Original Article

"How can I seek a consultation if I don't have a high fever ?": Barriers to Mental Healthcare Access for Women in the Perinatal Period in Rwanda

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Cite as: Umuziga MP , Gishoma D, Michaela H , Nyirazinyoye L, Nyiringango G. *"How can I seek a consultation if I don't have a high fever ?"*: Barriers to Mental Healthcare Access for Women in the Perinatal Period in Rwanda. Rwanda J Med Health Sci. 2024;7(2): 302-318. https://dx.doi.org/10.4314/rjmhs.v7i2.17

Abstract

Background
Literature highlights barriers to mental healthcare access in the perinatal period, but none specific to Rwanda. The unique historical context of the genocide against the Tutsi may present distinct challenges. This study aimed to identify these barriers in Rwanda.
Methods
This study employed a qualitative interpretive descriptive approach as part of a multi-method investigation. Four focus group discussions were conducted with 31 perinatal women, and 32 individual interviews were conducted with healthcare providers, including community health workers. Data were analysed thematically.
Results
Barriers were identified at multiple levels. At the individual level, barriers included low literacy about perinatal mental health symptoms, minimizing negative experiences, fear of being stigmatized, ignorance about the availability of mental health services in the perinatal period, and economic challenges. Family and social-cultural barriers included stigmatization of people with mental health problems, minimization of what happened by friends and family, and lack of support from partners and friends. Institutional and structural barriers included limited services, misdiagnosis, heavy workloads, staff unawareness, and lack of training and guidelines for screening and reporting.
Conclusion
This study identified barriers to perinatal mental healthcare at individual, family and social-cultural, institutional and structural levels. Addressing these barriers requires targeted strategies to improve perinatal mental healthcare access across all identified levels.
Rwanda J Med Health Sci 2024;7(2):302-318

Keywords: access to mental health care, barriers, perinatal mental health, perinatal period, Rwanda

Background

Many women experience fluctuations in their mental well-being throughout pregnancy and the year following childbirth, a time known as the perinatal period. Perinatal mental health problems refer to a group of common mental health conditions during the perinatal period that range from depression and anxiety disorders during pregnancy to maternity blues, postnatal depression, bipolar disorder, and post-partum psychosis.[1,2] The World Health Organization (WHO) indicates that one in five women encounters a mental health condition during the perinatal period.[3] Low and middle-income countries (LMICs) face a more significant burden of disease, where it is estimated that mental disorders affect 19.8% of postnatal women and 15.6% of pregnant women.[1]

The mental health of the Rwandan Population has been impacted deeply by the 1994 genocide against the Tutsi. A recent mental health survey reported a high prevalence of mental health problems in the general population (20.49%); mental disorders were more prevalent among women (23.2%) than men (16.6%) and genocide survivors are the most affected population (52.2%).[4] Perinatal mental health problems are also relatively common in Rwanda. Previous studies on perinatal depression demonstrated that antenatal depression affects one in four pregnant women,[5] and one in five women in the postnatal period.[6] Despite this high burden of mental health problems in Rwanda, and efforts made to improve and integrate mental health care at all levels of the health system, there is a low utilization of mental health services (5.3%),[4] and those affected do not receive the treatment they need and there is no guideline about perinatal mental health services.[5,6]

Mental health issues during the perinatal period (from pregnancy to one year after childbirth) often necessitate immediate intervention due to their potential impact on the infant's well-being as well as that of the mother. These challenges can affect a woman's capacity to manage daily tasks, like caring for her child and family. Perinatal mental health problems lead to reduced utilization of available services due to a lack of motivation and interest, diminished energy, and concerns about being discriminated against.[7] As access to care diminishes, it subsequently results in unfavorable outcomes for both the mother and baby, amplifying maternal stress levels and exacerbating her mental health issues.[8] It has been reported that perinatal mental health problems are among the principal causes of maternal morbidity and mortality.[9] Unfortunately, such issues frequently remain unnoticed and untreated during this critical period.

Despite the enormous need to care for perinatal mental health problems, different barriers to seeking maternal mental health care have been identified by various authors. Many women refrain from seeking assistance, fearing the stigma and potential repercussions of revealing their concerns, opting to keep their struggles private.[10] In Uganda, a study by Nakku et al. identified barriers such as poor partner support, stigma, lack of financial support and accessibility,[11] while Lara and colleagues have reported several additional barriers, including shortage of time among healthcare providers, lack of childcare, not knowing where to go, lack of transportation, cost, absence of interpersonal support, help-seeking and treatment experiences, and relationships with health professionals.[12] A systematic review to identify barriers to seeking help for postnatal depression reported women's inability to disclose feelings, an inability often reinforced by family members; and health professionals' reluctance to respond to mothers' emotional and practical needs, as common barriers to treatment.[13] Larsen and colleagues identified that a lack of validated tools for identifying symptoms of perinatal depression was a barrier to improving perinatal mental health in Sub-Saharan Africa.[14]

A systematic review by Bayrampour and colleagues noted other barriers to accessing mental healthcare including lack of training and time constraints on the part of providers, and lack of clinical support and supervision for primary healthcare providers.[10]

While available literature explains the prevalence and consequences of common perinatal mental disorders, there is a lack of knowledge on accessing evidence-based care for perinatal mental health problems in LMICs, including Rwanda, and more needs to be known about potential factors affecting help-seeking behaviours. Therefore, this study sought to identify barriers to accessing mental health services in Rwanda and a deeper understanding of those barriers that may be unique to the Rwandan context.

Study context

Rwanda is a landlocked, low-income country in East Africa with a population of around 13.2 million.[15] The government of Rwanda has prioritised mental health, promoting the accessibility and integration of mental health services at all levels of the healthcare system, including the community health workers' program. The country decentralized and integrated mental health services from national referral hospitals to health centers, where trained health professionals (including psychiatrists, mental health nurses, clinical psychologists, and general nurses and general practitioners) conduct assessments of, and provide care and treatment for, a wide range of mental health needs. This includes mental health units at district hospitals and at almost all health centers, which provide mostly individualized psychotherapy and pharmacotherapy to diagnosed patients.

The Rwanda health system is a pyramid structure, with community health workers (CHWs), health posts, and health centres at the bottom of this pyramid. CHWs play a crucial role within the healthcare system at the community level. Specifically focusing on maternal health, CHWs actively engage in connecting community members to the formal healthcare system to address various maternal care requirements, including preventive measures, routine check-ups, and managing acute care needs.[16,17] Therefore, the opportunity for screening perinatal women for mental health problems would be missed if there were no available guidelines and protocols at this level.

Methods

Study design

This study is part of a multi-method investigation on maternal mental health in several communities in Rwanda. In this part of our research, we utilized a qualitative research design employing the interpretive descriptive design outlined by Thorne,[18] to investigate barriers hindering perinatal women from accessing mental health services in Rwanda. Interpretive descriptive (ID) design, emphasizes offering detailed and contextualized descriptions of a phenomenon, highlighting the significance of understanding human experiences within particular contexts, and acknowledging the interpretative aspect inherent in qualitative research.[19] The choice of interpretive descriptive design aligns with the aims of this study for identifying barriers to accessing mental health services in the perinatal period in Rwanda. This methodology aligns with a constructivist and naturalistic orientation to inquiry, aiming to produce knowledge relevant to the natural context.[18,20]

Study participant recruitment and setting

The research was conducted across four health centers (HCs) situated in two administrative districts within the Southern Province of Rwanda. These HCs were chosen with consideration for their characteristics, specifically focusing on one urban and one rural HCs in each district. One focus group was conducted per HC for a total of 4 focus groups. The participants for the focus group discussions comprised 31 women in the perinatal period (antenatally and postnatally equally selected), aged between 19 to 45 years, seeking antenatal care or immunization services at the HC.

Each focus group discussion comprised from 6 to 10 participants at each site. The study also involved interviews with healthcare providers including managers of maternal healthcare services in each of the HCs. Interviews were conducted with 16 primary healthcare providers, four per HC, including nurses and midwives working in antenatal care (ANC), maternity, and immunization services. An informal discussion was held with one Community and Environmental Health Officer (CEHO) responsible for Community Health Workers (CHWs) in each site. Finally, 16 CHWs were also interviewed, four per HC. The selection of CHWs in charge of maternal health as participants was purposeful, considering factors such as accessibility and distance to the health center. For each HC, two CHWs were selected from villages near the HC, and another two were chosen from villages farther away.

Sampling strategies and sample size

In this study, we used purposive sampling to solicit data collection from perinatal women and healthcare providers including CHWs, about barriers to accessing mental health services in the perinatal period. Consistent with Burdine and colleagues,[20] the choice of this sampling strategy was based on identifying, in advance, the main groupings or conditions of individuals that can contribute significantly to the objectives of the study. The sample size was not determined by data saturation, but rather by the aim of gaining a comprehensive understanding of participant perspectives from different categories and site characteristics. According to Thorne, data saturation is not a desired outcome in ID because the applied and practice disciplines tend to appreciate that experience can theoretically possess infinite variation. Instead, the focus should be on obtaining a deeper understanding of participants' perspectives while recognizing that variations in perceptions and outliers may exist.[18] Consequently, each focus group consisted of six to ten individuals (women in perinatal period).

We also conducted 16 individual interviews (four in each HC) with primary healthcare providers (PHCPs) and CHWs.

As noted above, at each health center, we conducted individual interviews with four HC healthcare providers who work with women in the perinatal period, and four CHWs responsible for women in the perinatal period per each HC.

Data collection

After presenting the ethical approval to the manager of each health center (HC) and obtaining permission to collect data, we approached women in the perinatal period who were attending ANC and immunization programs and PHCPs affiliated with the selected HCs. We presented our study and invited them to take part. Participants signed the informed consent and then engaged in either a focus group discussion (perinatal women) or an individual interview (healthcare providers including CHWs). We conducted one focus group in each HC with women in perinatal period. All women contacted and who met inclusion criteria agreed to participate.

A semi-structured interview guide was developed to aid data collection based on the study objectives. The interview guide was developed in English and translated into Kinyarwanda, because many participants use Kinyarwanda as their language of communication. The data were collected by the first author with assistance from a data collector. For triangulation purposes, the study used focus group discussions and individual interviews. Both focus group discussions and individuals interviews were face-to-face. Before gathering data, participants were briefed about the audio recording of the interview and assured that there would be no collection of personal identifying information, guaranteed confidentiality, and informed of the option to halt the interview at any time without consequences. Moreover, participants were encouraged to ask questions, and the interviewers provided appropriate responses. Written consent was obtained from participants before we started.

The interview began with general questions to establish a comfortable conversational atmosphere before delving into specific subjects. Probing questions were utilized to gain further insight, and a second data collector documented field notes. The interviews were conducted in the local language (Kinyarwanda). Before commencing each subsequent interview, the data collectors reviewed the previous interview to familiarize themselves with effective strategies for the upcoming session. The focus group sessions ranged from 60 to 90 minutes, while individual interviews typically lasted 20 to 30 minutes. Following this, the interviews were transcribed verbatim and subsequently translated into English to aid the analysis process.

Data analysis

Data analysis was carried out using both inductive and deductive thematic analyses.[21] Inductive analysis was used for identifying the codes and forming subthemes, while deductive analysis was used in the presentation of themes. Both manifest and latent analyses were employed. Each interview was read in full by two researchers independently and then analysis was undertaken and comprised three levels: Level one: This involved a thorough examination of the data, leading to the identification of codes from the transcripts. This was done individually by the two researchers. A definition of each code was developed. Level two: The two researchers who were involved in coding collaborated to compare and organize data, forming subthemes through clustering and condensation of codes. Level three: The formed subthemes were then applied deductively to develop themes that illustrate barriers to mental health service accessibility in the perinatal period. Deductively, the subthemes that emerged from our results were classified into themes identified in the adapted multilevel conceptual framework for barriers to mental health services in the perinatal period proposed by Smith et al.. [22]

Smith et al. [22] framework for barriers to accessing perinatal mental health services was adapted in our study to aid the synthesis and summarizing of the study findings. The model posits that mental health service delivery in the perinatal period is affected at individual, organizational, sociocultural, and structural levels. The individual-level characteristics we identified were slightly different from those in the original model adapted by Smith et al.,[22] which includes behaviour of the community, health professionals, and health administrators working at different levels (see Table 1). We removed that in our study because the behavior, attitudes, perceptions, and beliefs of the family, healthcare providers, and the community constitute the culture and the behavior of the surrounding environment of a woman in a perinatal period in a given society.

In the adapted model by Smith et al.[22] the sociocultural-related barriers included language, cultural values of the community, and women's perceptions of perinatal depression. In the current study, we included family and social-cultural level barriers, but women's perceptions were moved to the individual level. The organizational-level barriers include the capacity and readiness of the health facilities or organizations to provide maternal mental health services. This might have elements such as lack of resources (trained workforce, money), time (patient load), space (lack of adequate offices), lack of clarity in roles and responsibilities, and lack of working manuals, screening tools, treatment guidelines, and protocols. Finally, structural level barriers include lack of policy, program, and strategies, low attention and initiation by the government, and lack of transparent system and structure. In our study, the two levels were merged. We observed that organizational and structural level barriers are closely interconnected.

Table 1. Adapted multilevel framework for barriers to mental health services in the perinatal period

Framework according to Smith [22]	**Framework adapted in this study**
Individual level factors (factors from patient, partner/family, and healthcare professionals)	Individuals (specific factors to the patient)
Social-cultural level factors (factors of language barrier, differences of cultural values)	Family social-cultural factors (Factors from partner, family, friends, and community in general)
Organizational level factors (Inadequate resources, fragmented services) Structural level factors (unclear policy)	Institutional-structural level (Factors from health institutions, health policies, and healthcare providers)

Ethical consideration

The research was approved by the University of Rwanda/College of Medicine Institutional Review Board (No 067/CMHS IRB/2019). Participants were informed about the purpose, objectives, and their right to decline participation or withdraw from participation at any time. Informed consent was obtained from each participant; all participants were above the legal age of assent for research in Rwanda (18 years of age). Privacy and confidentiality were maintained throughout the study.

Results

Characteristics of study participants

Table 2. Characteristics of participants involved in the study

Participants categories	**Perinatal women (N=31)**	**CHWs (N=16)**	**HCPs (N=16)**
Age (range)	19-45	35-50	28-49
Marital Status			
Single	8	0	2
Married	12	10	13
Living with a partner	10	0	0
Separated/divorced	1	0	0
Widow	0	6	0
Other (religious)	N/A	N/A	1
Education level			
Primary	23	14	0
High school (A2)	6	0	8
Advanced Diploma (A1)	1	0	5
Bachelor degree	1	0	3
Occupation/Position			
Farming and crops	21	13	0
Self-employed	2	3	0
Employed	1	0	16
No permanent job	2	0	0
Unemployed	5	0	0

A total of 63 participants consented to take part in this study; 31 women in the perinatal period in focus group discussions; 16 community health workers and 16 healthcare providers.

Socio-demographic characteristics are detailed in Table 2. The age range of perinatal women, both antenatal and postnatal, was between 19 and 45 years. Community health workers (CHWs) responsible for maternal health ranged in age from 35 to 50. Healthcare providers' ages ranged from 28 to 49 years old. The majority of perinatal women, as well as CHWs and healthcare providers, were legally married.

Identified multilevel barriers to perinatal mental healthcare access in Rwanda

In this study, the findings were organized into four levels based on the multilevel model by Smith and colleagues.[22] These include individual; family and socio-cultural; and institutional and structural level barriers.

Each of these subthemes had more than one quote. Quotes in the Individual theme were all taken from women in the perinatal period who participated in this study. Quotes in the other themes were from both the perinatal women and the health care professionals who participated in this study. The subthemes are grouped to form themes in Table 3. Quotes are presented using pseudonyms. "FGD" indicates focus group discussions, the pseudonym FGD, followed by a two letter code indicating the research site and perinatal women group (e.g. NP, MP, GP, KP), followed by the participant's individual code number. For individual interviews with healthcare providers, including CHWs, quotes are also presented using pseudonyms. KII indicates that it is a Key Informant Interview, which is then followed by the individual participant code and the research site code (e.g., "KII2N"). Pseudonyms used for Community Health Workers begin with CHW, followed by the number indicating the individual participant and a letter indicating the research site.

Table 3. Summary of barriers to mental healthcare access in the perinatal period in Rwanda

Theme	Subthemes
Individual level barriers	Low literacy about signs and symptoms of perinatal mental health problems (PMHP)
	Minimizing negative experiences
	Fear of being stigmatized
	Ignorance about the availability of mental health (MH) services in the perinatal period at HC
	Poverty and economic challenges
Family and Social-cultural level barriers	Stigmatization of people with mental health
	Minimization or advice from family and friends to forget
	Inappropriate friends' support
	Lack of partner support
Institutional and structural barriers	Misdiagnosis by Healthcare Providers (HCP)
	Heavy workload of HCPs
	Lack of awareness among HCPs
	Lack of specific training for HCPs about perinatal mental health
	Lack of guidelines for screening, and reporting for PMHP

I. Individual-level barriers

The theme at the individual level refers to the characteristics of the women that hindered access to mental health services in the perinatal period. The analysis identified five subthemes related to individual barriers comprising: minimizing or normalizing negative personal experiences; low literacy regarding perinatal mental health problems; fear of being stigmatized; lack of awareness about the existence of mental health services at healthcare facilities; and economic challenges and poverty.

Low literacy about the signs and symptoms of perinatal mental health problems

This study indicates a low literacy about the signs and symptoms of perinatal mental health problems among women in the perinatal period. Women who went through difficult moments during the perinatal period described symptoms that could be attributed to mental health problems, however, they associated these symptoms with other conditions like a physical condition (headache) and lack of necessities. Participants also described taking painkillers as a strategy to alleviate or cope with the effect of traumatizing events they had experienced.

When I was pregnant with this child, there was a disaster in which we lost our house! Since then, I started feeling something unusual with the movement of the fetus, and every time I had thoughts about that disaster, I got a headache. I tried to take many paracetamol and I was not getting better, maybe because I was pregnant" FGD-MP1. Perinatal woman.

I understand that those people with a disease that makes them fall unexpectedly, what we are used to saying is epilepsy (igicuri). I think it may be a disease that comes from the brain like a vein that nourishes the brain which may have a problem, so you understand that would also be a mental problem because it also comes from the brain". FGD-NP4. Perinatal women

Minimizing negative experiences

Participants reported the minimization of negative events that had happened and the effect it had on their mental health and wellbeing. As above, participants in the study reported trying to forget or taking painkillers as their way of relieving their suffering or pain.

My thoughts were also affected by the disaster, when I think about my house I always have a headache. I try to normalize things and try my best to forget what has happened, otherwise, my headache is chronic. FGD-MP1. Perinatal woman

Other than trying forget what happened, there is nothing else I can do about it. FGD-MP2. Perinatal woman.

Fear of being stigmatized

The mothers in this study reported a fear of being stigmatized if others were aware of their unconventional emotions and feelings. In describing this concern, they emphasized the absence of any identifiable illness despite experiencing discomfort. They indicated their concern that they don't have the signs of any disease, even while they are not feeling well.

How can I go to consult when I don't have a high fever? My husband won't believe me, others can laugh at me. FGD-GP5. Perinatal women

As mothers, we keep quiet, you think that you can't tell anyone because you can hear that from somebody else, and then the whole neighborhood recognizes what has happened to you. FGD-MP5. Perinatal woman

Ignorance about the availability of perinatal mental health services at the Health Centre

Perinatal women also indicated ignorance about the availability of mental health services at the health centre. When they were asked if they knew where they could seek help if they had a problem like fear, lack of sleep, or hopelessness, they indicated that they didn't know where to go and what to do about this problem. Moreover, they indicated that they would only go seek health services when they had physical health problems.

I know there is such mental health support because I know somebody who was brought here, but the person was not pregnant. At the HC the mental health support is not specific for pregnant women. FGD-MP11. Perinatal woman.

Most of the time people go for a consultation at the HC when they have an obvious problem, everyone can see that they are sick! We often like to go to the doctor when we are sick, and it is visible to people! But if you suffer inside yourself, and when I go to the doctor and tell him/her that I am sick? They will make me look crazy and say "Are you coming for treatment? Usually, I would go to consult at the HC if I am feeling and looking weak, or ambulating with assistance. When the pain in me is not visible to outsiders or my family, who would believe that I have a problem that needs a consultation at the HC?". FGD-NP6. Perinatal woman

Poverty and economic challenges

Under this subtheme, participants indicated poverty and economic challenges not only as a barrier to accessing mental health services in the perinatal period but also as a contributing factor to perinatal mental health problems. They admitted to feeling embarrassed and troubled when they did not have necessities during perinatal periods.

When you are about to give birth and you are alone, but others are used to say that there is "stress" and you start thinking about what is missing at home, for example, lack of sugar and porridge to feed kids, you think of the child, and have nothing to provide to them. FGD-MP1. Perinatal woman.

So, what makes me worry is thinking about the children you have, the stress and problems you have around you with no money, and the low energy you have which prevents you from working for money and you realize that there is nothing you can do about it". FGD_MP2. Perinatal woman.

Sometimes, when you are coming to the HC, and you are about to deliver, when they ask to bring the baby's clothes and diapers, you feel embarrassed if you don't have the necessities they ask for. FGD_KP5. Perinatal woman.

II. Family and social-cultural level barriers

In this theme, perinatal women and healthcare providers described various family and social-cultural barriers that deter women during the perinatal period from accessing mental health services. This theme describes how extended families and society in general view mental health problems and contains the following sub-themes: stigmatization of people with mental health problems; minimization of what happened by friends and family; inappropriate friends' support; and lack of partner's support.

Stigmatization of people with mental health problems

In this subtheme, the fear of being judged and misunderstood emerged as a reason for not sharing concerns at the individual level and is reinforced by descriptions of the nature of this stigma. This differs from the subtheme at the individual level because it refers to the social norms rather than the individual's fears (which may or may not be aligned with social norms). Participants in this study conveyed instances of societal stigmatization towards those with mental health challenges. Moreover, participants indicated that mental health struggles are often labeled as signs of weakness or an unwillingness to address personal problems. They continued that individuals are inclined to hide their mental health issues, potentially leading to delays in seeking help and disclosing their difficulties. One community health worker in charge of maternal health reported that:

Generally, pregnant women face problems but they seem to keep quiet because of fear of hearing others sharing their problems, due to the culture (kutiha rubanda). CHW-1N.

Minimization of what happened by friends and family

While minimization of perinatal women's negative experiences appears as a theme at the individual level, it also appears in this theme of family and social-cultural level barriers. Respondents in this study described the minimization of negative events, and thus attributed signs and symptoms of mental health problems to life difficulties. Close friends and family who realize the mental health problem a person is going through advise them to forget or to normalize what is happening to them as a strategy for overcoming the problem. Perinatal women who participated in this study said that…

My friends advised me to try to forget, otherwise, my baby could be affected too. FGD-NP1. Perinatal woman

Other women said that…

So, when you are pregnant, they tell you, your fetus will have a problem if you do not try to forget what happened to you. For sure it is only God who protected my pregnancy. FGD-NP5. Perinatal woman

Inappropriate friends' support

In this sub-theme, participants indicated the importance of friends' support, and at the same time how this friendship may delay seeking perinatal mental healthcare.

Having a friend to talk to it helps, she observed me, I had red eyes, and she advised me not to think much". FGD-MP5. Perinatal women

Lack of partner's support

Ideally, the partner of a woman in the perinatal period who is experiencing a mental health problem could take responsibility for the detection of a perinatal mental health problem and for support seeking appropriate treatment. However, the respondents in this study reported that partners aggravated the mental health problems instead of helping women with them.

When you have a husband who is not supportive, and who puts stress on you while you are a nursing or pregnant mother, it leads you to become distressed. When it is difficult to get him to give you money to buy what to cook for children (rasiyo byagoranye), you cannot expect him to give you money to go to the health center. FGD-KP1. Perinatal women

III. Institutional and structural barriers

Under this theme, both healthcare providers and women in the perinatal period reported the barrier of misdiagnosis. In addition, healthcare professionals reported heavy workloads and lack of guidelines as barriers to the appropriate delivery of perinatal mental health services. Under this theme, we have the following sub-themes: misdiagnosis; heavy workload; limited awareness; lack of specific training; and lack of guidelines for screening and reporting.

Limited awareness and misdiagnosis of perinatal mental health problems

The results of this study revealed limited awareness of perinatal mental health problems by healthcare providers and CHWs at health centers. Limited awareness is reflected by reports of misdiagnosis, resulting, for example, in repeated prescriptions for painkillers (paracetamol) to perinatal women with perinatal mental health disorders. The results also indicate the limited knowledge of CHWs regarding the symptoms and risk factors of perinatal mental health issues, which leads to barriers to early diagnoses, and the identification of women at risk.

I visited different health centers with the same problem of chronic headaches that came since the flooding disaster we had. At all these health centers I visited, they always prescribed me paracetamol, and they told me that they couldn't give me any other medication because I was pregnant. FGD-MP1. Perinatal woman

It is not easy at all for CHWs to detect a perinatal woman with or at risk of mental health problems because they have limited training on mental health in general. They cannot even know whether a person is having a mental health problem. KII4K. Healthcare provider (CHWs' coordinator).

I was staying with my husband but with a poor relationship. This was causing stress in me, he left us in a rented house, and I was chased away three times because I could not pay. It was very hard. I had contractions before time to deliver, and when I went to consult, I was told to try to forget problems. It means when you are pregnant you need to avoid problems because it has an impact on the unborn baby. FGD-MP10. Perinatal women (pregnant)

Lack of time and heavy workload

In this subtheme, many quotes from participants indicate a lack of time and heavy workload as factors that prevent healthcare providers from listening to perinatal women who may be having perinatal mental health problems and delivering appropriate services.

The first obstacle I have is the lack of time. I don't find enough time to be with a client, since I can run three services a day, so you receive a person and when you are talking to that person, you're also thinking that there is a long queue of other people in other services waiting for you. So, you talk to that person when you are in a hurry to meet other clients in different services. I think it is a problem unless we have someone in charge of mental health who is responsible only for such cases and following them up. KII1N. Healthcare provider (Midwife).

Lack of specific training about perinatal mental health

Healthcare providers reported that a lack of formal training regarding mental health issues among perinatal women contributed to low confidence in the ability to detect poor mental health status.

I am not confident I could help a perinatal woman with a mental health problem, I was not trained about it and I don't know how I can help her. KII2G. Healthcare provider (Midwife).

There is no specific training I received about maternal mental health. I only had training on general mental health problems, I have never been taught about maternal mental health. KII3N. Healthcare provider (A nurse from antenatal care service)

Lack of guidelines for screening and reporting for perinatal mental health problems

Participants described a lack of guidelines for screening tools and reporting perinatal mental health problems as an obstacle to early detection and management. There are also missed routine opportunities to screen for mental health problems during antenatal or postnatal care services, as expressed by perinatal women themselves.

Community health workers in charge of maternal health, usually have cards that facilitate them to detect health problems in expecting mothers, but regarding mental health for perinatal women, they don't have anything that can facilitate them to detect. You too you can see, there is nothing in the book of cards. KII4M. Healthcare provider (CHWs' coordinator)

We do not screen for perinatal mental health problems, I could be lying if I say that we screen them. Except when you talk to someone so that you can see something unusual in her. Maybe when you ask her about husband's name and you see that she is silent and not answering, you start to wonder. Most of the time when it comes to mental health, we don't do anything about it (we don't go into it) (reka ntiwirirwa ubyinjiramo). KII1N Healthcare provider (Midwife)

Actually, there is no conversation or talk about my mental well-being as a pregnant or a nursing mother with a midwife or a nurse, except when I may have a mental problem and go to seek care. FGD-MP9. Perinatal women

No, they don't ask such specific questions about your mental wellbeing. However, sometimes after delivery, they ask you questions about how you feel. I was asked how I felt when I delivered at [name of hospital].

Because I went there while I was in a very bad state, I was like a mad person, I was delirious and a woman health care provider helped me to regain consciousness. FGD-MP9. Perinatal woman

Discussion

The purpose of this study was to identify barriers to mental healthcare access in the perinatal period in Rwanda. The Multilevel Conceptual Framework for barriers hindering mental health services in the perinatal period,[22] informed the organization of themes and subthemes. From the analysis, barriers emerged at three levels: the individual, family and social-cultural, and institutional and structural level barriers.

While there is a lack of research on barriers to accessing mental health services in the perinatal period in Rwanda, this topic has been quite widely studied in other parts of the world.[9,23] This study suggests both similarities and differences with findings in other countries. In particular, findings differ according to health system organization and social-cultural context. For example, as a result of the structure of the healthcare system, in this study, the analysis found three main themes to be a more appropriate structure for understanding barriers. Interestingly, some of the subthemes cut across all three themes, presenting a unique set of results compared to findings in other studies.[24,25]

Low literacy about signs and symptoms of perinatal mental health problems emerged as a unique subtheme that cuts across all levels of barriers. At the individual level, low literacy among women in the perinatal period hinders their ability to recognize symptoms, delaying seeking help. At the family and socio-cultural level, families' limited awareness further compounds this issue. At the institutional and structural level, healthcare providers' insufficient knowledge similarly impedes timely diagnosis andintervention.

Other studies have similarly identified limited mental health awareness as a barrier to seeking help on time. A study by Ayrers has shown that a lack of mental health literacy relevant to the perinatal period hinders a woman's ability to identify symptoms, and therefore prevents them from seeking help.[26]

Our findings point to an interesting complication around the benefits of social support. Family members and friends of women in the perinatal period play an important role in ensuring the well-being of the women in the perinatal period, especially in detecting signs and symptoms of illness and the literature notes the importance of social support as a protective factor.[27] Our findings, however, suggest that when individuals who are facing mental health challenges confide in close friends and family, the advice they receive is often to overlook the severity of the issue, as a means of coping. Moreover, normalizing symptoms of mental illness during pregnancy and motherhood was also highlighted in several studies as a way of explaining changes in maternal behaviour. In line with the study by Smith and colleagues,[22] women with perinatal mental health problems commonly attributed symptoms to life difficulties during the perinatal period or tended to dismiss such symptoms as part of the normal pregnancy experience.

At the level of institutional and structural barriers, our study findings revealed that healthcare providers have shortcomings in formal training related to perinatal mental health problems, which contributes to a lack of confidence in detecting poor mental health status among perinatal women. This often leads to poor management of women who are susceptible to these problems. Women in this study who visited health centers complaining of chronic headaches were repeatedly prescribed painkillers when they could have potentially benefited from mental health screening. This observation aligns with the findings of a recent meta-review conducted by Webb and colleagues that identified

the necessity for healthcare providers to receive training on perinatal mental health problems to ensure the continuity of care.[28] Similarly, healthcare providers in several studies reported poor knowledge of perinatal mental health problems,[23,25] often attributed to inadequate training opportunities.[22,25] Instead, midwives with expertise and experience in perinatal mental health play a crucial role in enhancing access to care by assisting women in the perinatal period in identifying available mental health services and educating them about the diverse symptoms and manifestations associated with perinatal mental health conditions.[29]

The present findings indicate that shortcomings in perinatal mental health knowledge create intertwined barriers across different levels, making the issue more complicated to manage. To effectively address these barriers, interventions should be multifactorial, aiming both at raising awareness of perinatal mental health at the individual, community, and societal levels; by increasing the knowledge and competencies of healthcare providers; and by providing structural resources to support access to mental health services.

In accordance with previously published literature,[26] lack of time and a heavy workload were identified by healthcare providers as barriers that prevent them from thoroughly exploring potential mental health problems in perinatal women and/or offering adequate care. Nurses and midwives in Rwanda are responsible for conducting initial patient screening and proposing treatment plans, which may involve local management or referrals to the next level of the health system.[30] Although Rwanda has made significant strides in increasing the number of nurses and midwives, however, the staffing levels at the health centres still fall below government guidelines, resulting in a heavy workload.[31] At the health centre level, these healthcare providers receive many patients, limiting the time available for detailed consultations. The intertwined issues of heavy workload, short consultation durations, and long queues of clients waiting to be served by a single midwife or a nurse handling multiple services simultaneously lead to a prioritization of physical health over mental health. As a result, it is rare for nurses or midwives caring for perinatal women in different services to ask about their mental well-being.[25] While this is a challenge for all patients, individuals with mental health problems suffer more as they need time to express themselves. Additionally, other studies found that healthcare providers who focused on the emotional well-being of pregnant women and spent their consultation time talking about this with them were regarded by their colleagues as “slow” and inefficient.[25]

A unique finding of this study is the specific form of societal stigmatization towards women in perinatal period with mental health problems, who are labelled as weak or unwilling to address personal problems. This labelling leads women in the perinatal period to hide their mental health issues, potentially resulting in delays in seeking help and disclosing their difficulties. The reported fear of potential stigmatization after the disclosure of unconventional emotions and feelings aligns with the existing literature.[28,29,32] Unrealistic cultural expectations surrounding motherhood as barriers to seeking care have also been documented elsewhere.[29] In contrast, a study conducted by Ayres and colleagues in Australia identified an absence of concern about judgment in their study.[26]

The findings in the current study highlight the absence of national guidelines and protocols for detecting and managing mental health problems during the perinatal period. Healthcare providers including CHWs rely on national guidelines and protocols to screen and subsequently manage or refer cases of disease in the Rwandan context.[30] However, healthcare providers in this study, including CHWs, who play a crucial role in screening women for perinatal mental health issues, reported a lack of specific guidelines.

This gap can lead to the neglect of mental health issues or the false assumption that there is no risk if mental health problems go undetected, as underlined by previous research.[22–24,33] Such oversight at both health centres and community levels underscores the critical need for comprehensive guidelines to ensure the mental well-being of women during the perinatal period.

Conclusion

This study aimed to identify barriers to accessing perinatal mental health care in Rwanda. It has shed light on several critical barriers. Three overarching themes emerged: barriers at the individual level, family and social-cultural barriers, and barriers at the institutional and structural level. Low mental health literacy about perinatal mental health problems was a significant barrier across all levels. Women often lacked awareness of the signs and symptoms of perinatal mental health problems, leading to delays in seeking help. Additionally, inappropriate peer and family support further hindered early help seeking for the management of the problem Low mental health literacy combined with fear of being stigmatised and family attitudes all played a role in women and their families and friends downplaying the severity of these issues, contributing to further delays in seeking professional support. This underscores the urgent need for comprehensive education and awareness campaigns targeting individuals, communities and healthcare providers.

The study highlighted systemic shortcomings within healthcare institutions, particularly concerning the lack of training among healthcare providers and the absence of standardized guidelines for detecting and managing perinatal mental health problems. However, increased awareness is not enough. Work conditions, such as the heavy workload and time constraints faced by healthcare professionals, further exacerbated the problem, resulting in mental health concerns being overlooked or inadequately addressed during consultations.

To effectively address the identified barriers, multifaceted interventions are proposed across implications to policy, practice, and research. Findings from this study indicate the lack of in-service and pre-service trainings, and guidelines to screen and manage perinatal mental health problems. Developing and implementing comprehensive national guidelines for detecting and managing perinatal mental health issues is essential. These guidelines should be integrated into routine maternal healthcare and regularly updated based on the latest research. Additionally, improving resource allocation to health centres is crucial to enable them conduct thorough consultations that include mental health assessments. Designating mental health nurses or other mental health professionals at health centres can further enhance the focus on perinatal mental health care and support. Moreover, providing training for community health workers on recognizing and managing perinatal mental health issues will enable them to serve as the first point of contact and refer women to appropriate services.

The study revealed a low perinatal mental health literacy. Enhancing mental health literacy through developing and disseminating culturally appropriate materials focusing on the signs and symptoms of perinatal mental health issues, and through educational programs. Introducing self-screening tools that women in the perinatal period use to identify early signs and symptoms of mental health problems can empower them to seek help promptly. Moreover, integrating perinatal mental health screening tools into routine antenatal and postnatal care visits, and including perinatal mental health topics in educational talks for women attending antenatal and postnatal services, will ensure that these issues are routinely addressed.

Providing ongoing training for healthcare providers, including CHWs, on perinatal mental health topics such as symptom recognition, interventions, and the importance of addressing mental health during perinatal care, is essential. It is also important to integrate specific perinatal mental health content into the training curriculum for midwives, nurses, or other healthcare providers to further enhance their competencies. Furthermore, developing support networks by establishing peer support groups for perinatal women, facilitated by trained professionals, CHWs, or volunteers, will help women in the perinatal period to share experiences and receive support from others who have faced similar challenges.

Evaluating the effectiveness of educational programs and training initiatives in improving mental health literacy and reducing stigma around perinatal mental health issues could be useful. It is also recommended to investigate the socio-cultural factors that influence perceptions and management of perinatal health problems focusing on how social support systems can both help and hinder mental health care. There is further a need to assess the effectiveness of different interventions, including psychosocial interventions, that address perinatal mental health problems.

Authors contribution

All authors have played a significant role in the conception, design, data analysis, and writing of the article.

Conflict of interest

There is no conflict of interest in the publication of this article

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