

## Barriers and Facilitators of Mental Health Well-Being Among Postnatal Mothers: A Systematic Review

Simone Roberts Kent<sup>1\*</sup>, Joseph Jeganathan<sup>2</sup>

<sup>1</sup>Department of Public Health, Texila American University, Guyana

<sup>2</sup>Department of Nursing, College of Health and Sport Sciences, University of Bahrain, Kingdom of Bahrain

### Abstract

*The postnatal mothers experience mental health challenges which include depression, anxiety, and stress. Although frequency is markedly higher in low- and middle-income countries (LMICs), systemic and cultural barriers often impede help-seeking and access to care, even as various facilitators promote resilience and recovery. This systematic review aims to assess the barriers and facilitators to mental health and well-being among postnatal mothers in St. Vincent and the Grenadines, synthesising findings from both qualitative and quantitative studies. A thorough, systematic search was conducted in electronic databases, including EBSCOhost, PubMed, PsycARTICLES, Google Scholar, and ScienceDirect, for studies published between January 2015 and April 2025. Studies included in this review are qualitative, quantitative, or mixed methods. The identified themes were categorized as individual, interpersonal, organizational, community and societal. The systematic review included eighteen studies. The main barriers were as follows: (1) Individual: low mental health literacy, stigma, and fear of judgment; (2) Interpersonal: lack of partner or family support; (3) Organizational: healthcare systems focused predominantly on infant physical health, poor provider communication, and fragmented referral pathways; (4) Community: cultural norms discouraging disclosure of emotional distress; and (5) Societal: financial constraints, geographical inaccessibility, and under resourced mental health services. The main facilitators included: strong social support networks, perceived self-efficacy, culturally sensitive and integrated care models, peer support programs, and technology-enabled interventions. By focusing on the unique culture within regions like the Caribbean, researchers can build a support system that ensures no mother has to struggle through the postnatal period alone.*

**Keywords:** Barriers, Facilitators, Help-Seeking, Maternal Mental Health, Postnatal, Postpartum, Systematic Review, Well-being.

### Introduction

Postnatal mental disorders are a significant public health concern internationally, with major implications for maternal morbidity, child development, and family wellbeing [1]. The most common condition identified is postpartum depression (PPD), with research estimating worldwide prevalence at 10-15% in high-income countries and 18-30% in low- and

middle-income countries (LMICs) [2, 3]. In addition to depression, high levels of anxiety, post-traumatic stress disorders (PTSD), and adjustment disorders have been recorded, especially in resource-constrained environments with limited systemic support [4].

The implications of unaddressed postnatal mental illness are extensive, impacting mother-

to-infant attachment, child cognitive and emotional development, and overall family functioning [5]. Despite this significant burden, a substantial treatment gap persists, globally.

A multifaceted network of individual, social, and systemic barriers prevents many women from being diagnosed and accessing treatment [4, 6]. Concurrently, an increasing number of studies identify protective factors, facilitators, and effective intervention strategies that can encourage resilience and recovery [7, 8].

Although previous reviews have examined PPD prevalence or intervention effectiveness, none have comprehensively considered barriers and facilitators of postnatal mental health well-being as a broader construct integrating positive mental states and functioning. Furthermore, the evidence base is biased toward high-income Western settings, with a notable gap in Caribbean regions such as St. Vincent and the Grenadines, where no local research on this subject was identified during initial scoping.

This systematic review addresses these gaps by evaluating and synthesizing international evidence on factors that inhibit or promote mental health well-being in postnatal mothers. The findings are expected to inform culturally sensitive, realistic, and effective interventions to enhance maternal mental health outcomes, particularly in under resourced and under researched context.

## **Methodology**

### **Protocol Registration and Reporting**

This review has been registered with PROSPERO (registration number CRD420261298809). PRISMA outlines the process involved in identifying, screening and selecting eligible articles that meet the inclusion and exclusion criteria [9]. PRISMA provides an internationally accepted framework ensuring transparency, completeness, and reproducibility. Using PRISMA helped reduce bias in search, selection, appraisal, and synthesis procedures, improving the reliability and credibility of our findings.

Specifically, the PRISMA checklist guided documentation of the search strategy, study selection criteria, data extraction methods, quality assessment procedures, and synthesis approach. Details for all records were maintained at each review stage. This methodological order was important given the sensitive nature of maternal mental health research and the importance of basing conclusions on the best available evidence.

### **Inclusion and Exclusion Criteria**

The review included qualitative studies, quantitative cross-sectional studies, cohort studies, and mixed-methods studies meeting the following criteria: (1) focused on postnatal mothers up to 12 months postpartum; (2) investigated barriers and/or facilitators related to mental health well-being, help-seeking, or service utilization; (3) published in English between 2015 and 2025; and (4) peer-reviewed primary research.

### **Exclusion Criteria**

Studies focusing only on antenatal mental health; interventions not reporting baseline data on barriers or facilitators; studies where the postnatal period was not clearly defined or was combined with pregnancy data without separate analysis; and studies not in English.

### **Information Sources and Search Methods**

Studies were searched using online databases such as EBSCOhost, PubMed, Google Scholar, PsycARTICLES, and ScienceDirect from January 2015 to April 2025. One of the main criteria was the study must be in English. Search terms were combined using Boolean operators and included: "postnatal" OR "postpartum" as well as "mother" OR "maternal"," mental health" "wellbeing", "depression" OR "anxiety", "barrier" OR "facilitator\*" OR "help-seeking" OR "access".

## Selection of Studies

The study selection process was rigorously documented and visually represented using the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flowchart, as recommended by the PRISMA guidelines. This standardized approach ensured full transparency and reproducibility of our selection process.

The selection proceeded in four distinct phases, corresponding to the four main sections of the PRISMA flowchart, namely; identification, screening, eligibility, and inclusion. Each is detailed as follows: -

**Identification:** All records identified through the database searches were collated, and duplicates were removed using End Note reference management software.

**Screening:** The titles and abstracts of all unique records were screened independently by the researchers against the inclusion and exclusion criteria. Records that clearly did not meet the criteria were excluded at this stage.

**Eligibility:** The full texts of all potentially relevant records were retrieved and assessed in detail for eligibility by the same two independent reviewers.

**Inclusion:** Studies that met all eligibility criteria were included in the final synthesis.

At each phase of screening and eligibility assessment, discussion was held between the researchers.

Some studies were excluded at the full-text review stage. The reasons were systematically recorded as for example, the population focused only on antenatal mental health, wrong outcome, and incorrect study design. These numbers, along with the counts of records at each stage, were used to populate the PRISMA flow diagram as shown in Figure 1.

This diagram provides a clear summary of the volume of literature identified, screened, excluded, and finally included, thereby documenting the decision trail and minimizing selection bias.

## Data Extraction

The researcher reviewed titles and abstracts against the inclusion criteria. The full articles of prospective studies were retrieved and assessed. The data from included studies were extracted using a standardized form, capturing authors, year, country, study design, sample characteristics, key findings on barriers, as well as key findings on facilitators.

## Assessment of Risk of Bias in Included Studies

Given the inclusion of diverse study designs (qualitative, quantitative, and mixed-methods), a rigorous and appropriate quality appraisal was conducted for all eighteen (18) included studies to assess methodological thoroughness and potential sources of bias. This assessment informed the interpretation of findings and contributed to the overall certainty of the evidence synthesized.

The methodological quality of the included studies was appraised using the relevant checklists from the Critical Appraisal Skills Programme (CASP), a widely recognized and validated tool for evidence-based practice. The appropriate CASP checklist was applied based on each study's design. See Table 1: CASP Quality Appraisal of Included Studies (n=18)

## Certainty of Evidence - GRADE-CERQual

This approach was applied to qualitative findings to assess confidence in the findings based on methodological limitations, relevance, coherence, and data adequacy. Each synthesized qualitative theme was rated as having high, moderate, low, or very low confidence.

**Table 1.** CASP Quality Appraisal of Included Studies (n=18)

Authors (Year)	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	%Yes	Risk of Bias
<b>Qualitative Studies</b>												
Adams et al. (2023)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	Low
Ahmed et al. (2017)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	Low
Ash et al. (2025)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	Low
Oladeji et al. (2025)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	90%	Low
Meireles et al. (2025)	Y	Y	Y	Y	Y	Y	N	N	Y	N	70%	Moderate
Place et al. (2024)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	Low
<b>RCT Studies</b>												
Dimidjian et al. (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	88.9%	Low
Grote et al. (2015)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	88.9%	Low
Milgrom et al. (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	88.9%	Low
Shorey et al. (2019)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	88.9%	Low
Letourneau et al. (2011)	Y	Y	Y	Y	Y	N	Y	Y	Y	N/A	77.8%	Moderate
<b>Quantitative Cross-Sectional Studies</b>												
Gidey et al. (2025)	Y	Y	Y	Y	Y	Y	N/A	Y	Y	N/A	87.5%	Low
Al Nasr et al. (2020)	Y	Y	Y	Y	Y	Y	N/A	Y	Y	N/A	87.5%	Low
Letourneau et al. (2012)	Y	Y	Y	Y	Y	Y	N/A	Y	Y	N/A	87.5%	Low
<b>Mixed-Methods Studies</b>												
McLeish et al. (2023)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	Low
Uzobo et al. (2022)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	90%	Low
Zhu et al. (2025)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	90%	Low
Fonseca et al. (2015)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	90%	Low

*Q indicates questions based CASP Qualitative Studies Checklist*

## Data Synthesis

A convergent narrative synthesis was employed. Quantitative and qualitative findings were first analyzed separately and then integrated using a socioecological framework (individual, interpersonal, organizational, community, societal). Qualitative themes were used to contextualize and explain quantitative associations, enabling a comprehensive understanding of how and why barriers and facilitators operate across levels.

## Results

### Search Result

#### Search Yield and Screening Process

The systematic search across five electronic databases (EBSCOhost, PubMed, PsycARTICLES, Google Scholar, and ScienceDirect) yielded an initial pool of 2,156 records published between January 2015 and April 2025. After removing 524 duplicate records using EndNote reference management

software, 1,632 unique records remained for title and abstract screening.

### **Title and Abstract Screening**

During this initial screening phase, 1,498 records were excluded as they did not meet the predefined inclusion criteria. Primary reasons for exclusion at this stage included:

1. Studies focusing exclusively on antenatal mental health without postnatal data (n=402);
2. Studies not investigating barriers, facilitators, help-seeking, or service utilization related to mental health (n=531);
3. Studies with an irrelevant population (e.g., focusing on fathers, healthcare providers only, or non-postnatal women) (n=312); and
4. Non-primary research articles, such as reviews, commentaries, or editorials (n=253).

The full texts of the remaining 134 potentially relevant articles were retrieved and assessed in detail against the eligibility criteria. During this phase, 116 articles were excluded. The main reasons for exclusion were:

1. The study population or timeframe - (postnatal period not defined or combined with antenatal data without separate analysis); n=51.
2. The outcome was not related to the inclusion criteria (did not examine barriers/facilitators of mental health wellbeing or related constructs); n=39.
3. The study design (e.g., protocol papers, intervention studies without relevant baseline qualitative or quantitative data on barriers/facilitators); n=20.

Articles not published in English: n=6

### **Final Included Studies**

Eighteen (18) studies met all inclusion criteria and were included in the final systematic review and synthesis. See PRISMA flow diagram (Figure 1).

### **Study Characteristics**

The final review included eighteen (18) peer-reviewed studies published between 2015 and 2025. The studies employed diverse methodological approaches: qualitative designs (n=6), quantitative cross-sectional designs (n=3), randomized controlled trials (RCTs) (n=5), and mixed-methods designs (n=4). See *Table 2: Comprehensive Characteristics of All Included Studies (n = 18)*

The studies were conducted across fifteen different countries and regions, namely:

1. Low and Middle-Income Countries (LMICs) (10 studies): Ghana, Ethiopia, Nigeria, Belize, Brazil, China, Portugal, Singapore, and multinational LMIC studies.
2. High-Income Countries (HICs) (8 studies): United States (4 studies), Canada (2 studies), United Kingdom, and Australia.

The geographical distribution reflects a notable, though not exclusive, focus on LMIC contexts, with strong representation from North America and Europe. This balance allows for comparison of barriers and facilitators across different healthcare systems and resource settings.

The inclusion of several study designs enabled a comprehensive examination of the research question. Qualitative studies (e.g., Ahmed et al., 2017; Ash et al., 2025) provided in depth insights into lived experiences and contextual factors influencing mental health help seeking. Quantitative cross-sectional studies (e.g. Gidey et al., 2025; Letourneau et al., 2017) identified frequency rates and statistical associations with barriers like low social support. Whereas, Randomized Control Trials, (e.g., Milgrom et al., 2016; Grote et al., 2015) evaluated the effectiveness of specific interventions such as internet based cognitive behavioral therapy and collaborative care models. Mixed-methods studies (e.g., e.g., McLeish et al., 2023; Zhu et al., 2025) offered integrated perspectives by combining statistical trends with qualitative explanations.

## **Participant Characteristics**

Participants across eighteen included studies were postnatal mothers from diverse geographical, cultural, and socioeconomic backgrounds. The review captured experiences from both high-income settings (n=8 studies) and low and middle-income countries (n=10 studies), providing a global perspective.

The age range of participants across all studies was 18 to 45 years, consistent with the typical reproductive age for postnatal mothers. Sample sizes varied from smaller qualitative explorations (n=22-43) to larger quantitative surveys (n=300-800). Several studies specifically focused on populations facing distinct vulnerabilities or systemic barriers.

## **Barriers of Mental Health Well-being Among Postnatal Mothers**

The obstacles identified were many-sided and interrelated on five levels.

### **Individual Level Barriers.**

Commonly identified barriers included a lack of mental health literacy and stigma [10, 11]. In qualitative studies, participants described normalizing their distress as part of the “motherhood experience.” For example, one mother in Ghana shared:

*“I thought feeling sad was just part of having a baby... I didn’t know it could be treated.” (10)*

Another participant from a Syrian refugee community in Canada expressed:

*“If I say I am not well in my mind, people will say I am a bad mother.” (11)*

These narratives illustrate how shame and fear of being labeled an “unfit mother” deter help-seeking [12]. Quantitative studies supported this, showing that lower mental health literacy scores were significantly associated with delays in seeking care (17).

### **Interpersonal Level Barriers**

Lack of social support, particularly from intimate partners and family members was a powerful predictor of poor mental health outcomes and negatively influenced help-seeking [14, 15]. Qualitative data revealed emotional themes, as one mother noted:

*“That admitting to needing help would make them appear as “weak.” (15)*

Quantitative surveys confirmed that low partner support was a significant risk factor for postnatal depression (14).

### **Organizational and Institutional Barriers**

A major theme was the neglect of maternal mental health assessment in postnatal care services. Healthcare systems were perceived as primarily focused on infant physical health, with little attention to maternal mental health [10]. A mother in Belize explained as follows:

*“The nurse only checked the baby. She never asked how I was feeling.” [21]*

Fragmented care and ineffective referral systems also created uncertainty about where to seek help [11]. Quantitative studies from LMICs highlighted that fewer than 20% of postnatal visits included mental health screening [17].

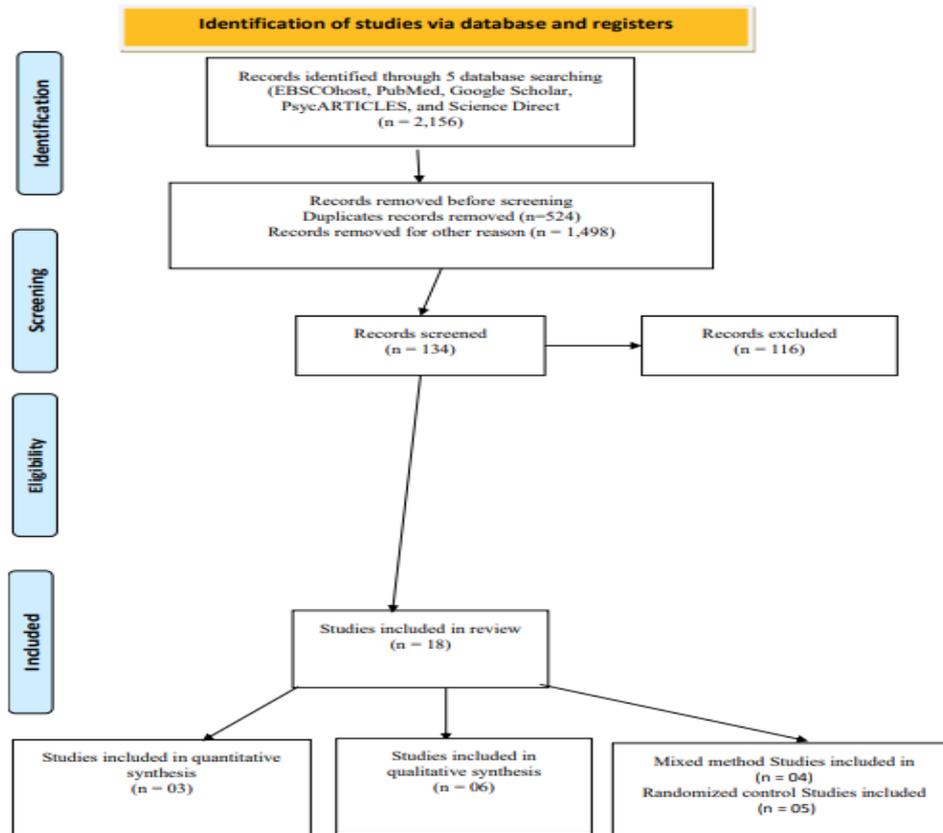


Figure 1. PRISMA Flow Diagram of Study Selection Process

Table 2. Summary of Included Study Characteristics

Author(s) (Year)	Country/Region	Study Design	Sample Size & Characteristics	Key Focus Area	Main Findings Related to Barriers	Main Findings Related to Facilitators
Adams et al. (2023)	Ghana	Qualitative descriptive	30 participants (15 mothers, 15 providers)	Postpartum care needs assessment	Focus on infant health; poor provider communication; low symptom awareness	Need for integrated maternal mental health screening (10)
Ahmed et al. (2017)	Canada (Syrian refugees)	Qualitative phenomenological	25 refugee postnatal women	Maternal depression in refugee women	Stigma; cultural shame; distrust of Western medicine	Importance of culturally safe spaces; interpreter services (11)
Ash et al. (2025)	USA	Qualitative focus groups	43 Black perinatal women	Barriers to accessing mental health supports	Affordability; medical distrust; racial bias	Culturally concordant providers; community-based programs (12)

Oladeji et al. (2025)	Belize	Qualitative exploratory	22 young mothers	Help-seeking barriers in SIDS	Stigma; service availability; awareness	Community education; youth-friendly services (21)
Meireles et al. (2025)	Brazil & Spain	Qualitative cross-cultural	35 postpartum women	Perinatal support and maternal mental health	"Baby blues" normalization	Cultural adaptation of interventions (26)
Dimidjian et al. (2016)	USA	RCT	86 women with depression history	Mindfulness-based cognitive therapy	Risk of relapse; anxiety about treatment	Mindfulness skills; relapse prevention strategies (16)
Grote et al. (2015)	USA	RCT (MOMCare)	168 disadvantaged mothers	Collaborative care for perinatal depression	Fragmented care; socioeconomic barriers	Stepped care; care coordination; psychotherapy access; 50% increased service utilization (18)
Milgrom et al. (2016)	Australia	RCT	63 postnatal women	Internet-based CBT (MumMoodBooster)	Stigma; accessibility issues	Online CBT accessible; private; effective (20)
Shorey et al. (2019)	Singapore	RCT	50 postnatal mothers	Technology-based peer-support intervention	Time constraints; childcare duties	Mobile apps convenient; peer support online (22)
Letourneau et al. (2011)	Canada	RCT	120 mothers	Home-based peer support for PPD	Isolation; transportation issues	Telephone support bridges access gaps (25)
Gidey et al. (2025)	Ethiopia	Quantitative cross-sectional	800 postnatal mothers	Prevalence of postpartum depression	High anxiety (22.2%); PTSD (8.3%); spiritual beliefs reduce help-seeking by 40%	Screening for anxiety disorders (17)
Al Nasr et al. (2020)	Saudi Arabia	Quantitative cross-sectional	246 postnatal mothers	Prevalence and predictors of PPD	Low social support; previous depression history	Partner support; family involvement (14)
Place et al. (2024)	USA	Qualitative systematic review	Qualitative systematic review	Not specified	Individual: stigma, embarrassment, fear of judgment, low mental health literacy Interpersonal: lack of	Multi-level recommendations: public awareness campaigns; partner involvement; integrated care models; culturally competent care;

					partner/family support, fear of child removal Organizational: poor provider communication, fragmented care Community: cultural norms, community stigma Societal: financial constraints, policy gaps	policy changes; universal screening (15)
McLeish et al. (2023)	UK	Mixed-methods realist review	150 postnatal mothers	Community-based perinatal mental health peer support	Isolation; lack of accessible services	Peer support reduces isolation; flexible service delivery (13)
Uzobo et al. (2022)	Nigeria	Mixed-methods	120 postnatal mothers	Prevalence and coping strategies for PPD	Stress from role transition; limited support	Resilience; adaptive coping; social support (19)
Zhu et al. (2025)	China	Mixed-methods convergent	561 screening-positive women	Mental health service utilization	Financial barriers (45.5%); spousal support lack	Financial support; partner education (23)
Fonseca et al. (2015)	Portugal	Mixed-methods	200 perinatal women	Acceptability of e-mental health interventions	Digital literacy; privacy concerns	High acceptance of online resources (24)
Webb et al. (2021)	UK (Systematic review)	Systematic review	52 studies included	Barriers and facilitators to implementing perinatal mental health care	Fragmented services; inadequate training; lack of referral pathways; stigma; time constraints	Collaborative care models; integrated services; specialist perinatal mental health teams; clear referral pathways; leadership support. (27)

*Comprehensive Characteristics of All Included Studies (n = 18)*

*Note. Note. PPD = postpartum depression; SIDS = Small Island Developing States; RCT = randomized controlled trial; CBT = cognitive behavioral therapy; PTSD = post-traumatic stress disorder.*

### Community and Cultural Barriers

Cultural attitudes that stigmatized mental health issues while glorifying maternal strength

inhibited disclosure. In some contexts, spiritual attributions prevented women from seeking medical care. As a participant from Nigeria stated,

*“In my culture, we say it’s an evil spirit... so you pray, you don’t go to hospital.” [19]*

Quantitative findings from Ethiopia showed that women who held spiritual beliefs about mental distress were 40% less likely to seek professional help [17].

### **Societal and Structural Barriers**

Practical and economic constraints were significant, especially in LMICs and marginalized communities. These included direct care costs, transportation challenges, childcare responsibilities, and inflexible work policies [16, 23]. For instance, a black mother in the U.S. shared:

*“I couldn’t afford therapy, and I had no one to watch the baby.” [12]*

Macro-level barriers included under resourced mental health services and lack of insurance coverage [27], which were quantitatively linked to lower service utilization in LMICs [23].

### **Integration of Qualitative and Quantitative Findings**

The synthesis followed a convergent narrative approach. Quantitative data identified the prevalence and statistical associations of barriers (e.g., low social support predicting PPD), while qualitative findings provided depth, context, and lived-experience explanations.

Examples of quantitative studies showed that stigma was correlated with help-seeking delays [17]; qualitative narratives illustrated how stigma was experienced in daily interactions and internalized as shame [11, 12].

This integration enabled a richer, multi-layered understanding of how barriers operate and reinforce each other across individual, interpersonal, and systemic levels.

### **Facilitators of Mental Health Well-being Among Postnatal Mothers**

From the review many of the facilitators were a direct opposite of those identified as barriers.

### **Individual and Interpersonal Levels**

High maternal self-efficacy and resilience were identified as key protective factors [14]. Qualitatively, mothers expressed how confidence in their parenting abilities improved their emotional well-being. One participant in Nigeria shared:

*“Knowing I can comfort my baby made me feel stronger in myself.” [19]*

Strong, empathetic social support from partners, family, and friends was especially vital [18]. A mother in Canada noted:

*“My sister listened without judgment. That alone lifted a weight.” [15]*

A recent systematic review confirmed that social support serves as a critical coping resource for psychosocial conditions throughout the postpartum period, with strong support networks significantly reducing the risk of adverse mental health outcomes [31, 32].

Peer support was particularly effective in reducing loneliness and normalizing emotional experiences. In a UK-based study, a participant explained:

*“Talking to other mums who felt the same, it made me feel normal, not broken.” [13]*

Quantitative studies reinforced these findings, showing that high social support scores were associated with significantly lower depression and anxiety scores [14, 17].

Organizational and Service-Level Facilitators Integrated healthcare models that incorporated mental health screening and support into routine maternal and child health visits were highly beneficial [21, 22]. A mother in the U.S. reported,

*“When my pediatrician asked about my mood, I finally felt seen.” [18]*

Trusting, compassionate, and knowledgeable healthcare providers who initiated mental health conversations were crucial. Warm referral pathways where providers directly connected mothers to mental health services also improved engagement.

Qualitative themes highlighted the importance of continuity and empathy, as reflected in a participant's comment from Ghana:

*"The midwife stayed with me, she explained everything. I trusted her advice."* [10]

Quantitative data from RCTs supported that integrated care models increased mental health service utilization by up to 50% in disadvantaged populations [18].

Intervention and Innovation Facilitators Evidence-based psychosocial interventions such as cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) delivered individually or in groups were effective [23, 24, 29]. Home-based peer support programs have also demonstrated significant improvements in maternal-infant interactions among women with postpartum depression [25]. Culturally adapted preventive interventions have shown particular promise for high-risk populations, including immigrant and minority women [30].

Technology based interventions, including internet-based CBT programs and mental health apps, showed promise in overcoming accessibility barriers and reducing stigma.

A participant from Australia noted: *"Doing the online program at night when the baby slept... it was private and on my time."* [20]

Another mother in Singapore appreciated the flexibility of mobile support:

*"The app connected me to other mums and tips, without having to leave home."* [22]

Quantitative RCT results confirmed that digital interventions significantly reduced depressive symptoms compared to usual care [20, 22].

Community and Societal Facilitators Community health worker programs and public health campaigns that promoted mental health literacy and reduced stigma helped create supportive environments.

Policies that mandated maternal mental health screening and provided perinatal resources served as critical structural

facilitators [21]. International guidelines, such as those from the World Health Organization, emphasize the importance of integrating mental health assessment into routine postnatal care [28].

In Belize, a young mother highlighted the role of community education: *"After the village talk about postnatal depression, my family started to understand."* [21]

Quantitative evaluations indicated that communities with active mental health awareness campaigns reported higher help-seeking intentions [23, 27].

### **Integration of Qualitative and Quantitative Findings**

The facilitators were synthesized using a convergent narrative approach, where quantitative evidence identified what works (e.g., effect sizes of interventions) and qualitative data explained why and how these facilitators are experienced as meaningful.

For example, quantitative studies showed peer support reduced depression score [13, 20]; qualitative accounts revealed that this was due to reduced isolation and increased validation. Similarly, while RCTs demonstrated the efficacy of digital tools [20, 22], qualitative feedback highlighted their value in providing privacy and flexibility. This integration underscores that effective facilitation requires both evidence-based strategies and empathetic, context-sensitive delivery.

### **Discussion**

This systematic review of eighteen (18) studies from multiple countries provided a multi-level analysis of factors impeding and promoting mental health well-being in postnatal mothers. Results reveal an intricate network of interrelated factors, with obstacles reinforcing each other across levels and creating cumulative disadvantages, particularly for women in LMICs and marginalized groups.

The findings reaffirm that challenges are rarely unidimensional. A mother experiencing

postnatal depression may simultaneously contend with internalized stigma (individual level), lack of childcare resources (interpersonal level), dismissive healthcare interactions (organizational level), and care unaffordability (societal level). These intersecting challenges are particularly acute for mothers in LMICs and marginalized groups [2, 17].

The identified facilitators offer a blueprint for intervention. These facilitators move beyond simply "increasing services" to emphasise how services should be delivered in an integrated, stigma-free, relationship-centred manner. The effectiveness of peer support and task sharing interventions suggests strengthening community networks as a high-impact strategy in resource-constrained areas. The effectiveness of peer support and task sharing interventions, including home-based programs [25] and culturally adapted approaches [30], suggests strengthening community networks as a high-impact strategy in resource-constrained areas.

Digital interventions show promise for reaching isolated mothers and those unable to access services in person.

The lack of research from Caribbean has been identified as a significant literature gap. It is therefore recommended that future studies address this to develop contextually appropriate interventions, potentially drawing on cross-cultural insights from similar contexts [26] and established international guidelines [28].

## Limitations

This review gathered both qualitative and quantitative data to examine existing barriers and facilitators to accessing mental health wellbeing among postnatal mothers. There are several limitations to our systematic review methods.

Firstly, the exclusion of research published in languages other than English may result in the omission of valuable data from non-English speaking regions, potentially introducing

language bias and limiting the global comprehensiveness of our findings.

Secondly, the heterogeneity of study designs included (qualitative, quantitative cross-sectional, RCTs, mixed-methods) presents challenges for direct comparison and synthesis. While this diversity allowed for a multi-faceted understanding of the issue, it limited our ability to conduct a meta-analysis or draw unified quantitative conclusions about the prevalence or effect sizes of specific barriers and facilitators.

Thirdly, there is an over representation of qualitative studies from LMIC contexts in our included studies. While this provides rich, context specific insights into under researched populations, it affects the balance of evidence and may limit the transferability of some findings to high income settings. Conversely, quantitative evidence, particularly intervention studies was more prevalent from high-income countries, creating a geographical imbalance in the types of evidence available.

Furthermore, some data might have been unrepresented, underreported, or misreported due to the sensitive and highly stigmatizing nature of mental health issues among postnatal mothers globally. This might have resulted in publication bias and methodological quality issues.

Additionally, while we conducted a quality appraisal using CASP checklists, the lack of a standardized, weighted quality scoring system across all study designs means our appraisal was primarily descriptive. Future reviews could benefit from a more quantitative approach to quality assessment to better weigh evidence from studies of differing methodological rigor.

Lastly, most studies lacked sufficient reflexivity about researchers' positions and assumptions, particularly in qualitative studies exploring culturally sensitive topics. This situation limited the critical interpretation of how the researcher's background has influenced data collection and analysis.

## Conclusion

This systematic review examined the barriers and facilitators to mental health well-being among postnatal mothers. The evidence suggests that stigma, practical constraints, and limited social support are major barriers for postnatal women. The main facilitators include strong support networks, accessible and appropriate services, and maternal resilience. These findings can inform the development of targeted interventions, policy changes, and clinical practices to better support postnatal mental health.

## Abbreviations

PPD = postpartum depression; LMICs = low- and middle-income countries; SIDS = Small Island Developing States; RCT = randomized controlled trial; CBT = cognitive behavioral therapy; IPT = interpersonal therapy; PTSD = post-traumatic stress disorder; DASS = Depression Anxiety Stress Scales; PRISMA-P: Preferred Reporting Items for Systematic Review and Meta-analysis Protocols; PROSPERO: International Prospective Register of Systematic Reviews; WHO: World Health Organization.

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## 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.

## Data Availability Statement

The data used in this systematic review were obtained from publicly available databases, including EBSCOhost, PubMed, Google Scholar, PsycARTICLES, and Science Direct and are fully referenced in the manuscript. Data are available on reasonable request to the corresponding author.

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## Ethics Approval and Consent to Participate

Not applicable.

## Consent for Publication

Not applicable.

## Competing Interests

Authors declare that they have no competing interests.

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