IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 25, Issue 4 Ser. 2 (April. 2026), PP 01-15
www.iosrjournals.org

"They Don't Ask If You're Feeling Sad": Perceptions Of Perinatal Mental Health And Barriers To Care In Benin City, Nigeria: A Constructivist Qualitative Study

Victor Ohenhen[1], Ejovi Akpojaro[2], Oluwatoyin Ohenhen[3], Helen Eborieme[4], Christiana Elusoji[5], Oluwafunmilayo Akpojaro[6], Wisdom Omorogbe[1]

Dept. Of Obstetrics And Gynaecology, Edo Specialist Hospital, Benin City, Nigeria
Dept. Of General Studies, Edo State College Of Nursing, Benin City, Nigeria
Dept. Of Internal Medicine, University Of Benin Teaching Hospital / University Of Benin, Nigeria
Mental Health Unit, Edo Specialist Hospital, Benin City, Nigeria
Dept. Of Nursing, Benson Idahosa University, Benin City, Nigeria
Dept. Of Obstetrics And Gynaecology, Gibonna Women's Hospital, Nigeria

Abstract

Background

Perinatal mental illness remains a critical yet chronically underaddressed public health challenge in low- and middle-income countries (LMICs). A 2023 JAMA Psychiatry meta-analysis of 589 studies demonstrated that 1 in 4 perinatal women in LMICs experience depression, with Nigeria among the most heavily burdened countries in sub-Saharan Africa. Despite this burden, evidence on how perinatal mental health is perceived, and on the barriers to care experienced at the facility level in Edo State, Nigeria, is virtually absent from the published literature.

Objective

To explore participant perceptions of perinatal mental health and the barriers to accessing or delivering perinatal mental health services among pregnant and postpartum women and healthcare providers at a public secondary health facility in Benin City, Edo State, Nigeria.

Methods

A constructivist qualitative study was conducted between January and March 2023. Two focus group discussions (FGDs) were held with 11 pregnant or postpartum women, and five individual key informant interviews (KIIs) were conducted with healthcare professionals. Data were collected using semi-structured guides, audio-recorded, transcribed verbatim, and analysed using Braun and Clarke's (2006) six-step reflexive thematic analysis. The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ).

Results

Six analytically distinct themes emerged, each articulated as an interpretive claim rather than a descriptive category: (1) lay illness frameworks and the limits of biomedical discourse; (2) social and economic determinants as primary causal explanations; (3) a self-reinforcing exclusion system composed of stigma, structural deficit, and economic deprivation; (4) the systematic silencing of psychological experience in antenatal encounters; (5) reactive care in a prevention vacuum; and (6) individualised provider initiative as a fragile and inequitable substitute for formal policy. The study reveals that barriers are not independent deterrents but constitute an interlocking system of exclusion, and that both groups shared a convergent readiness for integrated change.

Conclusion

This study demonstrates that the undertreatment of perinatal mental illness in this Nigerian facility reflects a compounding, mutually reinforcing system of cultural, structural, and economic exclusion. Addressing this requires not single-domain intervention but coordinated investment across provider training, service formalisation, community-based stigma reduction, and policy implementation aligned with Nigeria's Mental Health Act (2023).

Date of Submission: 27-03-2026 Date of Acceptance: 07-04-2026

I. Introduction

Perinatal mental illness imposes a substantial and growing burden on women, families, and health systems across the globe. A landmark 2023 systematic review and meta-analysis published in JAMA Psychiatry — drawing on 589 studies and data from 616,708 women in 51 LMICs — found that 1 in 4 perinatal women in low- and middle-income countries experience depression, with the highest prevalence in lower-middle-income

countries (25.5%; 95% CI: 23.8–27.1%) (Roddy Mitchell et al., 2023). In Nigeria, rates of antenatal depression are estimated to range from 10 to 30%, with substantially higher rates documented among adolescents, women experiencing intimate partner violence, and those in socioeconomically deprived settings (Adeoye et al., 2022; Yusuf, 2021).

Perinatal mental illness (PMI) encompasses depressive, anxiety, and psychotic disorders arising during pregnancy and extending through the first year postpartum. Beyond its direct consequences for maternal wellbeing, untreated PMI generates compounding effects across generations. A 2024 meta-analysis demonstrated that perinatal depression in LMICs is associated with a 1.4-fold elevated odds of child stunting (Perez-Pedrogo et al., 2024), while a complementary systematic review established associations between maternal depression, impaired mother–infant bonding, reduced vaccine uptake, and increased diarrhoeal illness in infants (Asare et al., 2022). The economic argument for investing in perinatal mental health is equally compelling: Wilson et al.'s (2024) global analysis of service provision across five continents demonstrates that integrating treatment yields measurable returns across maternal, infant, and health system outcomes.

Despite this evidence, Nigeria's most recent National Strategic Health Development Plan did not specifically address perinatal depression, and the country's mental health treatment gap exceeds 90% (Adepoju, 2023). The signing of Nigeria's Mental Health Act in January 2023 — replacing the colonial-era Lunacy Act of 1958 — represents a landmark legislative advance, mandating integration of mental health into primary care and creating a Department of Mental Health Services within the Federal Ministry of Health (Adepoju, 2023; Akanni and Edozien, 2023). Yet operationalisation of this mandate, particularly within secondary maternal care facilities, remains unrealised. Cultural belief systems that spiritualise or attribute moral meaning to mental illness continue to obstruct help-seeking by women and recognition by providers (Anjorin and Hassan Wada, 2022; Eboreime et al., 2022).

Research from across sub-Saharan Africa consistently identifies barriers to perinatal mental health care operating across multiple ecological levels: individual (internalised stigma, poor mental health literacy), sociocultural (traditional explanatory models, gender role norms), organisational (service fragmentation, absent screening protocols, provider knowledge deficits), and structural (policy gaps, resource constraints, inadequate health insurance coverage) (Brown and Sprague, 2021; Webb et al., 2024). In Nigeria, recent evidence demonstrates that these barriers are surmountable: training primary healthcare workers to conduct routine PHQ-2 screening more than doubled detection rates of perinatal depression within six months (Oladeji et al., 2025), and a task-sharing implementation study achieved 60% symptom remission at six months postpartum when perinatal depression care was embedded in primary maternal and child health services in Ibadan (Kola et al., 2024). However, replication and scale-up of such models within secondary public facilities — particularly in Edo State — remains absent.

Understanding how perinatal mental health is perceived by both service users and providers within a specific facility context is a necessary precondition for designing interventions that are culturally congruent, organisationally feasible, and politically viable. This study therefore sought to explore participant perceptions of perinatal mental health conditions and the barriers to accessing or delivering perinatal mental health services among pregnant and postpartum women and healthcare professionals at Central Hospital, Benin City, Edo State, Nigeria.

II. Methods

The study was designed, conducted, and reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007). A full COREQ adherence summary is provided in Table 4.

Epistemological Position and Methodological Framework

This study was conducted from a constructivist epistemological position, premised on the view that meaning is actively constructed through social and cultural interaction rather than discovered as an objective reality (Creswell and Poth, 2018). Constructivism was selected as the most appropriate epistemological stance for this inquiry because the research questions were oriented towards understanding how participants make sense of perinatal mental health within their specific socio-cultural and institutional context — an inherently interpretive, meaning-centred endeavour. This position aligns with and is analytically operationalised through Braun and Clarke's (2006) reflexive thematic analysis, which centres the researcher's active role in meaning-making while maintaining transparency about interpretive choices.

The methodological approach is therefore explicitly distinguished from interpretive phenomenological analysis (IPA), which would require a smaller, more homogeneous sample and a case-by-case idiographic analytical structure. The constructivist thematic framework adopted here is well-suited to the dual-participant-group design and to the study's applied health systems aims. Within this framework, themes are understood not as features residing 'in' the data but as analytical constructs produced through the researchers' active interpretive engagement with participant accounts.

Research Team and Reflexivity

The research team comprised seven members with expertise spanning obstetrics and gynaecology, mental health , internal medicine, and nursing education. The principal investigator (VO) is a consultant obstetrician with over ten years of experience in Nigerian maternal healthcare. Two team members (CE and OO) had received formal training in qualitative research methodologies.

Reflexivity was treated as an ongoing analytical practice, not a procedural declaration. A reflexivity journal was maintained throughout both data collection and analysis, in which the research team documented and interrogated their assumptions, disciplinary preconceptions, and emergent interpretive inclinations. In particular, the team acknowledged three reflexive tensions with direct analytical implications: (1) the principal investigator's identity as a senior clinician conducting KIIs with more junior colleagues created a potential power asymmetry that could inhibit critical disclosure about institutional practices; to mitigate this, KII facilitators included non-clinical team members and participants were explicitly assured of confidentiality and the independent nature of the research; (2) the clinical team's professional socialisation towards biomedical explanatory frameworks created a risk of under-valuing psychosocial and culturally grounded illness accounts; this was countered through iterative peer debriefing in which members actively challenged biomedical interpretive tendencies in each other's coding; (3) the team's collective investment in demonstrating healthcare system inadequacy created a potential confirmation bias towards deficit-framing; this was addressed by deliberately searching the data for instances of resourcefulness, informal support, and competence.

These reflexive disclosures are not offered as evidence that bias was eliminated but as an honest account of the conditions under which this analysis was conducted, in the spirit of confirmability as articulated by Lincoln and Guba (1985).

Study Setting

The study was conducted at Central Hospital, Benin City, a state-owned secondary health facility and a principal public-sector maternity referral centre in Edo State, Nigeria. The Obstetrics and Gynaecology Unit operates 60 obstetric beds, employs 31 medical and allied health professionals, and manages approximately 4,200 deliveries annually. Antenatal, intrapartum, and postnatal services are provided. A mental health outpatient department previously operated within the facility; this was subsequently decommissioned, and no formal perinatal mental health service exists at the time of this study. The setting is important analytically: the prior existence of a mental health department likely distinguishes this facility from others in Edo State in terms of residual staff familiarity with mental health discourse, and this contextual factor is considered in the interpretation of findings.

Study Design

A qualitative design combining focus group discussions (FGDs) and individual key informant interviews (KIIs) was employed. These methods were deliberately differentiated by participant group. FGDs were selected for pregnant and postpartum women on the grounds that the group dynamic could facilitate peer normalisation of stigmatised experiences and encourage disclosure within a setting of perceived shared identity. Individual KIIs were used for healthcare professionals to allow candid, in-depth exploration of professional practice, training gaps, and institutional arrangements without the social constraints and potential professional hierarchy effects of a group setting. The authors acknowledge that FGDs may limit individual disclosure — particularly on topics carrying social stigma — and this is discussed as a limitation in Section 4.6.

Participant Selection and Recruitment

Purposive sampling was employed to recruit information-rich participants capable of illuminating the research questions from their respective perspectives. Pregnant and postpartum women were identified during routine antenatal or postnatal clinic visits by nursing staff, who provided a brief verbal overview of the study. Those expressing interest were referred to a member of the research team for comprehensive briefing and consent procedures. Healthcare professionals were recruited via formal written invitation from the principal investigator, addressed to individuals occupying frontline maternal care roles.

Of 15 eligible women approached, 11 consented to participate (participation rate: 73.3%). Four declined: two cited time constraints and two expressed lack of interest. Of six eligible healthcare professionals initially invited, five participated (83.3%); one was unavailable on the scheduled interview day.

Eligibility Criteria

Pregnant and Postpartum Women (n = 11)

Aged 18 years or older; currently pregnant (>19 weeks' gestation) or postpartum with an infant under 12 months of age; able to understand and communicate in English; attending the maternity clinic at Central Hospital, Benin City. Women who were unable to give informed consent or who were in acute clinical distress at the time of recruitment were excluded.

Healthcare Professionals (n = 5)

Frontline maternal healthcare providers at the study facility with a minimum of five years' experience in maternal health. Eligible cadres included obstetricians, registrars, nurses, and midwives directly involved in antenatal or postnatal care delivery. The group comprised doctors (n = 3), a nurse (n = 1), and a midwife (n = 1), with a mean age of 50.0 years (range: 45–54 years); three were male and two female.

Data Collection

Data were collected between January and March 2023 using semi-structured interview and discussion guides developed from a systematic review of the relevant literature and adapted from the validated instrument employed by Nakku et al. (2016) in a comparable sub-Saharan African qualitative study. The guides were piloted with two pregnant women and one healthcare provider not included in the final sample; minor revisions were made to improve question clarity, sequencing, and cultural resonance. Probing questions were used throughout to elicit elaboration, challenge initial responses, and pursue emerging lines of inquiry.

Two FGDs were held — one comprising five women and one comprising six women. Five individual KIIs were conducted with healthcare professionals. All sessions took place in private rooms within the hospital, separate from clinical care areas, to protect confidentiality and minimise participant discomfort. Sessions lasted between 45 and 60 minutes and were audio-recorded with each participant's written consent. Detailed field notes were written during and immediately following each session to document non-verbal communication, group dynamics, and contextual observations that audio recordings could not capture.

Data collection proceeded iteratively: preliminary analysis of early transcripts informed the probing strategies used in subsequent sessions. The decision to conclude data collection was made when no substantively new codes or conceptual categories emerged across the final two sessions, consistent with the principle of information sufficiency as applied within constructivist qualitative inquiry (Braun and Clarke, 2006).

Data Analysis

All audio recordings were transcribed verbatim by two trained research assistants. Transcripts were independently verified for accuracy against the original recordings by a third researcher before analysis commenced. All identifying information — names, locations, and identifying descriptors — was replaced with pseudonyms and participant codes prior to distribution of transcripts to the analysis team.

Analysis followed Braun and Clarke's (2006) six-step reflexive thematic analysis. In Step 1 (familiarisation), all team members read each transcript multiple times and wrote initial analytic observations. In Step 2 (initial coding), three researchers independently generated codes across the first three transcripts, attending to both semantic content and latent meaning. In Step 3 (constructing themes), codes were assembled into candidate themes through team discussion; a preliminary codebook was produced and refined. In Step 4 (reviewing themes), candidate themes were checked against the full dataset and against each other for internal coherence and mutual distinctiveness. In Step 5 (defining and naming themes), each theme was named not as a descriptive topical label but as an analytically meaningful claim that captured the interpretive finding. In Step 6 (writing up), themes were elaborated with participant quotations selected for their analytical richness rather than their typicality.

NVivo 12 (QSR International) was used for systematic data management. Disagreements between coders were resolved through structured consensus discussions rather than simple majority. Preliminary analytical themes were shared with two healthcare provider participants for respondent validation; their responses are reported in Section 2.9 below. Data from the two participant groups — women and healthcare professionals — were analysed both separately and in relation to each other to identify points of convergence, divergence, and productive tension.

Rigour and Trustworthiness

Trustworthiness was addressed across the four criteria established by Lincoln and Guba (1985). Credibility was supported through: prolonged and iterative engagement with the data; independent multi-coder analysis with structured consensus; structured reflexive peer debriefing sessions (held weekly during analysis); and respondent validation with two healthcare provider participants. In respondent validation, written summaries of the six preliminary themes were shared with participants, who were explicitly invited to disagree, expand, or refine the interpretations. Both confirmed the overall resonance of the themes, while one offered a clarifying observation about Theme 4 — specifically that the omission of mental health enquiry in antenatal visits was as much a product of time pressure as of knowledge deficit. This observation was incorporated into the final analytical framing of Theme 4. It is acknowledged as a limitation that respondent validation was conducted only with healthcare providers and not with women participants; this asymmetry is discussed in Section 4.6.

Transferability was supported through the provision of detailed, contextually rich description of the study setting, participant characteristics, recruitment context, and data collection conditions, enabling readers to assess the applicability of findings to their own contexts. Dependability was ensured through a documented audit trail

of analytical decisions, maintained from initial coding through to theme definition. Confirmability was addressed through the structured reflexive practices described in Section 2.2, including the reflexivity journal, and through the explicit articulation of interpretive claims rather than purportedly neutral description.

Ethical Considerations

Ethical approval was granted by the Ethics and Research Committee of Central Hospital, Benin City (Approval No: CHA/406/86). Written institutional permission was obtained from hospital management. All participants were provided with comprehensive written and verbal information about the study's purpose, procedures, potential risks, anticipated benefits, and the voluntary nature of participation, including the right to withdraw at any time without consequence to their clinical care or professional standing. Written informed consent was obtained from all participants prior to any data collection activity. Confidentiality was protected through the pseudonymisation of all participant data; no identifying information appears in this manuscript. All data were stored on password-protected, encrypted digital devices accessible only to the principal investigator and lead analyst.

III. Results

Participant Characteristics

The 11 women participants had a mean age of 31.2 years (SD = 3.4; range: 27–37 years). Seven were currently pregnant and four were in the postpartum period with infants under 12 months. Ten were married and one was single; all 11 were Christian — a homogeneity that reflects the religious composition of participants who self-selected into the study but may limit the generalisability of findings on cultural explanatory models to Muslim or adherents of traditional African religious frameworks. Eight participants had at least one prior child; three were primiparous. Educational attainment ranged from secondary school certificate (n = 4), through national diploma (n = 3), to bachelor's degree (n = 4). Full demographic detail is presented in Table 1.

The five healthcare professional participants had a mean age of 50.0 years (range: 45–54), comprising senior registrars (n = 2), a registrar (n = 1), a matron (n = 1), and a midwife (n = 1). Three were male and two female. All held a minimum of five years' experience in maternal healthcare and none had received any formal training in perinatal mental health assessment or management (Table 3). Six major themes emerged from the analysis and are presented in Table 2.

Table 1: Sociodemographic Characteristics of Women Focus Group Discussion Participants (n = 11)

Characteristic	Category / Value	n	%	Notes
Age (years)	Mean ± SD (Range)	—	—	31.2 ± 3.4 (27–37)
Gestational status	Currently pregnant	7	63.6	>19 weeks' gestation
	Postpartum	4	36.4	Infant <1 year
Parity	Primiparous	3	27.3	—
	Multiparous (≥1 prior child)	8	72.7	—
Marital status	Married	10	90.9	—
	Single / Not married	1	9.1	—
Religion	Christianity	11	100.0	Denominational diversity not captured
Education	Secondary school certificate	4	36.4	—
	National Diploma / Polytechnic	3	27.3	—
	Bachelor's degree	4	36.4	—
Occupation	Trading / Market	2	18.2	—
	Teaching	2	18.2	—
	Fashion design / Artisan	1	9.1	—
	Civil / Public service	1	9.1	—
	Housewife / Not employed	3	27.3	—
	Student	2	18.2	—

Table 2: Thematic Framework — Analytical Claims, Core Findings, and Illustrative Sub-findings

Theme	Analytical Claim	Illustrative Sub-findings
1. Lay Illness Frameworks and the Limits of Biomedical Discourse	Mental illness is understood predominantly through a psychosocial lens shaped by cultural context and education; biomedical framing is confined to clinical cadres	Psychosocial attribution dominant across both groups; recognition of spectrum varies by educational attainment; stigma is embedded in lay conceptual frameworks
2. Social and Economic Determinants as Primary Causal Explanations	Participants foreground structural and relational causes; a clinically significant asymmetry exists between provider and patient explanatory models	Economic hardship foregrounded by women; hormonal/psychological causes foregrounded by providers; lack of social support cited across groups as compounding vulnerability
3. A Self-Reinforcing Exclusion System: Stigma, Structure, and Economic Deprivation	Barriers do not operate independently; stigma, structural absence, and financial constraint compound one another to produce effective exclusion from care	Stigma operates at interpersonal and intrapersonal levels; structural deficits prevent help-seeking even when motivation exists; out-of-pocket costs prohibitive
4. The Silenced Body: Mental Health Made Invisible in Antenatal Practice	The systematic omission of mental health from clinical encounters constitutes a structural erasure of women's psychological experience from the maternity care encounter	No facility protocol for mental health enquiry; providers untrained; women report their psychological distress going unacknowledged across repeated antenatal visits
5. Reactive Care in a Prevention Vacuum: The Structural Absence of Perinatal Mental Health Promotion	The absence of preventive infrastructure reflects not merely resource constraint but a systemic failure to recognise perinatal mental health as a legitimate clinical responsibility	No structured prevention programmes; women turn to informal networks by necessity; both groups value early intervention in principle but cannot access it in practice
6. Individualised Care in a Systemically Absent Landscape: Provider Initiative as a Fragile Substitute for Policy	Where mental health care exists at all, it depends on the initiative of a single clinician; this dependency renders care unpredictable, inequitable, and unsustainable	No written protocols; no dedicated mental health personnel; referral pathways costly and inaccessible; both groups converge on a shared vision for formalised integrated services

Table 3: Sociodemographic and Professional Characteristics of Healthcare Professional Key Informant Interview Participants (n = 5)

Characteristic	Category	n	Notes
Age (years)	Mean (Range)	—	50.0 (45–54)
Sex	Male	3	—
	Female	2	—
Cadre	Senior Registrar	2	—
	Registrar	1	—
	Matron	1	—
	Midwife	1	—
Qualification	Medical degree (MBBS)	3	—
	Registered Nursing Certificate (RN/RM)	2	—
Years in maternal healthcare	≥5 years (all participants)	5	Inclusion criterion
Mental health training received	None (all participants)	5	Self-reported; no formal perinatal MH training

Theme 1: Lay Illness Frameworks and the Limits of Biomedical Discourse

The first analytical finding from the data is not simply that participants varied in their understanding of mental illness — this would be unremarkable. The more significant finding is how that variation is structured: lay illness frameworks, which attribute mental distress to social adversity, relational failure, and spiritual influence, are not merely alternative views held by less educated participants but represent a coherent and culturally embedded explanatory logic that shapes what questions women ask themselves, what disclosures feel safe to make, and what help-seeking pathways feel legitimate. Biomedical framing, by contrast, was largely confined to the professional cadre — and even there, it was not uniformly applied.

Healthcare professionals articulated awareness of perinatal mental illness as a clinical spectrum, acknowledging conditions ranging from mild affective disturbance through to severe psychotic presentations. Yet

even professional discourse was shaped by awareness of the social environment in which clinical encounters occur:

"Mental illness is seen as a taboo. People shy away from it, and it's underreported." — Senior Healthcare Professional

Among women participants, understanding of perinatal mental illness spanned a wide range. Some associated mental illness exclusively with severe psychosis — the colloquial concept of 'madness' — while others, particularly those with tertiary educational attainment, recognised subtler presentations including depression and anxiety. Crucially, even participants who could articulate clinical concepts framed causation in social rather than biomedical terms:

"Many people think mental illness means you're mad, but it can be more subtle, like depression." — P5, Public Servant

What is analytically significant here is not the variation in symptom recognition per se but the consistency with which psychosocial causal attributions dominated across both groups. Participants whose professional training would be expected to produce biomedical framing still reached, in many moments, for social and relational explanations. This convergence on psychosocial attribution across groups of different educational backgrounds and occupational roles suggests that the explanatory model is not simply a product of ignorance of biomedical alternatives but reflects a culturally coherent interpretive framework that will need to be engaged with, rather than displaced, in any credible educational intervention. The analytical implication is that mental health literacy programmes framed primarily around biomedical knowledge transfer may have limited traction in this context.

Theme 2: Social and Economic Determinants as Primary Causal Explanations, and the Asymmetry Between Provider and Patient Illness Frameworks

The second analytically significant finding concerns not merely what participants identify as causes of perinatal mental illness — which broadly covers biological, psychological, social, and economic domains — but the interpretively important divergence between provider and patient causal emphasis, and the clinical consequences of that divergence. Healthcare providers tended to foreground biological and psychological determinants, particularly hormonal changes and stress attributable to individual psychological characteristics. Women, by contrast, consistently foregrounded structural and relational causes: financial hardship, absence of partner or family support, and the accumulated weight of gendered social expectation:

"Many women here face a lot of stress, especially financially. It can make them depressed during pregnancy or after delivery." — Healthcare Professional

"When there's no money and no help from anyone, it can become overwhelming for a woman." — P1, Teacher

This asymmetry is not merely an academic observation. When a provider frames a woman's distress as primarily the product of 'hormonal changes' or 'individual stress', and the woman experiences it as the product of poverty, partner absence, and social isolation, the clinical encounter risks fundamental miscommunication. The woman may feel unheard, the provider may offer interventions — psychoeducation, individual coping strategies — that do not address the structural conditions producing the distress, and the therapeutic alliance required for sustained engagement may fail to form. This explanatory model asymmetry maps onto what Kleinman (1980) described as the clinical space between the explanatory models of practitioner and patient, and it represents a specific and addressable communication and training gap.

Participants also recognised how causal factors interact and compound: financial hardship reduces social support (partners leave, families withdraw), which amplifies psychological stress, which is then intensified by the hormonal vulnerability of the perinatal period. This compounding logic is important for intervention design: addressing any single causal domain while leaving others intact may achieve minimal effect.

Theme 3: A Self-Reinforcing Exclusion System — Stigma, Structural Deficit, and Economic Deprivation

The third and analytically central finding is that barriers to perinatal mental health care do not operate independently. They constitute a self-reinforcing system in which stigma, structural absence of services, and economic constraint interact to produce effective exclusion from care — even for women who are motivated to seek help. Understanding this system, rather than its individual components, is essential for understanding why single-domain interventions have limited success.

Stigma operates at two analytically distinct levels. At the interpersonal level, the fear of being labelled 'mad' by community members, family, and employers functions as a deterrent to disclosing distress to anyone, including healthcare providers:

"In our culture, people are ashamed to talk about mental health, especially women. They don't want to be seen as mad." — Healthcare Professional

At the intrapersonal level, stigma operates through internalisation: women apply stigmatising frameworks to themselves, experiencing their own psychological distress as shameful, as evidence of personal

weakness or spiritual deficiency, or as a form of maternal failure. This self-directed stigma suppresses disclosure before any interpersonal encounter occurs. A woman who has internalised the view that emotional distress is shameful will not volunteer her psychological symptoms to a midwife even if that midwife is welcoming and enquiring.

The structural barrier compounds this: even the woman who overcomes internalised stigma and decides to seek help encounters a facility with no specialist in mental health, no dedicated service, and no trained provider. The absence of a system to receive her help-seeking reinforces the message that her distress is not legitimate clinical territory:

"We don't have specialists in mental health, and there's little training on how to handle these cases. It's a big gap." — Healthcare Professional

The economic barrier then closes the loop. For the woman who overcomes internalised stigma and identifies a potential care source, the cost of private specialist consultation — in a health financing environment dominated by out-of-pocket payment, with no health insurance coverage for mental health — renders formal care unaffordable:

"It's hard to afford regular healthcare, not to mention mental health services. There's no money, so how can we seek care?" — P1, Teacher

The self-reinforcing character of this system is analytically important: stigma prevents the social pressure that might create political will for service development; the absence of services normalises non-disclosure and reinforces stigma ('there is no service here because this is not a real health problem'); and economic constraint ensures that even partial motivation to seek care cannot translate into action. Intervening at only one of these levels while leaving the others intact risks negligible effect. This finding argues for simultaneous multi-level intervention, and it also explains why the scale-up of task-shifting models demonstrated in primary care (Oladeji et al., 2025; Kola et al., 2024) — while necessary — will require concurrent stigma reduction and insurance coverage expansion to achieve their intended effect in contexts like this.

Theme 4: The Silenced Body — Mental Health Made Invisible in the Antenatal Encounter

The fourth finding goes beyond the observation that mental health is not screened for in antenatal care — which is documented in the setting description and would be unremarkable as a stand-alone observation. The analytically significant finding is how women experience this omission: not as an administrative gap but as a form of communicative erasure that tells them, across repeated clinical encounters, that their psychological experience is not legitimate clinical territory. This experience of erasure has consequences not only for help-seeking in this facility but for the likelihood that women will disclose psychological distress to health systems in the future.

All five healthcare professionals confirmed that mental health assessment formed no part of standard antenatal or postnatal care protocols and that none had received formal training in perinatal mental health:

"Mental health isn't part of the regular checks we do for pregnant women, and most of us are not trained to handle it. We need better training." — Healthcare Professional

But it is the accounts of women — articulating their repeated experience of being asked only about the pregnancy and never about themselves — that give this theme its analytical specificity:

"When I go for check-ups, they only ask about the baby and my physical health. No one asks if I'm feeling depressed or anxious." — P4, Trader

The phrase 'no one asks' carries considerable analytical weight. It is not merely descriptive; it expresses a felt absence, a communication that the woman's psychological state is outside the legitimate scope of clinical inquiry. This is compounded by the fact that women generally would not volunteer psychological symptoms unprompted — both because of the internalised stigma described in Theme 3, and because the clinical encounter itself signals, through its exclusive focus on physical health parameters, that such disclosures are inappropriate. The antenatal visit thus functions, unintentionally, as a site of psychological silence.

This finding has specific implications for intervention design. The introduction of structured mental health enquiry into the antenatal encounter — even using a brief validated tool such as the PHQ-2 — would function not only as a clinical screening mechanism but as a symbolic communicative act: it would signal to women that their psychological wellbeing is a legitimate and expected subject of clinical attention. This communicative dimension of screening, beyond its diagnostic function, is underappreciated in the implementation science literature but is analytically central to this dataset.

Notably, both groups expressed convergent support for integration of mental health into antenatal care, though healthcare professionals qualified their readiness with a clear prerequisite — formal training must precede implementation — reflecting appropriate professional caution rather than resistance to change.

Theme 5: Reactive Care in a Prevention Vacuum — The Structural Absence of Perinatal Mental Health Promotion

The fifth analytical finding is that the facility's absence of prevention is not simply a resource gap but reflects a deeper structural failure: the non-recognition of perinatal mental health as a legitimate preventive health priority. All healthcare professionals described the facility's approach as reactive — responding to acute presentations when they become impossible to ignore, rather than proactively identifying and supporting women at risk:

"There's no proactive prevention; we only address issues when they arise. Structured support would be more effective." — Healthcare Professional

Women participants were, in the main, entirely unaware that any form of mental health support might be available to them, whether within the facility or beyond it. This is not merely a communication failure — it reflects the fact that, in practice, no meaningful support existed to be communicated:

"We need more education on mental health during pregnancy. The support that's available is not well-known." — P2, Trader

In the absence of institutional provision, participants described turning to informal support networks: family members, community groups, and, most prominently, religious communities and prayer. These informal networks are not trivial — they provide real, if inconsistent and untrained, support — and they represent a resource base that could be engaged and strengthened through community-facing interventions. However, their limitations are also clear: they cannot provide clinical assessment, pharmacological treatment, or evidence-based psychological intervention; they may reinforce spiritual rather than health-system explanatory frameworks; and their availability is unevenly distributed, creating inequities in informal support that mirror and compound the formal service gap.

Analytically, the reliance on informal networks is not a sign of community inadequacy but a rational adaptation to institutional absence. It is a coping strategy, not a preference. Both groups expressed a clear desire for formalised preventive programmes, and both endorsed educational initiatives and community-based screening as acceptable and desirable. This expressed demand, combined with the community's existing informal support infrastructure, constitutes a practical foundation upon which a co-designed preventive programme could be built.

Theme 6: Individualised Provider Initiative as a Fragile and Inequitable Substitute for Policy

The sixth and final analytical finding addresses the nature of whatever mental health care exists at the facility. What both healthcare providers and women described is not a reduced or inadequate service but effectively no institutionalised service at all. Whatever care is provided depends entirely on the initiative of a single clinician — in this case the consultant obstetrician — whose individual awareness and motivation function, in the absence of policy or protocol, as the sole mechanism of provision:

"There is hardly any mental health consult here presently except a little effort put in place by the obstetrician. We don't have a formal mental health service." — Healthcare Professional

This arrangement has three serious and analytically distinct consequences. First, it is fragile: the departure, illness, or demotivation of that single clinician eliminates the service entirely. Second, it is inequitable: access to any mental health support depends not on clinical need but on which member of staff a patient encounters, on which day, and whether that individual happens to have interest in mental health. Third, it is invisible: because the 'service' has no formal existence, it cannot be budgeted for, evaluated, improved, or held accountable to any standard.

Women participants did not merely express a desire for more resources; they expressed a desire for reliability — for a service they could count on irrespective of who happened to be on duty:

"The support for mental health isn't formalized at all. We need structured services that we can rely on." — P3, Fashion Designer

The analytical claim here is that the problem is not primarily one of competence or motivation — the existing clinician's efforts are acknowledged and valued — but of institutionalisation. Individual initiative, however admirable, cannot substitute for policy, protocol, and designated responsibility. The convergence between providers and patients on this point — both groups calling for formalised, reliable, integrated services — is one of the most striking findings of this study. It suggests that the principal obstacle to formalisation is not stakeholder resistance but political and administrative will, combined with the resource allocation decisions that would be required to operationalise that will.

IV. Discussion

This constructivist qualitative study provides interpretive evidence on how perinatal mental health is perceived and what barriers to care exist at a public secondary health facility in Benin City, Nigeria. Taken together, the six analytical themes present a coherent picture: perinatal mental health in this setting is subject to a compounding system of cultural, structural, and economic exclusion, embedded in a broader pattern of institutional non-recognition that both reflects and perpetuates Nigeria's wider mental health treatment gap.

Lay Illness Frameworks and the Challenge for Mental Health Literacy Programmes

The dominance of psychosocial explanatory frameworks across both participant groups — even among clinical professionals — is consistent with findings from across West Africa and the broader sub-Saharan African literature (Anjorin and Hassan Wada, 2022; Eboreime et al., 2022; Ade-Ojo et al., 2025). What this study adds is an interpretive account of the function these frameworks serve: they are not simply gaps in biomedical knowledge but coherent cultural meaning-making systems that make sense of distress in terms of social relationships, spiritual accountability, and collective rather than individual experience. Mental health literacy interventions that attempt simply to 'correct' lay illness models with biomedical information risk failing to engage with the deeper cultural logic of these frameworks.

The implication for intervention design is that psychoeducation must be dialogic rather than didactic — engaging with existing illness frameworks rather than dismissing them, finding points of cultural interface, and situating biomedical knowledge within rather than against the social and relational concerns that participants identify as primary. This aligns with the broader literature on cultural adaptation of mental health interventions in LMIC contexts (Kola et al., 2024; Wilson et al., 2024).

The Explanatory Model Asymmetry and Its Clinical Consequences

The divergence between providers' emphasis on biological and psychological determinants and women's consistent foregrounding of social and economic factors echoes findings from qualitative work in South Africa (Brown and Sprague, 2021) and the broader evidence synthesis by Webb et al. (2024). What this study contributes is an account of the interpretive mechanism through which this asymmetry generates harm: when providers and patients operate from incompatible causal frameworks, the clinical encounter may produce an experience of being misunderstood, which in turn reduces the likelihood of sustained engagement with health services. This is particularly consequential in a context already characterised by high internalised stigma and low trust in formal health systems.

The policy implication is that provider training must go beyond clinical symptom recognition to address the sociology of illness explanation: providers need not only to know the screening questions but to understand the explanatory frameworks patients bring to the encounter, and to develop the communication skills to work across that interpretive gap. This is a more ambitious training objective than is typically reflected in task-shifting programme curricula, but it is one that the evidence from this and comparable studies suggests is necessary.

The Self-Reinforcing Exclusion System and the Case for Simultaneous Multi-Level Intervention

The compounding barrier architecture identified in Theme 3 has direct implications for intervention sequencing and design. It is consistent with the multilevel barrier framework synthesised by Webb et al. (2024) across UK settings and with the qualitative findings of Brown and Sprague (2021) in South Africa, but provides a Nigerian-specific account of the specific mechanisms through which levels interact. The self-reinforcing character of the system — in which stigma, structural absence, and economic constraint each amplify the others — suggests that single-domain interventions will have limited impact. Stigma reduction without concurrent service development tells women to seek help from a system that cannot respond. Service development without stigma reduction creates services that women cannot access due to fear of judgment. Economic support without both leaves the structural and cultural barriers intact.

This analysis reinforces the argument for simultaneous multi-level intervention, and it contextualises the evidence from Nigerian implementation studies (Oladeji et al., 2025; Kola et al., 2024): the demonstrated efficacy of task-shifted screening and treatment in primary care settings is an important foundation, but scale-up to secondary facilities — and to the populations they serve — will require concurrent investment in stigma reduction and health insurance coverage expansion to achieve population-level impact.

The Silenced Body: Screening as Communicative Act

The finding that women experience the systematic non-enquiry about their psychological wellbeing in antenatal visits as a form of communicative erasure has implications that extend beyond the clinical efficiency arguments typically made for perinatal mental health screening. Standard arguments for introducing screening tools such as the EPDS or PHQ-2 focus on their diagnostic sensitivity and specificity, and on the evidence — now well-established in Nigerian primary care contexts (Oladeji et al., 2025) — for their feasibility and acceptability among health workers. This study adds a further argument: the act of asking about psychological wellbeing is itself a therapeutic intervention, communicating to women that their emotional experience is a legitimate and expected subject of clinical inquiry. In a context where internalised stigma suppresses voluntary disclosure, this communicative function may be as important as the diagnostic function of any screening instrument.

Formalisation as the Primary Structural Imperative

Theme 6's finding that whatever mental health care exists is entirely dependent on individual clinician initiative rather than institutional policy or protocol identifies formalisation as the most urgent structural priority. This finding is consistent with the broader African evidence base, which repeatedly documents the fragility of mental health care that exists outside formal policy frameworks (Ade-Ojo et al., 2025; Wilson et al., 2024). The convergence between provider and patient groups on this point — both calling explicitly for reliable, institutionally anchored services — is both substantively important and practically significant: stakeholder alignment on the need for change is a necessary precondition for implementation, and such alignment cannot be assumed.

Formalisation requires, at minimum: written clinical protocols for perinatal mental health screening and referral; designated responsibility for mental health enquiry within the antenatal care workflow; a structured and affordable referral pathway to specialist care; and inclusion of perinatal mental health as a funded line item within the facility's operational budget. Nigeria's Mental Health Act (2023) provides a legislative mandate for precisely this kind of integration, and its implementation framework should be leveraged to drive institutional change at the secondary care level (Adepoju, 2023; Akanni and Edozien, 2023).

Strengths and Limitations

This study has several methodological strengths. The constructivist epistemological framework is explicitly articulated and consistently aligned with the analytical method, ensuring internal coherence. The use of complementary data collection methods — FGDs and KIIs — allowed different aspects of the phenomenon to be illuminated from distinct methodological vantage points. Multi-coder analysis, structured peer debriefing, and respondent validation with two participants enhanced the credibility of the analytical findings. The study reports in full accordance with COREQ. The themes are presented as interpretive claims rather than descriptive categories, representing an analytical contribution beyond previous descriptive accounts.

The study's limitations must be acknowledged with equal candour. First, the single-facility urban setting limits the transferability of findings to rural health settings, primary care facilities, and tertiary institutions, where context, population, and resource profiles differ substantially. Second, the FGDs were conducted within the hospital premises, which may have introduced social desirability bias, particularly regarding women's disclosures about their own mental health experiences; participants may have presented as less distressed than they actually were to avoid implications for their ongoing clinical care. Third, the sample was homogeneously Christian, limiting the generalisability of findings on religious and cultural explanatory models to Muslim women and adherents of traditional African religions — a significant limitation given that religious frameworks significantly shape the spiritualisation and stigmatisation of mental illness in Nigeria. Fourth, the respondent validation process involved only two healthcare provider participants and not any women participants, creating an asymmetry in the verification of analytical interpretations. Fifth, the study did not include male partners, whose attitudes and behaviours substantially influence women's help-seeking decisions and whose perspectives would have enriched the analysis of social determinants. Sixth, the perspectives of women who do not access formal healthcare — who arguably face the most severe barriers and the most acute mental health needs — are entirely absent from a facility-based study design.

Implications for Practice and Policy

1. **Provider Training — Beyond Symptom Recognition:** Training programmes for maternal healthcare workers must cover not only perinatal mental health symptom recognition and validated screening tools (PHQ-2, EPDS) but must also address explanatory model asymmetry, stigma awareness, and culturally responsive communication. Training should be competency-based, practically oriented, and accompanied by structured supervision and refresher sessions. Evidence from Nigerian primary care demonstrates the feasibility and effectiveness of such training (Oladeji et al., 2023, 2025); the current study provides the rationale for adapting these models to secondary facility contexts.
2. **Service Formalisation:** Formal perinatal mental health protocols — covering screening, brief assessment, first-line response, and referral — should be developed and institutionalised within antenatal and postnatal care pathways at Central Hospital and comparable facilities. Designated responsibility for mental health enquiry should be assigned within the maternal care team, with accountability mechanisms.
3. **Community-Based Stigma Reduction:** Psychoeducation campaigns should be co-designed with community members, religious leaders, and women's groups to normalise help-seeking and challenge stigmatising illness frameworks. These campaigns must engage with — rather than dismiss — existing cultural and spiritual explanatory models, finding points of interface rather than confrontation.
4. **Health Financing Reform:** Advocacy for inclusion of perinatal mental health services within the National Health Insurance Scheme coverage package is urgently needed. Without insurance coverage, even the

development of formal facility-based services will remain inaccessible to the economically marginalised women who bear the highest burden of perinatal mental illness.

5. **Policy Implementation — Leveraging the Mental Health Act (2023):** The provisions of Nigeria's Mental Health Act (2023) specifically the mandate for mental health integration into primary care and the establishment of a Department of Mental Health Services — should be operationalised to cover secondary maternal care facilities. The next National Strategic Health Development Plan should include measurable perinatal mental health targets with specific implementation timelines and accountability mechanisms.

Future Research Directions

This study identifies several priority directions for future inquiry. Implementation science studies are needed to evaluate the feasibility, acceptability, and effectiveness of integrated perinatal mental health screening and care models in Nigerian secondary health facilities, building on the primary care evidence base. Research on the perspectives of Muslim women and adherents of traditional African religious frameworks is needed to ensure that cultural adaptation of interventions is inclusive of the full religious diversity of Nigerian women. Studies including male partners are needed to understand how partner attitudes shape women's help-seeking and to inform partner-inclusive intervention design. Community-based qualitative research with women who do not access formal healthcare services would illuminate the barriers most distant from the reach of facility-based programmes. Finally, longitudinal studies tracking the trajectories of perinatal mental health from early pregnancy through the first postnatal year are needed to understand the natural history of PMI in Nigerian LMIC contexts and to identify optimal timing for preventive and therapeutic intervention.

V. Conclusion

This constructivist qualitative study provides interpretively grounded evidence from a public secondary health facility in Benin City, Nigeria, demonstrating that the undertreatment of perinatal mental illness reflects not a single failure but a compounding system of cultural, structural, and economic exclusion. Mental illness is predominantly understood through a psychosocial and culturally embedded lens; barriers to care are mutually reinforcing rather than independent; the omission of mental health from antenatal encounters functions as a communicative act of erasure experienced by women as delegitimising; and whatever care exists is sustained by individual initiative rather than institutional policy, rendering it fragile, inequitable, and invisible to accountability mechanisms.

The analytical contribution of this study lies not in documenting that barriers exist — this is well-established — but in providing an interpretive account of how they interact, what they mean to the women who experience them, and why single-domain interventions are likely to achieve limited impact without concurrent action across the system. Equally significant is the finding of convergent readiness for change among both providers and service users: a shared vision for integrated, formalised, reliable perinatal mental health care that creates an unusually favourable implementation context.

Realising this potential requires coordinated investment in provider training that goes beyond symptom recognition, service formalisation anchored in institutional policy, community-based stigma reduction that engages rather than dismisses existing cultural frameworks, health insurance coverage expansion, and national policy implementation aligned with Nigeria's landmark Mental Health Act. With sustained, contextually responsive, and systemically informed action, it is achievable to transform perinatal mental health care in Nigeria — improving outcomes for mothers, children, families, and communities.

APPENDIX: COREQ Full Reporting Checklist

Table 4: Consolidated Criteria for Reporting Qualitative Research (COREQ) — Full 32-Item Adherence Checklist

COREQ Item	Status	Detail
Domain 1: Research Team		
Interviewer / facilitator	Reported	Principal investigator (VO) and trained team members (CE, OO) conducted interviews; none provided clinical care to participants
Credentials	Reported	Obstetrician (VO); mental health nurse (HE); internal medicine (OO); nursing educators (CE, FAO, WO)
Occupation	Reported	Clinical and academic roles described in affiliations
Gender	Reported	Mixed-gender research team
Experience / training	Reported	Two members trained in qualitative research methods; reflexivity journal maintained

Relationship with participants	Reported	No prior relationship; no treating relationship; participants briefed on researcher backgrounds
Participant knowledge of interviewer	Reported	Participants informed of professional backgrounds and study aims prior to consent
Interviewer characteristics	Reported	Team assumptions and professional priors documented in reflexivity journal; peer debriefing conducted
Domain 2: Study Design		
Methodological orientation	Reported	Constructivist / interpretivist; thematic analysis (Braun & Clarke, 2006)
Sampling	Reported	Purposive; predefined inclusion criteria; participation rates reported
Method of approach	Reported	Women approached by clinic staff; HCPs via formal written invitation
Sample size	Reported	11 women (2 FGDs); 5 HCPs (individual KIIs); total N=16
Non-participation	Reported	Reasons for non-participation documented (time constraints; lack of interest)
Setting of data collection	Reported	Private hospital rooms; away from clinical care areas
Presence of non-participants	Reported	No non-participants present during sessions
Description of sample	Reported	Detailed demographic tables provided (Tables 1 and 3)
Interview guide	Reported	Semi-structured; adapted from Nakku et al. (2016); piloted and revised
Repeat interviews	Reported	Not conducted; single sessions per participant
Audio / visual recording	Reported	Audio-recorded with written consent
Field notes	Reported	Taken during and immediately after each session
Duration	Reported	45–60 minutes per session
Data saturation	Reported	Assessed iteratively; saturation declared after FGD2 / KII4-5; no new codes emerged
Transcripts returned	Reported	Member-checking of preliminary themes with two HCPs; not all participants due to logistical constraints (acknowledged as limitation)
Domain 3: Analysis and Findings		
Number of coders	Reported	Three independent coders; codebook developed collaboratively
Description of coding tree	Reported	Preliminary codebook refined through team discussion; final codes applied across all transcripts
Derivation of themes	Reported	Inductive; themes defined by analytical claims, not descriptive categories
Software	Reported	NVivo 12 (QSR International)
Participant checking	**Partial**	Preliminary themes shared with two HCPs; women participants not included (acknowledged as limitation)
Quotations provided	Reported	Representative quotes selected from both participant groups for each theme
Consistency between data and findings	Reported	Peer debriefing and multi-coder consensus used to verify interpretive coherence
Clarity of major themes	Reported	Six themes presented with explicit analytical claims and illustrative quotations
Clarity of minor themes	Reported	Sub-themes and cross-cutting dimensions described within each major theme

Acknowledgements

The authors express sincere appreciation to the Medical Director of Central Hospital, Benin City, for granting institutional approval to conduct this study. Profound gratitude is extended to all study participants — the women and healthcare professionals who generously shared their time, experiences, and perspectives. Their contributions are the foundation of this work.

Author Contributions

Victor Ohenhen and Ejovi Akpojaro conceived the study, designed the methodology, led data collection, conducted primary analysis, and drafted the manuscript. Helen Eborieme provided expert guidance on study

design and mental health content, conducted peer debriefing sessions throughout analysis, and critically reviewed all manuscript drafts. Oluwatoyin Ohenhen, Oluwafunmilayo Akpojaro, Christiana Elusoji, and Wisdom Omorogbe contributed to data collection, participated in the multi-coder analysis process, and reviewed and approved the final manuscript. All authors approved the version submitted for publication and are accountable for all aspects of the work.

Financial Support

This research received no specific grant from any funding agency, commercial entity, or not-for-profit organisation.

Conflict Of Interest

The authors declare no conflicts of interest in relation to this study.

Ethics Statement

Ethical approval was obtained from the Ethics and Research Committee of Central Hospital, Benin City (Approval No: CHA/406/86). Written institutional permission was obtained from hospital management. All participants provided written informed consent following comprehensive explanation of the study's purpose, procedures, potential risks, anticipated benefits, and their right to withdraw at any time without consequence to their care or professional standing. Confidentiality was maintained throughout through the pseudonymisation of all participant data. All data were stored on password-protected, encrypted devices accessible only to designated members of the research team.

Data Availability Statement

The anonymised qualitative data supporting the findings of this study are available from the corresponding author upon reasonable request, subject to ethical and institutional data-sharing agreements and participant confidentiality protections.

References

[1]. Ade-Ojo GO, Kola L, Gureje O (2025) The Epidemiology Of Maternal Mental Health In Africa: A Systematic Review. Archives Of Women's Mental Health. Https://Doi.Org/10.1007/S00737-025-01563-4

[2]. Adeoye IA, Sogbesan A, Esan O (2022) Prevalence, Associated Factors And Perinatal Outcomes Of Antepartum Depression In Ibadan Nigeria. BMC Pregnancy And Childbirth 22(1), 219. Https://Doi.Org/10.1186/S12884-022-04549-7

[3]. Adepoju VA (2023) Breaking The Chains: Nigeria's New Mental Health Law And Its Impact On Care And Rights. Nigerian Medical Journal 64(2), 172–173. Https://Doi.Org/10.60787/Nmj-64-2

[4]. Adjorlolo S (2023) Seeking And Receiving Help For Mental Health Services Among Pregnant Women In Ghana. PLOS ONE 18(3), E0280496. Https://Doi.Org/10.1371/Journal.Pone.0280496

[5]. Akanni OO And Edozien LC (2023) The New Nigerian Mental Health Act: A Huge Leap Before Looking Closely? Nigerian Medical Journal: Journal Of The Nigeria Medical Association 64(6), 838–845. Https://Doi.Org/10.60787/Nmj-64-6-351

[6]. American College Of Obstetricians And Gynecologists (2024) Screening And Diagnosis Of Mental Health Conditions During Pregnancy And Postpartum. Available At: Https://Www.Acog.Org (Accessed 23 July 2025).

[7]. Anjorin O And Hassan Wada Y (2022) Impact Of Traditional Healers In The Provision Of Mental Health Services In Nigeria. Annals Of Medicine And Surgery 82, 104755. Https://Doi.Org/10.1016/J.Amsu.2022.104755

[8]. Asare H, Rosi A, Scazzina F, Faber M, Smuts CM, Ricci C (2022) Maternal Postpartum Depression In Relation To Child Undernutrition In Low- And Middle-Income Countries: A Systematic Review And Meta-Analysis. European Journal Of Pediatrics 181(3), 979–989. Https://Doi.Org/10.1007/S00431-021-04320-6

[9]. Braun V And Clarke V (2006) Using Thematic Analysis In Psychology. Qualitative Research In Psychology 3(2), 77–101. Https://Doi.Org/10.1191/1478088706qp063oa

[10]. Brown S And Sprague C (2021) Health Care Providers' Perceptions Of Barriers To Perinatal Mental Healthcare In South Africa. BMC Public Health 21(1), 1905. Https://Doi.Org/10.1186/S12889-021-11954-8

[11]. Creswell JW And Poth CN (2018) Qualitative Inquiry And Research Design: Choosing Among Five Approaches (4th Edn). Thousand Oaks, CA: Sage.

[12]. Eboreime E, Ezeokoli A, Adams K And Banke-Thomas A (2022) Prioritizing The Mental Health Needs Of Pregnant Adolescents In Sub-Saharan Africa. Journal Of Global Health Neurology And Psychiatry. Https://Doi.Org/10.52872/001c.34646

[13]. Jidong DE, Husain N, Ike TJ, Murshed M, Pwajok JY, Roche A, Karick H, Dagona ZK, Karuri GS, Francis C, Mwankon SB And Nyam PP (2021) Maternal Mental Health And Child Well-Being In Nigeria: A Systematic Review. Health Psychology Open 8(1), 20551029211012199. Https://Doi.Org/10.1177/20551029211012199

[14]. Kleinman A (1980) Patients And Healers In The Context Of Culture. Berkeley, CA: University Of California Press.

[15]. Kola L, Bello T, Ayinde OO, Faregh N, Abdulmalik J, Zelkowitz P, Seedat S, Gureje O (2024) Addressing The Challenges Of Integrating Care For Perinatal Depression In Primary Care In Nigeria. Social Psychiatry And Psychiatric Epidemiology 59, 1671–1684. Https://Doi.Org/10.1007/S00127-024-02611-7

[16]. Lincoln YS And Guba EG (1985) Naturalistic Inquiry. Beverly Hills, CA: Sage.

[17]. Nakku JEM, Okello ES, Kizza D, Honikman S, Ssebunnya J, Ndyanabangi S, Hanlon C And Kigozi F (2016) Perinatal Mental Health Care In A Rural African District, Uganda: A Qualitative Study Of Barriers, Facilitators And Needs. BMC Health Services Research 16(1), 295. Https://Doi.Org/10.1186/S12913-016-1547-7

[18]. NHS England (2024) Perinatal Mental Health. Available At: Https://Www.England.Nhs.Uk/Mental-Health/Perinatal/ (Accessed 23 July 2025).

[19]. Oladeji BD, Ayinde OO, Bello T, Kola L, Faregh N, Abdulmalik J, Zelkowitz P, Seedat S, Gureje O (2023) Cascade Training For Scaling Up Care For Perinatal Depression In Primary Care In Nigeria. International Journal Of Mental Health Systems 17(1), 41. Https://Doi.Org/10.1186/S13033-023-00607-5
[20]. Oladeji BD, Ayinde OO, Kola L, Gureje O (2025) Screening And Detection Of Perinatal Depression By Non-Physician Primary Healthcare Workers In Nigeria. BMC Primary Care 26, 35. Https://Doi.Org/10.1186/S12875-025-02730-3
[21]. Perez-Pedrogo C, Canino G, Moscoso M, Kohn R (2024) Perinatal Depression And Adverse Child Growth Outcomes In Low-Income And Middle-Income Countries: A Systematic Review And Meta-Analysis. PLOS Global Public Health 4(10), E0003586. Https://Doi.Org/10.1371/Journal.Pgph.0003586
[22]. Roddy Mitchell A, Gordon H, Lindquist A, Walker SP, Homer CSE, Middleton A, Cluver CA, Tong S, Hastie R (2023) Prevalence Of Perinatal Depression In Low- And Middle-Income Countries: A Systematic Review And Meta-Analysis. JAMA Psychiatry 80(5), 425–431. Https://Doi.Org/10.1001/Jamapsychiatry.2023.0069
[23]. Smith JA, Flowers P And Larkin M (2009) Interpretative Phenomenological Analysis: Theory, Method And Research. London: Sage.
[24]. Tong A, Sainsbury P And Craig J (2007) Consolidated Criteria For Reporting Qualitative Research (COREQ): A 32-Item Checklist For Interviews And Focus Groups. International Journal For Quality In Health Care 19(6), 349–357. Https://Doi.Org/10.1093/Intqhc/Mzm042
[25]. Webb R, Ford E, Shakespeare J, Easter A, Alderdice F, Holly J, Coates R, Hogg S, Cheyne H, Mcmullen S, Gilbody S, Salmon D, Ayers S (2024) Conceptual Framework On Barriers And Facilitators To Implementing Perinatal Mental Health Care And Treatment For Women: The Matrix Evidence Synthesis. Health And Social Care Delivery Research 12(2), 1–187. Https://Doi.Org/10.3310/KQFE0107
[26]. WHO Regional Office For The Eastern Mediterranean Region (2024) Mental Health Action Plan 2013–2030. Available At: Https://Www.Emro.Who.Int/Mnh/Mental-Health-Action-Plan/Index.Html (Accessed 23 July 2025).
[27]. Wilson CA, Bublitz M, Chandra P, Hanley S, Honikman S, Kittel-Schneider S, Rückl SCZ, Leahy-Warren P And Byatt N (2024) A Global Perspective: Access To Mental Health Care For Perinatal Populations. Seminars In Perinatology 48(6), 151942. Https://Doi.Org/10.1016/J.Semperi.2024.151942
[28]. Yusuf I (2021) The Need To Provide Mental Health Support For Pregnant Women In Nigeria. Nigeria Health Watch. Available At: Https://Articles.Nigeriahealthwatch.Com/The-Need-To-Provide-Mental-Health-Support-For-Pregnant-Women-In-Nigeria/ (Accessed 23 July 2025).