy scale has a very strong negative relationship with psychological distress and accounted for 29.16% unique variance in the IES-R. This is in line with a previous finding⁴⁸ which revealed that strong self-efficacy could associate with low psychological distress. This is probably due to the fact that individuals with greater self-efficacy could succeed in attaining the resources in hand to cope with such difficult circumstances and its consequences.

During the current study, some limitations were identified that could need further future studies to overcome. At its first instance, the cross-sectional nature of the study limits the inference of cause-effect relationships. Additionally, as this study was conducted at a single setting and participants were recruited through a consecutive sampling technique, it is difficult to generalize the findings. Moreover, the details of personal income level was

not assessed which might be affecting the living situations of the study subjects.

Despite these limitations, this study was the first of its kind nationally and has highlighted some important aspects of pandemic impacts among pregnant women. As such, the current study assumed to point out some hypotheses for future interested researchers under related topics. Furthermore, using the standardized tools to examine dependent variable and major predictors was the other strength of the current study.

Conclusions

Unfortunately, the current pandemic has imposed severe psychological distress on Ethiopian pregnant women. The results revealed that the presence of anxiety and depressive symptoms and pandemic-related fears were identified as positive predictors of psychological distress. In contrast, better self-efficacy of the pregnant women was linked to lower psychological distress.

Displaying the differing ways in which the current pandemic could affect the mental wellbeing of pregnant women, the results of this study had practical and research implications. The findings of this study underlines some important facets of pandemic effects and its contributors. In this regard, identifying the positive and negative predictors of psychological wellbeing of pregnant women during this pandemic could assist care givers and health planners in fighting undesirable outcomes and boosting positive enhancers. In doing this, the health professionals should widen their sight beyond their rudimentary services. Additionally, it is better for both ANC and psychiatry clinics to collaborate towards providing the comprehensive services in a holistic approach.

Data Sharing Statement

The data supporting the findings are available from the corresponding author on reasonable request.

Ethical Approval and Informed Consent

Written consent was signed by all participants of the study and all information was kept confidential. Ethical clearance was gained from the ethical review committee of the College of Health, Mettu University and the study was performed as per as Helsinki Declaration principles.

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