Barriers to Maternal Mental Health Care: A Mixed-Methods Study of Postpartum Women in Rural Bengaluru

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ABSTRACT

The issue of maternal mental health in rural contexts is not well addressed, particularly in terms of access to mental health professionals and locally available services, even though postpartum mental distress is prevalent. This paper explores the access to maternal mental health services among women in rural Bengaluru with a particular emphasis put on awareness of postpartum depression among women, help seeking patterns, and barriers to service use. This study used a mixed methods design to evaluate stigma, awareness, and access to mental health services among postpartum mothers. A survey was used to collect data whereby a structured questionnaire was used to interview a purposive sample of 45 lactating mothers a year after delivery. The survey assessed self-reported data on distress, awareness of postpartum depression, readiness to get professional help, and perceived obstacles to care. The findings suggest that there is a significant discrepancy between mental health requirements and the use of service. Almost fifty percent (48.89%) of respondents reported having periods when they felt mentally distressed in the postpartum time but did not seek help. The most common barrier was the limited access to available services. Another reason that was widely mentioned as a cause of lack of support was stigma and fear of judgment. Simultaneously, the willingness to access mental health support was comparatively high. Most of the participants (68.89%) said that they would attend maternal mental health support programmes if these services were available. The findings imply that the access to enhancing local mental health services and addressing social stigma can boost the rates of help-seeking among postpartum mothers. Making mental health screening a standard practice in maternal health examinations and making community-based awareness campaigns may aid in detecting psychological distress early and enhancing service uptake in rural communities.

Keywords: *Post-partum health, Maternal mental health, Stigma, Rural healthcare*

INTRODUCTION

Perinatal depression affects approximately 1 in 4 women during pregnancy or within the first year after childbirth in low- and mid--income countries (Wang et al., 2023). The perinatal period includes both the prenatal stage, which represents pregnancy, and the postnatal stage which represents the first twelve months following childbirth (Biaggi et al., 2016). Maternal mental health is a crucial factor that influences

this period. The World Health Organization (WHO) defines maternal mental health as "a state of well-being in which a mother realizes her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her community. (World Health Organization, 2022)

The prevalence of maternal mental health disorders is significant. Worldwide, approximately 10% to 25% of pregnant women and postpartum women experience depression, with rates reaching 24.7% overall in low- and middle-income countries (Mitchell et al., 2023; Wang et al., 2021). In India, the pooled prevalence of postpartum depression is around 22%, higher in southern regions at 26% and lower in northern areas at 15% (Panolan & Thomas, 2024). If left untreated, perinatal depression impairs mother-child bonding, contributes to infant developmental delays (e.g., socio-emotional, language, and motor issues), and elevates risks of family strain and maternal suicide (Slomian et al., 2019). These effects underscore perinatal mental health as a critical global public health issue. During the antenatal period, more emphasis is placed on physical problems than on psychological and emotional well-being. Physical problems such as pregnancy-induced hypertension are treated as high-risk pregnancies, whereas mental illness is not addressed adequately unless it is severe (Manjrekar & Patil, 2018).

In India, postpartum depression (PPD) is one of the most under diagnosed and untreated conditions with the overall occurrence being 22%. The highest prevalence was in the southern regions (26%; 95% confidence interval [CI]: 19–32) and the lowest in the northern regions (15%; 95% CI: 10–21) (Panolan & Thomas, 2024). While prevalence rates are similar between rural and urban areas, rural areas face significantly more socioeconomic barriers in accessing postpartum depression treatment. Widespread stigma and discrimination prevent many individuals with mental health conditions from accessing necessary care, particularly in rural regions. Barriers include social stigma and shame surrounding mental illness, gender-based disadvantages in many communities, fear of being labeled or rejected if diagnosed, poverty resulting in inability to access referral pathways and support, lower levels of education and lack of awareness about mental health and treatment options. This results in delays in seeking mental health services, missed diagnosis and treatment, hindrances to recovery and rehabilitation, impacted relationships with the child and family, and an overall reduced ability to participate fully in everyday life (Alok et al., 2023).

Perinatal mental health remains under emphasized in India's National Health Mission maternal and child health programs despite calls for routine integration (Gajaria & Ravindran, 2018; Nair et al., 2023). Task-sharing models using general practitioners, nurses, and health workers have been implemented successfully internationally, however, face implementation challenges in India due to resource limitations and training gaps (Votruba et al., 2025). Low awareness, social stigma, organizational barriers, insufficient funding, and administrative weaknesses collectively hinder these efforts (Gajaria & Ravindran, 2018)

Screening tools like the Patient Health Questionnaire-9 (PHQ-9) and Edinburgh Postnatal Depression Scale (EPDS) show increasing but inconsistent use in India, requiring local language validation and facing large-scale implementation barriers (Goyal et al., 2020; Manjunath et al., 2019). Perinatal depression symptoms include anhedonia, sleep/appetite changes, fatigue, worthlessness, poor concentration, irritability, anxiety, and suicidal ideation (Howard et al., 2020). High maternal anxiety and depression impair infant motor and cognitive development while increasing risks of childhood behavioral problems, emotional dysregulation, and adolescent psychopathology (Talge et al., 2007; Slomian et al., 2019).

Despite the high prevalence of Postpartum depression (PPD), most women aren't screened or treated for it (Upadhyay et al., 2017). A study published in the journal of social psychiatry showcased the prevalence of depression among the women (an EPDS score of 10 and above) was 11%. Among women with depression, a history of depression before the last delivery was given by 42.5% of women. Out of these, only 7.5% of women had sought some form of consultation from healthcare professional (Patel et al., 2002). Merely 48.2% of postpartum mothers demonstrated adequate PPD knowledge, directly contributing to psychosocial, cultural, and structural barriers including stigma, service unavailability, lack of education, and negative perceptions among perinatal women and providers (Gandhi et al., 2023). Tailored interventions addressing these barriers are essential for improving maternal mental health outcomes.

This study addresses maternal mental health gaps in rural Bengaluru communities by examining postpartum women's awareness of postpartum depression, help-seeking patterns, and barriers to mental health service utilization through a mixed-methods approach. Among 45 lactating mothers that were surveyed at one year postpartum, 48.89% of them reported having postpartum mental distress but had not accessed professional help, which was mainly because of the lack of services and stigma. The fear of the family and community judgment. Despite these obstacles 68.89% showed receptiveness to participate in maternal mental health programs provided they are available. These findings emphasize the necessity of regular mental health screening during maternal healthcare interventions, widened. community awareness, and stigma reduction to enhance service uptake in rural settings, which is in line with Sustainable Development Goals 3 (Good Health and Well-being) and 5 (Gender Equality) and the objectives of the National Health Mission of India in maternal child.

METHODOLOGY

Research Design

This was mixed-methods research that explored variables such as postpartum depression (PPD) awareness, and receiving mental health services among rural, postpartum women in Bengaluru. Depressive symptoms, awareness, stigma perception were all quantitative components included in the study. Qualitative data acquired socio-cultural and structural obstacles to help-seeking through open-ended responses. Triangulation combined quantitative measures (e.g. depression scores, stigma scales) with. emerging themes, which offer detailed information about rural Indian context.

Participants and Sampling

Purposive sampling technique was used and 45 lactating mothers were recruited within one year after delivery in rural areas of Bengaluru. Data was collected between 1st October 2025 to 31st October 2025. Local health networks and community leaders in Bengaluru communities were approached to recruit the sample. In this purposive sampling, its recruitment was with a convenience aspect, as the samples were selected from the mothers who were eligible in the local health networks and community leaders throughout the data-collection period. The obtained age range (21-40 years) was therefore a function of the availability of the participants and not a predetermined age cutoff. This period represented peak periods of PPD risks and ensured geographic specificity to contextual depth.

Instruments

A Google Forms survey was conducted as a structured survey that had sections on demographics (age, parity, education, income), PPD knowledge (10-item true/false scale), perceived stigma (5-point Likert scale), service access (availability, affordability, cultural readiness), and self-reported depressive symptoms (composite score from overwhelm, crying episodes, hopelessness, anhedonia, sleep disturbance). Questions that were open-ended were used to address the barriers, family attitudes, cultural beliefs, and so on. logistical issues to thematic analysis.

Data Collection Procedures

Following electronic informed consent that provides the study objectives, voluntary participation, privacy of data and. withdrawal rights, the participants took the surveys one by one through guided community facilitators. This method decreased the barriers to literacy and preserved the response consistency ethical standards.

Data Analysis

Quantitative analysis used Excel for descriptive statistics (means, frequencies, percentages) and Pearson/Spearman correlations to test relationships between stigma, awareness, and service utilization.

Additionally, based on severity of symptoms experienced, they were assessed using a 5-point rating scale. Individual item scores were summed to compute a composite depression score for each participant. Qualitative data underwent inductive thematic analysis via manual coding of barriers, attitudes, and constraints, with triangulation validating quantitative findings.

The quantitative analysis was done with the help of Excel as a means of descriptive statistics (means, frequencies, percentages). Additionally, the score of depression was calculated depending on the intensity of the symptoms experienced. Pearson/Spearman correlations to test relationships between depression scores and demographic factors. Thematic analysis using inductive manual coding of barriers to barriers was utilized on qualitative data. attitudes, and constraints and quantitative results are triangulated.

Ethical Considerations

Informed consent was taken which focused on voluntariness, confidentiality, use only in academic purposes, and right to withdraw without penalty. No identifiable data were collected and reported.

RESULTS

Table No. 1 Distribution of depression scores

Score category	***Score range***	***n***
Minimal	0-9	15
Mild-Moderate	0-14	27
Moderately severe	≥15	4

Depression scores revealed a predominance of mild–to–moderate symptoms among participants. As shown in Table 1, 32.6% scored in the minimal range (0–9), 58.7% fell in the mild–to–moderate range (10–14), and 8.7% exhibited moderately severe depression (≥15). This suggests that the majority of participants had some level of depressive symptoms, but most of the majority were mild to moderate, consistent with the study's overall results that mental distress during the postpartum period was present, but not consistently severe.

Table No. 2 Correlations between age and depression score

	r	***p***	***95% CI***
Age and Depression Score	-0.07	.658	[-0.35, 0.023]

The correlation was not statistically significant, suggesting that age was not meaningfully associated with depression scores in this sample. In other words, depressive symptoms were observed across different age groups, rather than being concentrated among either younger or older participants. This indicates that, in this sample, age was not the only factor that could account for any differences in the number of depressive symptoms reported, further emphasizing the importance of investigating other social and access-related factors.The wide confidence interval further indicates substantial variability, reinforcing that depression scores were relatively distributed across ages without a clear trend. This finding suggests that postpartum depressive symptoms may represent a broader maternal mental health concern that affects women irrespective of age.

Table No. 3 Awareness of post-partum depression

Category	***Frequency (%)***
Yes	19.57
Heard of it but don’t know much	15.22
No	65.22

Among the sample, 65.22% had awareness ranging from low to none. Only a small portion of the sample, 19.57%; had heard about postpartum depression. 15.22% reported that they had heard about it but did not possess sufficient knowledge on the topic. The frequency distribution was uneven, with a clear concentration of the population in the "no awareness" category. This poor awareness can be a barrier for mothers to identify mental health issues after birth and when professional help might be required.

Table No. 4 Help seeking behaviour

Reasons for not seeking help	***n***	***%***
Didn’t want to seek help	4	15.4
Stigma/fear of judgement	4	15.4

Didn't know where to go	4	15.4
Family restrictions	3	34.6
No services nearby	9	11.5
Financial barriers	2	7.6

Almost half of the sample (48.89%), admitted to feeling mentally unwell, and did not seek help. The most frequently reported barrier to seeking help was lack of nearby services (34.6%), followed by reluctance to seek help, stigma, and lack of knowledge about where to go (each 15.4%), while family restrictions (11.5%), cost (3.8%), and financial barriers (7.6%) were reported less frequently. This pattern also suggests that barriers were not only related to individual willingness: a mother's decision to seek assistance was influenced by social factors and services made available.

Table No. 5 Willingness to attend mental health support sessions

Category	***Frequency (%)***
Yes	68.89
Maybe	11.11
No	20

Most participants, 68.89% selected that they would be open to attending mental health support systems. 20% of the sample selected "No", and 11.11% selected "Maybe". There is an uneven distribution, skewed to the side of willingness to attend these sessions. It suggests that there may have been considerable openness to support when it was offered, which suggests that access to services and awareness of need may be significant contributors to why there is a gap between need and help-seeking.

DISCUSSION

This study examined maternal mental health awareness, help seeking behaviour, and barriers to service utilization among postpartum women in rural Bengaluru. A mixed methods design was used to explore relationships between depressive symptoms, awareness of postpartum depression, stigma, and access to mental health services. The study surveyed 45 lactating mothers within one year postpartum using a structured questionnaire that included measures of depressive symptoms, knowledge of postpartum depression, perceived stigma, and service accessibility. The quantitative data were analyzed with the help of descriptive statistics and correlation analysis, and the qualitative responses were analyzed to determine

the barriers to seeking help. Out of the respondents, 48.89% had reported that they suffered mental problems in the postpartum period but had not consulted a professional for help. Lack of services nearby and stigma, especially not wanting to be judged by people around and even family members, were the most often reported obstacles. Despite these barriers, 68.89% of respondents stated that they would attend maternal mental health support programmes should they be available.

The scores in the sample fell mostly within the mild and moderate range. Most of the respondents (58.7%) were within the mild to moderate group, and 32.6% displayed minimal symptoms and 8.7% moderate to severely depressive symptoms. The results are in line with international estimates that suggest that 17.22% of women all over the world have postpartum depression (Wang et al., 2021). Research in India has found a greater prevalence rate of approximately 22% on a pooled national estimate and more prevalent in the southern part of the country (Panolan & Thomas, 2020). The trend witnessed in this sample is thus a general indication of the findings that postpartum psychological distress is still a critical maternal health issue.

This research did not find significant correlation between age and depression scores ($r = -0.07$, $p = .658$). Depressive symptoms were observed across age groups rather than being concentrated among younger or older mothers. This observation reinforces studies which indicate the role of psychosocial and contextual factors in the development of postpartum depression more than the role of demographic variables alone. Several studies revealed the risk factors leading to perinatal depression which comprised maternal anxiety, history of depression, life stress, absence of social support, unintended pregnancy, and relationship problems (Lancaster et al., 2010). Certain studies have found greater prevalence in older mothers, including 40–44-year-old women in a Canadian sample (Muraca & Joseph, 2014), but these trends may differ in sociocultural and other healthcare settings.

The present sample had low awareness of postpartum depression. Most of the respondents (65.22%) reported no awareness and a mere 19.57% showing that they were aware of the condition. Other studies on maternal health have also reported similar trends. According to Vijayalakshmi et al. (2015), it was only a half of postpartum mothers who showed sufficient knowledge on postpartum depression. Poor awareness can decrease the possibility of identifying symptoms and seeking medical aid.

Structural and social barriers were manifested in help seeking behaviour in this study. Nearly half of the respondents (48.89%) said they felt mentally distressed, yet they had not sought help. The most commonly cited barrier was the lack of nearby services, then was reluctance to seek help, stigma and lack of understanding of where to access care. Past studies have also reported some systemic issues in the provision of maternal mental health care, such as the lack of qualified staff, the inadequate incorporation of mental health services into the primary care system, and the poorly established referral pathway (World Health Organization, 2016).

Despite these barriers, willingness to attend mental health support sessions was relatively high. In this study, 68.89% of participants reported that they would be open to attending maternal mental health

programmes, while 11.11% remained uncertain and 20% reported that they would not attend. This suggests that the gap between mental health need and service utilization may be driven more by limited access and awareness than by resistance to intervention. Strengthening routine mental health screening during antenatal and postnatal care visits, expanding community-based awareness initiatives, and improving availability of local mental health services may increase service utilization among postpartum mothers. Improving maternal mental health support also contributes to broader public health priorities, including Sustainable Development Goal 3 on health and well-being and Sustainable Development Goal 5 on gender equality (Upadhyay et al., 2017).

CONCLUSION

Despite the barriers, the readiness to participate in mental health support sessions was moderate. In this research, 68.89% of the participants reported that they would be open to attending maternal mental health programmes, or 11.11% were not sure and 20 % said that they would not. This indicates that accessibility and insensitivity to intervention might be the main cause of the disparity between the mental health need and service utilization rather than resistance to intervention. Enhancing regular mental health screening or review at the antenatal and postnatal care visit, increasing community based mental health awareness programs, and enhancing access to local mental health may enhance the service usage by postpartum mothers. Enhanced mental health support for mothers also advances greater population health interests, such as Sustainable Development Goal 3 on health and well-being and Sustainable Development Goal 5 on gender equality.

These findings have several limitations which need to be taken into consideration. The study employed a relatively small sample consisting of 45 participants sampled using purposive sampling and this affects generalization of the findings to a broader audience. The self-reported surveys were used to gather the data, which can be affected by the recall bias or by the social desirability effect, especially when speaking about mental health experiences or stigma. The cross-sectional design also limits the possibility of establishing the causal relations between the awareness, stigma, and depressive symptoms. Moreover, the research was being conducted in a particular rural area of Bengaluru, and the results might not apply in an urban setting or in a different area that has different healthcare facilities and sociocultural factors. Further studies involving bigger and more heterogeneous samples and longitudinal analyses could offer more understanding into the trends and predictors of maternal mental health service utilization. In addition, further research may include mothers who are not currently lactating to be asked to think back on their experience of lactation, and report on their emotions as well as any resources or support they felt they needed. This may give a wider picture of what the mothers' mental health experience is like throughout the postpartum period.

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