

A Mixed-Method Study on Barriers and Facilitators of Mental Health Well-Being Among Postnatal Mothers: A Preliminary Study

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Abstract

Perinatal mental health disorders affect approximately 10–20% of women globally, yet research in Caribbean Small Island Developing States remains limited. Understanding context-specific barriers and facilitators to mental health care among postnatal mothers is essential for developing appropriate interventions. A mixed method, cross-sectional design was adopted. Ten postnatal mothers were selected by purposive sampling and completed a self-administered questionnaire comprising socio-demographic proforma, the Depression Anxiety and Stress Scale (DASS-21), and the 36-Item Short Form Survey (SF-36) were used. Four postnatal mothers and two healthcare workers were interviewed. Descriptive statistics and thematic analysis were employed. The study findings revealed that in the DASS Scale, 50% of participants reported depressive symptoms above the normal range, 100% for anxiety, and 20% for stress. The SF-36 revealed that the lowest scores were in role limitations due to emotional problems (mean 45.8) and energy/fatigue (mean 52.5), while physical functioning (mean 77.6) was higher than mental health (mean 67.6). Cross-tabulation revealed that younger mothers (18–24 years) had the lowest mean mental health score (61.0) compared to mothers aged 25–34 years (72.0) and 35–44 years (72.0). The majority of participants (40%) were in the early postpartum period (1–4 weeks). Qualitative findings identified barriers including cultural expectations of strength, stigma, lack of partner support, financial constraints, inconsistent screening practices, unclear referral pathways, and inadequate training among healthcare workers. Facilitators included emotional safety, supportive partners and family, trust in healthcare providers, and willingness among healthcare workers to receive training. This study finding reported that postnatal mothers had anxiety symptoms above the normal range warrants urgent attention and highlights the critical need for integrated perinatal mental health services in St. Vincent and the Grenadines.

Keywords: *Anxiety, Barriers, Depression, Facilitators, Mental Health Well-Being, Postnatal Mothers, Stress, St. Vincent and the Grenadines.*

Introduction

Over the past decade, the recognition of perinatal mental health as a critical public health priority has increased worldwide. The World Health Organization (WHO) has identified maternal mental health as essential for achieving universal health coverage and the

Sustainable Development Goals, particularly Goal 3, which aims to ensure healthy lives and promote well-being for all at all ages [1]. Perinatal mental health disorders affect approximately 10–20% of women during pregnancy and the postpartum period, making them one of the most common complications of childbearing [2].

The consequences of untreated perinatal mental illness extend beyond maternal well-being to include adverse effects on infant development, child attachment, and family functioning [3]. Children of mothers with untreated perinatal depression are at increased risk for cognitive, emotional, and behavioral difficulties [4]. In low- and middle-income countries, the prevalence of postnatal depression has been reported as high as 25%, with substantial treatment gaps attributed to limited resources, stigma, and inadequate integration of mental health services into routine maternal care [5].

Within the Caribbean region, the burden of perinatal mental health disorders is increasingly recognized. A cohort study conducted in Havana, Cuba, found that 20.0% of women reported elevated anxiety symptoms and 16.4% reported depressive symptoms during the four weeks of postpartum, with rates of depression persisting to 14.5% at six months postpartum [6]. In Jamaica, qualitative research has documented that rates of postpartum depression may range from 26% to 60%, with cultural expectations of strength, stigma, and limited awareness serving as key barriers to help-seeking [7]. A qualitative study from Barbados similarly confirmed that maternal depression exists and is underrecognized, with women reporting lack of formal information on maternal depression at the postnatal period and social stigmas around mental health as major barriers to accessing care [8]. These findings highlight that perinatal mental health disorders are a significant but often neglected public health issue across the Caribbean region.

Internationally, a systematic review and meta-analysis reported that the prevalence of postpartum depression ranges from 10–15% in high-income countries to over 20% in low- and middle-income countries, with risk factors including low education, unemployment, unmarried status, cesarean birth, unplanned pregnancy, preterm delivery, poor partner support, and past psychiatric conditions [9].

Research from the United States indicates that higher perceived social support is significantly associated with lower postpartum depression and anxiety symptoms, with emotional support identified as the most commonly reported and protective form of support [10]. A 64-country cross-national study of perinatal well-being during the COVID-19 pandemic found that a large proportion of participants (31%) scored at or above the cut-offs for depression and anxiety, underscoring the global scale of this public health challenge [11]. Additionally, a systematic review of barriers and facilitators to perinatal mental health care in low- and middle-income countries found that stigma, lack of social support, financial constraints, and inadequate integration of mental health services into maternal care consistently impede access to care, while family involvement, trust in healthcare providers, and culturally sensitive services facilitate help-seeking [12].

The Caribbean region, characterized by Small Island Developing States (SIDS), faces unique challenges in addressing perinatal mental health. These include fragmented healthcare systems, limited specialized mental health personnel, cultural factors that shape help-seeking behaviors, and geographical dispersion of populations [7].

In Saint Vincent and the Grenadines (SVG), mental health services are largely centralized within one Mental Health Centre, reflecting a predominantly institutional model of care. Although some outreach activities such as community clinics and home visits are conducted, the lack of a structured community-based mental health system limits accessibility and continuity of care. Importantly, specialized services for vulnerable groups, including postnatal mothers are absent, highlighting a significant gap in maternal mental health support. Cultural attitudes toward mental health, including stigma and expectations of maternal resilience, may contribute to underreporting of distress and delayed help-seeking [13].

Understanding the barriers and facilitators to mental health well-being is essential for developing effective interventions. Barriers are factors that impede access to care or negatively affect mental health, while facilitators are factors that promote mental well-being or enable access to care [14]. In the context of postnatal mental health, barriers may include stigma, lack of social support, financial constraints, and health system limitations, while facilitators may include supportive partners, family involvement, accessible healthcare services, and culturally sensitive care [12].

Despite growing recognition of perinatal mental health as a public health priority, no published studies have systematically examined the barriers and facilitators to mental health well-being among postnatal mothers in St. Vincent and the Grenadines. This evidence gap impedes the development of contextually appropriate interventions and policies. The present study was designed to address this gap through a comprehensive mixed-methods investigation.

Materials and Methods

This study employed a mixed-methods approach, incorporating both quantitative and qualitative components. The quantitative component consisted of a cross-sectional survey administered to ten postnatal mothers, while the qualitative component included in-depth interviews with four postnatal mothers and two healthcare workers. The study was conducted at the Milton Cato Memorial Hospital and selected community district clinics across Saint Vincent and the Grenadines, clinics included were the Belair, Kingstown, Georgetown and Calliaqua Health center, and the Stubbs poly clinic.

Purposive sampling technique was used to recruit participants who met the inclusion criteria. The study was conducted among ten postnatal mothers and two health care workers. The quantitative data collection instrument

comprised three sections: (1) sociodemographic characteristics of the participants, (2) the Depression Anxiety Stress Scales-21 (DASS-21) used to assess levels of depression, anxiety, and stress, and (3) the Short Form Health Survey (SF-36) used to evaluate overall health-related quality of life across multiple domains, including physical and mental well-being.

The reliability of the instruments was evaluated using Cronbach's alpha coefficient based on the pilot study sample ($N = 10$). The DASS-21 demonstrated excellent internal consistency, with an overall Cronbach's alpha of $\alpha = 0.962$. The subscale reliability coefficients were $\alpha = 0.930$ for depression, $\alpha = 0.827$ for anxiety, and $\alpha = 0.918$ for stress, indicating good to excellent reliability. The SF-36 is a standardized and widely validated instrument with reported reliability coefficients ranging from $\alpha = 0.78$ to $\alpha = 0.93$ across its respective domains, reflecting acceptable to excellent internal consistency in previous studies. These findings support the reliability and suitability of the instruments for assessing mental health well-being among postnatal mothers in this pilot study.

The qualitative component utilized semi-structured face-to-face interviews to explore participants' experiences, perceptions, and challenges related to postnatal mental health and well-being. All interviews were conducted in person based on participant preference, audio-recorded using a digital recorder, and subsequently transcribed verbatim for analysis.

Quantitative data were analyzed using descriptive statistics to summarize sociodemographic variables and scale scores from the DASS-21 and SF-36 instruments. Qualitative data were analyzed thematically to identify key patterns and emerging themes related to barriers and facilitators of mental health among postnatal mothers.

Results

Demographic Characteristics of Respondents

Table 1 shows the frequency and percentage distribution of demographic characteristics of the 10 postnatal mothers who completed the survey.

Regarding age, 40% were between 18–24 years of age, 40% were 25–34 years, and 20% were 35–44 years. With respect to marital status, the majority (60%) were single, 30% were married, and 10% were in common-law relationships. According to education status, 70% had completed secondary education, and 30% had completed college or vocational training. Regarding employment status, 60% were employed and 40% were unemployed.

Regarding monthly income, 50% earned between \$800–\$1400, 30% earned less than

\$600, 10% earned between \$1500–\$2500, and 10% earned more than \$3000. With respect to ethnicity, 80% identified as African Black, 10% as Mixed, and 10% as Other. Regarding postnatal period, 40% were in 1–4 weeks of the postpartum, 30% were in 5–8 weeks, 20% were 9–12 weeks, and 10% were more than 12 weeks.

According to number of children, 80% had 1–3 children and 20% had 4–5 children. Regarding family type, 50% belonged to nuclear families, 40% in extended families, and 10% were single-parent. With respect to residential status, 50% resided in rural areas, 40% in urban areas, and 10% in the Grenadines. Regarding mode of delivery, 70% had vaginal delivery and 30% had cesarean section. According to main source of support, 40% identified their spouse/partner, 30% identified a family member, 20% identified their mother, and 10% reported no consistent support.

Table 1. Frequency and Percentage Distribution of Demographic Characteristics of the Respondents n=10

No.	Demographic Characteristics	Frequency	Percentage
1	Age		
	18-24 years	4	40%
	25-34 years	4	40%
	35-44 years	2	20%
2	Marital Status		
	Single	6	60%
	Married	3	30%
	Common-law	1	10%
3	Education		
	Secondary	7	70%
	College/Vocational	3	30%
4	Employment Status		
	Employed	6	60%
	Unemployed	4	40%
5	Monthly Income		
	Less than \$600	3	30%
	\$800 - \$1400	5	50%
	\$1500 - \$2500	1	10%
	More than \$3000	1	10%
6	Ethnicity		
	African Black	8	80%

	Mixed	1	10%
	Other	1	10%
7	Weeks Since Delivery		
	1-4 weeks	4	40%
	5-8 weeks	3	30%
	9-12 weeks	2	20%
	More than 12 weeks	1	10%
8	Number of Children		
	1-3 children	8	80%
	4-5 children	2	20%
9	Family Type		
	Nuclear	5	50%
	Extended	4	40%
	Single-parent household	1	10%
10	Residential Status		
	Urban area	4	40%
	Rural area	5	50%
	Grenadines	1	10%
11	Mode of Delivery		
	Vaginal delivery	7	70%
	Cesarean section	3	30%
12	Main Source of Support		
	spouse/partner	4	40%
	mother	2	20%
	Family member	3	30%
	No consistent support	1	10%

Table 1 presents the demographic characteristics of the postnatal mothers included in the study (N = 10). The findings indicate that the sample was relatively young, with the majority (80%) between 18–34 years, suggesting that most participants were within the typical reproductive age group. A high proportion of participants were single (60%), which may have implications for social and emotional support during the postnatal period. Most respondents had attained secondary education (70%), and over half were employed (60%), although income levels were generally low, with 80% earning \$1400 or less per month, indicating potential financial constraints.

The majority of participants identified as African Black (80%), reflecting the

predominant ethnic composition of the population. Most mothers were in the early postpartum period, particularly within 1–4 weeks (40%), a critical time for both physical recovery and emotional adjustment. In terms of family structure, half lived in nuclear families (50%), while a considerable proportion resided in extended families (40%), which may influence support systems.

Additionally, most participants had between 1–3 children (80%), and vaginal delivery was the most common mode of childbirth (70%). Regarding support, spouses/partners were the primary source (40%), although 10% reported having no consistent support, highlighting a potential risk factor for poor mental health outcomes. Overall, the findings suggest that

while some participants had support systems in place, socioeconomic challenges and variations

in support may influence their postnatal mental health and well-being.

Table 2. Frequency and Percentage Distribution of Depression, Anxiety and Stress Scores of Postnatal Mothers n=10

Psychological Problems	Categories	Frequency	Percentage
Depression	Normal	5	50
	Mild	2	20
	Moderate	2	20
	Severe	1	10
Anxiety	Mild	3	30
	Moderate	4	40
	Severe	2	20
	Extremely Severe	1	10
Stress	Normal	8	80
	Moderate	1	10
	Severe	1	10

Table 2 revealed that for depression, 50% of participants reported symptoms above the normal, with 20% had mild depression, 20% had moderate, and 10% had severe depression. For anxiety, all the participants reported symptoms above the normal range, with 30% in

the mild range, 40% in the moderate range, 20% in the severe range, and 10% in the extremely severe range. For stress, 20% of participants reported symptoms above the normal range, with 10% in the moderate range and 10% in the severe range.

Table 3. Mean and SD of Domain Wise Scores of Mental Health Well-being of Postnatal Mothers n=10

Domain	Mean Score	Standard Deviation	Minimum	Maximum	Description
Physical Functioning (PF)	77.6	11.8	60.0	95.0	Ability to perform physical activities
Role Limitations due to Physical Health (RP)	67.2	12.4	50.0	85.0	Extent physical health limits work/activities
Role Limitations due to Emotional Problems (RE)	45.8	25.1	0	75.0	Extent emotional problems limit work/activities
Energy/Fatigue (EF)	52.5	16.7	25.0	75.0	Vitality and energy levels
Mental Health (MH)	67.6	10.9	44.0	84.0	Psychological distress and well-being
Social Functioning (SF)	62.4	15.3	40.0	85.0	Interference with social activities
Pain (P)	75.6	12.8	55.0	90.0	Bodily pain intensity and interference
General Health (GH)	68.7	13.6	45.0	85.0	Personal evaluation of health

Table 3 presents the SF-36 scores across the eight domains of health-related quality of life. The SF-36 scores range from 0 to 100, with higher scores indicating better health status. The results revealed that the lowest scores were in role limitations due to emotional problems this domain explains the extent emotional problems limit work/activities (mean 45.8, range 0–75) and energy/fatigue that focus on the participants vitality and energy levels (mean 52.5, range 25–75).

The physical functioning domain highlights the participants ability to perform physical activities had a mean score of 77.6 (range 60–95), while the mental health domain which assess the psychological distress and well-being of the participants had a mean score of 67.6 (range 44–84), indicating that physical health was less affected than emotional health in this sample. The general health of the participants had a mean score of 68.7, range (45 – 85).

Table 4. Frequency and Percentage Distribution of Physical Functioning Score of Postnatal Mothers n=10

Physical Functioning	Frequency	Percentage
Moderate limitation	3	30.0
Mild limitation	2	20.0
Very Mild limitation	3	30.0
No limitation	2	20.0

Table 4 shows that in physical functioning domain majority of participants (50%) had mild to very mild limitations in physical functioning,

with 20% reporting no limitations and 30% reporting moderate limitations.

Table 5. Frequency and Percentage Distribution of Mental Health Scores of Postnatal Mothers n=10

Mental Health	Frequency	Percent
Poor mental health	1	10.0
Below average mental health	2	20.0
Average mental health	3	30.0
Above average mental health	2	20.0
Good mental health	2	20.0

Table 5 illustrates that in Mental Health domain only 30% of participants reported average mental health scores, while 20% reported good mental health. The remaining 50% reported mental health scores classified as poor (10%), below average (20%), or above average (20%). This indicates that half of the participants are experiencing significant mental health challenges.

Qualitative Findings: Barriers and Facilitators Identified by Postnatal Mothers and in Hospital and Community Clinics

Four major themes emerged from the thematic analysis: (1) Support Systems as Facilitators, (2) Systemic Barriers, (3) Socio-cultural Influences, and (4) Personal Coping Strategies. Within each theme, setting-specific patterns were observed. See Table 6.

Table 6. Summary of Qualitative Themes and Sub-Themes on Barriers and Facilitators of Mental Health Well-Being Among Postnatal Mothers in St. Vincent and the Grenadines

Theme	Sub-Themes	Key Illustrative Settings / Groups
1. Support Systems as Facilitators	1.1 Partner support 1.2 Family assistance 1.3 Community and religious support	Hospital & clinic attendees; extended family, church networks
2. Systemic Barriers	2.1 Limited access to mental health services 2.2 Inadequate screening and follow-up 2.3 Financial and practical constraints	Hospital (lack of screening) vs. clinic (transport, geography); healthcare workers
3. Socio-cultural Influences	3.1 Stigma and silence 3.2 Cultural expectations of motherhood	Universal across settings; intergenerational attitudes
4. Personal Coping Strategies	4.1 Prayer and spirituality 4.2 Social connection (WhatsApp groups, breastfeeding support) 4.3 Self-care practices	Hospital (online groups) vs. clinic (in-person networks); all mothers

Theme 1: Support Systems as Facilitators

Subtheme 1.1: Partner Support

Partner support was consistently identified as crucial across both settings.

"My husband has been my rock. When I'm feeling overwhelmed, he knows just what to say. Just having him understand without me having to explain makes all the difference." (Postnatal Mother 1, 28 years, first-time mother)

"Sometimes I feel like I'm failing, but my husband reminds me that I'm doing a good job. He says, 'Look at our baby, she's healthy and happy because of you.' Those words keep me going." (Postnatal Mother 4, 32 years, mother of two)

Subtheme 1.2: Family Assistance

Extended family support was particularly important for clinic attendees, many of whom lived in multi-generational households. "My mother comes over every day after work. She helps with bathing the baby, cooking, and just talks to me. In Vincentian culture, we don't always talk about feelings but having her there makes me feel less alone." (Postnatal Mother 2, 24 years, single mother)

"I live with my grandmother and aunt. They help with the baby at night so I can sleep. I don't know how single mothers manage alone." (Postnatal Mother 3, Clinic, 26 years, mother of one)

"My family is in the Grenadines. I'm here in Kingstown alone with my husband who works long hours. It's hard not having my mother nearby." (Postnatal Mother 4)

Subtheme 1.3: Community and Religious Support

Church communities were mentioned by participants in both settings, but clinic attendees more frequently described practical support from church members.

"The women from my church brought meals for two weeks after I came home from the hospital. They prayed with me and offered encouragement that kind of community support is priceless." (Postnatal Mother 4, 32 years)

"My pastor's wife organized a 'baby shower' for me through the church. They gave me diapers, clothes, and a hamper of food. It took so much pressure off of me financially." (Postnatal Mother 1, 28 years)

Theme 2: Systemic Barriers

Subtheme 2.1: Limited Access to Mental Health Services

Participants in both settings described poor access, but the nature of barriers differed. Hospital attendees reported lack of screening and information, while clinic attendees emphasized transportation and geographic barriers.

Hospital Participants

"I delivered my baby in the hospital and came for my 6-week check. They checked my blood pressure, my incision, and the baby. Nobody asked how I was feeling emotionally. I didn't even know that was something they might ask about." (Postnatal Mother 1,)

"There's an outpatient clinic for mental health department here at the hospital, but I wouldn't know how to access it. Do I need a referral? Can I just walk in?" (Postnatal Mother 3,)

Clinic Participants

"The mental health clinic is in Kingstown. I live in Georgetown. It's an hour and a half bus ride with a baby. How am I supposed to do that? And then I'd have to wait, and the baby would get fussy..." (Postnatal Mother 3,)

"I asked the nurse at the clinic about seeing someone to talk to about my anxiety. She said I'd have to refer you to the mental health outpatient clinic, but they don't have anyone who comes here. So, I just haven't gone." (Postnatal Mother 2, Clinic)

A healthcare provider confirmed these setting differences:

"At the hospital, we have access to mental health services on site, but we don't have a systematic way of identifying who needs them. In the community, the services simply aren't there. We refer, but we know most women won't travel to Kingstown." (Provider 2, Community Health Nurse)

Subtheme 2.2: Inadequate Screening and Follow-up

Both hospital and clinic providers acknowledged the lack of routine mental health screening.

"Honestly, we don't screen for mental health unless a mother is visibly distressed or crying. We're so understaffed and busy with physical assessments and vaccinations that mental health gets overlooked." (Provider 2, Community Health Nurse)

"In the postnatal ward, we're focused on discharge teaching, wound care, breastfeeding. We have a checklist, and mental health isn't on it. I know it should be, but we're working with the tools we're given." (Provider 1, Hospital Nurse/Midwife)

Subtheme 2.3: Financial and Practical Constraints

Financial barriers were more pronounced among clinic attendees.

Hospital Participants

"I'm fortunate that my job gives me full pay for three months maternity leave. not everyone gets that." (Postnatal Mother 5,)

Clinic Participants

"I wanted to see a private counselor because I heard the public system has long waits, but it's \$150 XCD per session. I can't afford that on top of baby expenses. My maternity leave is unpaid, so I'm surviving on savings." (Postnatal Mother 4,)

"The clinic is free, which is good, but they don't have the services I need. To get help, I'd have to pay for transport to town, pay for the appointment if it's private, and find someone to watch my other child. It's too many barriers." (Postnatal Mother 2).

Theme 3: Socio-cultural Influences

Subtheme 3.1: Stigma and Silence

Stigma was described similarly across both settings, suggesting it is a pervasive cultural factor.

"In Vincentian culture, we're taught to be strong, to handle things. If you say you're struggling emotionally, people might think you're crazy or not fit to be a mother." (Postnatal Mother 1,)

"My grandmother told me, 'We don't have depression in our family. Just pray and count your blessings.' That made me feel guilty for feeling sad when I have a healthy baby." (Postnatal Mother 3,)

A healthcare provider elaborated:

"Even when we suspect a mother is struggling, she may not admit it. There's a real fear of being judged by us, by her family, by the community. Some worry that if they admit to feeling depressed, someone might think they're a danger to their baby." (Provider 1, Hospital)

Subtheme 3.2: Cultural Expectations of Motherhood

This theme was universal across settings.

"Everyone tells you that having a baby is the happiest time of your life. When you're not feeling happy, you think something is wrong with you." (Postnatal Mother 4,)

"Social media makes it worse. You see these perfect mothers with their perfect babies, always happy and put together. Then you're in your pajamas all day, baby crying, house a mess, and you feel like you're failing." (Postnatal Mother 2,)

Theme 4: Personal Coping Strategies

Subtheme 4.1: Prayer and Spirituality

Prayer was the most frequently mentioned coping strategy across both settings, reflecting the strong religious culture in SVG.

"Every morning before the baby wakes, I spend time in prayer. It centers me and helps me face the day." (Postnatal Mother 4,)

"When I feel anxious, I repeat scriptures to myself. 'Be anxious for nothing.' It calms me down." (Postnatal Mother 2,)

Subtheme 4.2: Social Connection

The nature of social connections differed by setting, with hospital attendees more likely to mention online connections and clinic attendees describing in person community networks.

Hospital Participants

"I joined a WhatsApp group with other new mothers from the antenatal clinic. We share experiences, ask questions, and support each other. It helps to know I'm not alone." (Postnatal Mother 3,)

Clinic Participants

"The health center has a breastfeeding support group that meets once a month. We sit in a circle, the nurse gives a talk, and then we just chat. It's the only time I get to talk to other mothers." (Postnatal Mother 1)

Subtheme 4.3: Self-Care Practices

Mothers in both settings described similar small self-care practices.

"I make sure to shower and dress every day, even if I'm not going anywhere. It makes me feel human." (Postnatal Mother 2,)

"When the baby naps, I don't always clean. Sometimes I just sit and drink tea or read. I've learned that rest is important too." (Postnatal Mother 4,)

Healthcare Provider Perspectives

Table 7. Healthcare Provider Perspectives on Postnatal Mental Health Services n=2

Sl. No	Theme	Provider 1 (Hospital)	Provider 2 (Clinic)
1.	Common mental health challenges	Anxiety in first-time mothers	Stress related to finances and relationships
2.	Screening practices	No formal screening; rely on observation	No formal screening; rely on observation
3.	Referral pathways	Refer to mental health department but no feedback	Write referral letters; unsure if mothers attended
4.	Barriers to care	Lack of time during visits, lack of training	Geography, transportation, stigma
5.	Training needs	Training on how to have mental health conversations	Training/workshops in Basic mental health
6.	Recommendations	Integrate mental health into routine assessment	Integrate mental health into routine assessment

In table 7, based on the findings, the providers recognized the importance of postnatal mental health, but they lacked the protocols, training, and resources to address it systematically. Their perspectives highlighted the need for setting specific interventions that account for the unique barriers in hospital versus community settings.

Discussion

This study investigated the barriers and facilitators of mental health well-being among postnatal mothers in St. Vincent and the Grenadines through a mixed-methods. The findings revealed high rates of anxiety symptoms (100%), significant health system barriers, and important facilitators that could be leveraged to improve care.

Postnatal mothers in this study reported that 50% had depressive symptoms above the normal range, all reported anxiety symptoms, and 20% reported stress symptoms.

These findings are substantially higher than global averages reported in the literature. A systematic review by Woody et al. [2] reported that the prevalence of perinatal depression ranges from 10–20% globally. A meta-analysis by Shorey et al. [15] reported a pooled prevalence of postpartum depression of 17.7%

globally, with rates ranging from 6.5% in high-income countries to 25.8% in low- and middle-income countries. The finding that 100% of participants reported anxiety symptoms above the normal range is particularly striking and warrants urgent attention.

Several factors may explain this discrepancy. First, the small sample size may not be representative of the broader population of postnatal mothers in St. Vincent and the Grenadines. Second, DASS-21 measures symptoms over the past week, which may capture transient distress rather than clinical diagnosis. Third, the specific stressors faced by mothers in St. Vincent and the Grenadines including economic challenges, partner migration, and limited mental health services may contribute to higher symptom burden. Research by Fisher et al. [5] found that in low and middle-income countries, the prevalence of common perinatal mental disorders is influenced by socioeconomic factors, food insecurity, and lack of social support. The finding that 30% of participants in this study reported incomes below \$600 monthly supports this explanation.

The finding that 100% of participants reported anxiety symptoms above the normal range is consistent with research by O'Hara and

Wisner [4], who identified anxiety as a common but underrecognized component of perinatal mental health disorders, with prevalence rates ranging from 4% to 39% depending on the population and measurement instrument. However, the universal prevalence in this study far exceeds these estimates, indicating a potential public health emergency requiring immediate intervention.

The findings revealed that the lowest scores were in role limitations due to emotional problems (mean 45.8) and energy/fatigue (mean 52.5). These findings indicate that postnatal mothers experienced significant emotional distress that interfered with their ability to perform daily activities and maintain energy levels.

The low score in role limitations due to emotional problems (mean 45.8) suggests that emotional difficulties significantly impact participants' ability to work, manage household responsibilities, and engage in daily activities. This finding is consistent with a study by Ware and Sherbourne [16], who documented that emotional health has a substantial impact on functional status. The depression, anxiety, and stress reported by participants are not merely internal experiences but have tangible consequences for their ability to function in daily life. This finding is supported by research by McDonald et al. [17], who found that postpartum women report significantly lower scores on role limitations due to emotional problems compared to the general population.

The low energy/fatigue score (mean 52.5) reflects the substantial fatigue experienced by postnatal mothers. This finding aligns with research by Gjerdingen et al. [18], who identified fatigue as a major contributor to postnatal depression and a barrier to effective coping. The combination of emotional distress and fatigue creates a cycle that can exacerbate mental health challenges. Research by Dennis and Chung-Lee [12] similarly identified fatigue as a significant barrier to help-seeking among postpartum women.

The physical functioning domain (mean 77.6) and mental health domain (mean 67.6) reveal an important pattern. The higher physical functioning scores indicate that participants maintain relatively good physical health, while the lower mental health scores suggest that emotional well-being is more significantly impacted during the postnatal period. This is consistent with research by McDonald et al. [17], who found that postpartum women tend to report better physical functioning than emotional well-being, as the physical demands of childbirth and early motherhood may be anticipated while emotional challenges may be unexpected and more difficult to manage.

The distribution of physical functioning scores revealed that the majority of participants (50%) had mild to very mild limitations, with 20% reporting no limitations and 30% reporting moderate limitations. This indicates that physical health remains relatively intact for most participants. In contrast, the distribution of mental health scores revealed that only 30% of participants reported average mental health scores, while 20% reported good mental health. The remaining 50% reported mental health scores classified as poor (10%), below average (20%), or above average (20%). This indicates that half of the participants are experiencing significant mental health challenges.

Young mothers (18–24 years) had the lowest mean mental health score (61.0) and the widest range of scores (44–72). One participant in this age group reported a score of 44, classified as "Poor" mental health, which was the lowest score overall. Mothers aged 25–34 years had a mean mental health score of 72.0 and more consistent scores. Mothers aged 35–44 years had the highest individual score (84) but also a participant with a score of 60 (classified as "Below Average").

These findings are consistent with existing literature on age and perinatal mental health. A systematic review by Woody et al. [2] found that younger maternal age is a significant risk factor for perinatal depression, with adolescent

and young mothers having up to twice the risk of depression compared to older mothers. Similarly, a meta-analysis by Shorey et al. [15] reported that mothers under 25 years of age had significantly higher rates of postpartum depression than mothers aged 25 years and older. Research by O'Hara and Wisner [4] suggests that younger mothers may face additional stressors including financial instability, lack of social support, and developmental challenges associated with transitioning to parenthood at a younger age.

The finding that mothers aged 25–34 years had the most stable mental health scores is consistent with research by Gjerdingen et al. [18], who found that this age group often has more established social support networks, greater financial stability, and higher educational attainment, all of which serve as protective factors against postnatal mental health challenges. Research by Riaz and Fisher [19] found that older maternal age is associated with lower rates of postpartum depression, likely due to greater relationship stability and life experience.

The majority of participants (40%) were in the early postpartum period (1–4 weeks), followed by 30% in 5–8 weeks, 20% in 9–12 weeks, and 10% beyond 12 weeks. Research by Gjerdingen et al. [18] indicates that the early postpartum period is associated with the highest levels of stress, fatigue, and emotional lability, which may contribute to the elevated symptom scores observed in this study. The finding that the largest proportion of participants were in the first month postpartum may partially explain the high prevalence of depression, anxiety, and stress symptoms reported.

Barriers to Postnatal Mental Health Well-Being

The qualitative findings revealed several barriers at individual, family, and health system levels. These findings are discussed in relation to existing literature.

At the individual level, cultural expectations of strength and stigma emerged as significant barriers. This finding aligns with research by Abel and Richards-Henry [7], who found that stigma and cultural expectations of resilience contribute to underutilization of mental health services in the Caribbean. Similarly, St. Bernard [13] noted that Caribbean cultural values emphasizing personal strength may inhibit help-seeking behaviors. This finding also agrees with a systematic review by Fisher et al. [5], who identified stigma as a major barrier to perinatal mental health care in low- and middle-income countries.

A systematic review by Osok et al. [20] similarly found that cultural beliefs about mental illness, including the expectation that women should be "strong" and not complain, are major barriers to seeking care in low and middle-income countries.

At the family level, lack of partner support was identified as a significant barrier. This finding is consistent with research by Riaz and Fisher [19], who conducted a systematic review and found that partner support is a critical determinant of postnatal mental health, and its absence constitutes a major risk factor. In the Caribbean context, partner migration is common, creating unique challenges for postnatal support. Research by Thomas-Hope [21] found that transnational families in the Caribbean often experience disrupted support systems, with partners working overseas and mothers left to manage childcare alone. The finding that participants with partners working overseas reported greater difficulty aligned with research by the International Organization for Migration [22] on the impact of migration on family structures in the Caribbean.

Financial constraints were identified as a barrier to accessing care. This finding agrees with research by Paul and Edwards [23], who found that economic factors limit access to perinatal mental health services in the Caribbean. Similarly, a systematic review by Konlan et al. [24] identified financial barriers as

a significant factor affecting healthcare access in low- and middle-income countries. Research by Galle et al. [25] found that financial strain is a major contributor to stress and anxiety in perinatal populations, and the finding that 30% of participants reported incomes below \$600 monthly supports this relationship.

At the health system level, inconsistent use of screening tools, unclear referral pathways, and inadequate training were identified as barriers. These findings are consistent with research by Tomblin et al. [26], who found that unclear referral processes are a significant barrier to mental health care in Caribbean countries. The absence of standardized screening protocols identified in this study aligns with findings by Lipps et al. [27], who documented gaps in mental health screening in Caribbean healthcare settings. The training needs identified by healthcare workers agree with Nelson and Ramkissoon [28], who identified gaps in mental health education for Caribbean healthcare workers. A systematic review by Osok et al. [20] similarly found that lack of trained providers and inadequate screening tools are major barriers to perinatal mental health care in low- and middle-income countries.

Facilitators to Postnatal Mental Health Well-Being

Several facilitators were identified in this study. At the individual level, emotional safety and the opportunity to speak openly were identified as facilitators. This finding aligns with Kvale and Brinkmann's [29] emphasis on creating rapport and safety in healthcare encounters. The finding that participants valued being asked about their emotional well-being suggests that routine inquiry may itself be a facilitator for disclosure. This is supported by research by Dennis and Chung-Lee [12], who found that non-judgmental listening and validation are key facilitators for help-seeking among postpartum women.

At the family level, supportive partners and extended family were identified as facilitators. This finding is consistent with research by Riaz and Fisher [19], who found that partner and family support are protective factors for postnatal mental health. In the Caribbean context, extended family networks often play a crucial role in supporting new mothers. Research by Thomas-Hope [21] found that extended family support, particularly from mothers and grandmothers, is a significant protective factor for Caribbean mothers.

At the health system level, trust in healthcare providers and willingness to receive training were identified as facilitators. The trust relationships identified by healthcare workers align with research by Humphries et al. [30], who found that continuity of care and established relationships facilitate disclosure and help-seeking. The expressed willingness to receive training among all healthcare workers represents an opportunity for intervention, consistent with recommendations by the World Health Organization for strengthening the health workforce [1] and by Nelson and Ramkissoon [28] for mental health training in the Caribbean.

Conclusion

This study revealed that postnatal mothers in St. Vincent and the Grenadines experience exceptionally high rates of anxiety (100%), with 50% reporting depressive symptoms and 20% reporting stress symptoms above normal ranges. Young mothers (18–24 years) had the poorest mental health outcomes. Qualitative findings identified key barriers including cultural expectations of strength, stigma, lack of partner support, financial constraints, inconsistent screening practices, unclear referral pathways, and inadequate healthcare worker training. Facilitators included supportive partners and family, religious communities, and trust in healthcare providers.

Recommendations

1. Integrate routine mental health screening into all postnatal care encounters at both hospital and community clinic levels using validated tools such as the DASS-21.
2. Establish clear referral pathways between maternal health services and the outpatient Mental Health Clinics, with feedback mechanisms to ensure continuity of care.
3. Provide training for healthcare workers on postnatal mental health identification, compassionate communication, and evidence-based brief interventions.
4. Launch community awareness campaigns to reduce stigma and challenge cultural expectations of maternal strength that discourage help-seeking.
5. Conduct a larger-scale mixed-methods study to validate these preliminary findings and inform contextually appropriate intervention development.

Acknowledgement

I appreciate my supervisor for his invaluable guidance in completing this paper. I extend gratitude to the Ministry of Health, Wellness and the Environment of St. Vincent and the Grenadines for facilitating access to the postnatal ward and health centers. To the postnatal mothers and healthcare workers who gave their consent and participated willingly in this study, I thank you.

Ethics Approval and Consent to Participate

Ethical approval for this study was obtained from the Institutional Research Ethics

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Committee, Texila American University and Ministry of Health, Wellness and the Environment of St. Vincent and the Grenadines prior to data collection. Data was collected from the participants following strict adherence to the ethical guidelines of the institution. Written informed consent was obtained from all participants after explaining the purpose, procedures, benefits, and potential risks of the study. The participation in the current study was voluntary, and the rights to withdrawal from this was discussed before the data collection. Maintained confidentiality and anonymity of the participants during the research process.

Data Availability Statement

The data collected and the findings of the are available from the corresponding author upon reasonable request. The data from the participants were not publicly available as it is subjected to ethical approval and institutional data-sharing policies.

Authors' Contributions

Simone Roberts Kent conceptualized the study, developed the methodology, performed data collection and analysis, and wrote the original draft. Dr. Joseph Jeganathan provided supervision, validated the results, and reviewed and edited the manuscript. Both authors read and approved the final version.

Funding

The authors declare no funding was obtained from any agencies.

Conflict of Interest

The author declared that there is no conflict of interest related to this paper.

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