Mental Healthcare-Seeking Behavior during The Perinatal Period among Rural Women in Bangladesh

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Abstract

Introduction: Mental health conditions are of rising concern due to their increased contribution to the global burden of disease. Mental health issues are inextricably linked with other sociocultural and health dimensions, especially in the rural areas in developing countries. The complex relationship between mental health issues and sociocultural settings may largely toll upon the healthcare-seeking behavior. Evidence suggests that mental illness affects more than 10% of women and one year after childbirth. So, it urges to document the current status of mental healthcare-seeking behavior during the perinatal period among rural women in Bangladesh to develop a context-specific intervention in the future.

Methods: This study was carried out in one sub-district in Bangladesh from April 2017 to June 2018. We conducted 21 In-depth Interviews and seven Focus Group Discussions with different groups of purposively selected participants such as perinatal women, head of the family, community stakeholders, and community level healthcare providers. After collecting the recorded interview and making the verbatim transcription, the data were coded through Atlasti 5.7.a. Data were analyzed thematically to explain the findings.

Results: Most of the women with mental disorders at the community level did not seek healthcare during the perinatal period. Women with mental illness also did not know who and where the mental health services are provided. The study found that only one respondent out of twenty-one sought maternal mental healthcare from a gynecologist from a private hospital. In this regard, socio-cultural factors such as social stigma traditional beliefs and practices, social and religious taboos, and social capital also negatively influence healthcare-seeking behaviors. Besides, the community-level service providers were not trained and did not have any guidelines regarding its proper management.

Conclusion: The study findings provide us evidence that there is an urgent need to increase the awareness for service users and formulate a guideline for the community-level service provider to manage maternal mental problems during the perinatal period of women in rural Bangladesh.

Introduction

Globally, mental health conditions are of rising concern due to increased contribution to disease burden (1). Mental well-being is inextricably linked with the social and physical environment. Thus it, cannot be determined by only the absence of mental disorders but also determined by related socio-economic, biological, and environmental factors (2). Mental health disorders refer to a set of medical conditions that can affect a person's thinking, feelings, mood, ability to relate to others, and daily functioning (3). Poor maternal mental illnesses affect more than 1 in 10 women during pregnancy and the first year after childbirth and can have a devastating impact on them and women (4-6).

Due to physiological changes during the perinatal period, -defined as the time spans from conception to when the infant reaches the age of one, many women are affected by mental disorders (5). However, there is still a big concern over the extent which pregnant mothers seek care for mental health problems,

especially in the low and middle-income countries (7). Evidence suggests, only 13.6% of women have sought help for their depressive symptoms (8). Healthcare-seeking behavior and the socio-cultural influencing factors have a huge impact on the lives of women as well as on the early childhood development (ECD) of the baby (4, 9). In terms of the perinatal health services in low and middle-income countries where women's familial, social, and physical environment are crucial determining factors, the decision to seek care is highly complicated ((2, 9-13). Besides, at the population level, there is also a lack of clear understanding among the service users regarding where to seek service for particular types of disease, which often hampers appropriate and timely care-seeking (14-18).

Mental health issues have been incorporated as an essential prerequisite for good health and well-being in the UN-declared Sustainable Development Goals (SDGs) (19). It also necessitates that, mental health services are available at the community level. However, there is a huge knowledge gap regarding the availability and accessibility of these services in Bangladesh, especially when there are traditional beliefs and social taboos (20) which ultimately hinders them from seeking care for mental health problems fearing discrimination (14).

Understanding healthcare-seeking behavior in a community is necessary to develop appropriate health policies, health systems, and educational strategies to facilitate access (10). Besides, its determinants of optimal healthcare-seeking behavior of perinatal women in this period can significantly contribute to reducing the impact of severe illness on children's growth and development (21). Given the variability of socio-demographic and cultural contexts, there are differentials in the perception of vulnerability or risk for newborns, and prevailing customs, traditions, and beliefs within communities. Therefore, it is critically important to understand community-specific patterns, and determinants of population-level antenatal, delivery, and post-natal care-seeking practices, especially for the perinatal period of women. The objective of this study was to explore the healthcare-seeking behavior regarding maternal mental health problems during the perinatal period and the influencing factors to seek healthcare of women in rural Bangladesh.

Research Design And Methods

It was formative research where we applied a qualitative approach (22). We used a phenomenological theoretical framework to describe the meaning and significance of respondents' experiences regarding healthcare-seeking behavior of women's perinatal mental health. We conducted in-depth interviews (IDIs) and focus group discussions (FGDs) to collect data from different populations.

Study settings

The study was carried out at the community level in one sub-district in the *Rajbari* district of Bangladesh. The *Upazila* is divided into one municipality and seven unions (the smallest administrative unit in Bangladesh). We only covered all unions of the *Upazila* for the study.

Study population, sample size, and sampling criteria

We conducted 21 IDIs in this study. Among them, we interviewed 14 IDIs with mothers who have at least one year of aged children to collect information on their perception of having mental health issues and experience of seeking care for these illnesses. Besides, we also interviewed seven IDIs with the community service providers such as sub-assistant community medical officer (SACMO), family welfare visitor (FWV), family welfare assistant (FWA), health assistant (HA), community healthcare provider (CHCP), and village doctors. All the IDI participants were selected purposively considering the types of respondents and willingness to participate in this study as an interviewee. To triangulate data, we also conducted seven FGDs with community stakeholders like household heads, Union Parisad (UP) members, teachers, religious leaders, and service users who took other services without maternal health care. For the selection of FGD participants, we considered homogeneity regarding age, sex, education, occupation, etc.

Data collection and quality control

The data collection guidelines were developed separately for different groups. The data collection tools were finalized after incorporating of findings from pre-testing done with a similar group of the population living in another area far from the study site. It was then translated from English to Bengali and in the local dialect for conducting interviews due to understanding their local dialect as an outsider. Furthermore, to ensure reliability, we assessed the meaning and explored health and mental healthcare-seeking behaviors in different socio-cultural influencing factors during the perinatal period of women at the community level. Content validity was assured by seeking confirmation of each health belief by other women on different days to understand each from various sources. We ensured comprehensive collection and assessment of the socio-cultural health beliefs and practices on healthcare-seeking behavior during the perinatal period of women in the study area. A data collection team with two Senior Research Assistants and one Research officer, experienced in qualitative data collection, was formed. The data collection team has been trained intensely on all pros and cons of data collection, including consent taking, different data collection methods, antenatal, delivery, postnatal maternal mental health problems of women, and community health service in the perinatal period. The team visited the household of the selected antenatal and postnatal women, and mothers who had recent experience in child birthing and caring at their homes for conducting IDIs. The IDIs were taken one to one basis at the home of the respondents and took 30-40 minutes each. In addition, the FGDs were conducted with 5-8 respondents at Community Clinic and took 40-50 minutes each. To obtained data, we followed the saturation level of information. Data were checked every day through feedback sessions at the end of the day. We listened to the recorded interviews to identify new issues and find out any missed opportunities to further explore them. A central monitoring team of the investigators was involved in continuous monitoring of the data collection to ensure the quality.

Data Analysis

All the data were collected through audio recording along with note-taking. The audio recordings were transcribed verbatim (in their original form). Then the transcripts were organized through cross-checking

with the interview notes. Transcripts were randomly checked against audio recording to ensure the quality of the transcription. The data were analyzed using a thematic approach. We identify themes, as per the research objectives. The transcribed data were systematically indexed or coded, synthesized, and interpreted to explain the findings. Results on the same issues from different types of respondents and areas were compared to strengthen the validity of the findings. We used *Atlas ti 5.7.a.* software for coding and organizing the data.

Results

Socio-demographic characteristics of the respondents

The study participants' socio-demographic characteristics revealed that the highest percentage (64%) of study participant's age was 30 years or above. Among the total participant's 34.67% was male and 65.33% female. Most of the participants (86.67%) were Muslims and the rest of the participants (13.33%) were Hindus by religion. About one-third of study participants (32%) had higher secondary or above level education, 33.33% had secondary level education but one-fifth of the participants had no formal education. Among the study participants, 38.67% were housewives, 38.67% were service holders, 10.67% were businessmen, 8% were farmers, and 4% were teachers. There were also members of local governments such as Upazila Parishad, religious leaders, and retired persons. Forty percent of the participants had a monthly household income of more than 12,000 takas while 24% had a monthly household income of fewer than 3,000 takas.

Perception on maternal mental health problems

Most of the respondents said that maternal mental health problems are not a problem to them during the perinatal period of women due to their nature. The mood swings, dizziness, bad dreams in the sleep, and the fears of death for pregnancy, that the mother's experience, are explained due to the extra burden for being pregnant and child-rearing this period and are viewed as usual symptoms of this period. Therefore, additional support or medications are not deemed necessary. These symptoms are regarded as usual for women not labeled as a disease condition to treat.

Mental health issues, on the other hand, are significantly related to the matter of social stigma for a woman in the community. If the woman has mental diseases, they call her "*pagol"* (mental sickness/mad). So, she has to seek treatment from Mental Hospital locally known as "*Pagla Garod"* (loosely translated as a sanctuary for the mad people). A few respondents said that they are reluctant to seek healthcare during this period to this perception of maternal mental health and any mental health in the study area. They do not know who serves this support or medication and practitioner in the community (primary level) for mental health, especially maternal mental health problems during the perinatal period of women. One respondent (mother) said that,

"*I felt worried during pregnancy. I think, it is happening during this period of women. But I did not seek any doctor. Even I did not know who serves the treatment.*" (Age: 19 years female, Education: class five,

Occupation: Housewife)

Most community service providers said that they did not hear about the women's perinatal mental health problems. They listened to some mental health diseases names from their colleague, such as depression, anxiety, stress, etc. They shared that they provide counseling for taking nutritious food, preparing for arranging money, and vehicles for the emergency period. Apart from these, they did not provide any psycho-social counseling during the perinatal period of women for their mental health and well-being. One community healthcare provider said that maternal mental health is closely related to their circumstances, social and physical factors during this period. Suppose they cannot treat any kind of symptoms of women. In that case, they can refer to the Upazila Health Complex (UHC), a high-level facility of primary level healthcare in Bangladesh. So, they cannot suggest any support and management for mental health-related problems like depression, anxiety, stress, and postnatal psychotic disorders in general due to the absence of training and treatment guidelines.

Maternal mental healthcare-seeking during the perinatal period

Recognitions of antenatal mental health and care-seeking

All of the respondents said that when women conceived, they locally called her '*poati'* (pregnant), *pet hoice* (being pregnant), or '*Maa hote cholechhe'* (would-be a mother). They inform their senior family members (mother-in-law if present, husband) after being confirmed. In most cases, husband and/ or senior family members decide to seek care if needed. The majority of the total participants reported that being pregnant is not a serious issue requiring doctors. In terms of maternal mental health problems, most of the respondents reported that pregnancy may be associated with would-be mother's mental concerns. In this connection, many mothers have experienced anxiety for their upcoming child's good health and well-being, the impending birth, during the pregnancy period. They also added that poor mental health conditions may lead to increased risk in childbirth, followed by postnatal mental illness and improper child care. Some women had a mental illness when they become pregnant, and some had mental health problems during the maiden pregnancy. One respondent described her experience as,

"*After crossing my menstruation date, I felt a change in my appetite. I could not eat anything and felt uneasy; I thought about what had happened to my body! Then I had taken a quick pregnancy test and the result was positive. So, I was very nervous. My husband told me; he was happy about that. I could not express my mood at that time."* (Age: 18 years female, Education: class one, Occupation: Housewife)

One respondent (Husband) reported that ignorance of husband during pregnancy period created mental problems. A few mental sufferings of the pregnant women have been seen unexpectedly, reported by their husband. For an example

"*One day my wife told me; please forgive me for my any fault if die while giving birth. My wife felt fear of her delivery and related danger signs. Sometimes, she dreamt like this Since I did not recognize that it was mental health problems.*" (Age: 32 years male, Education: HSC, Occupation: Businessman)

The other dimension of mental health is closely related to the sex of the upcoming baby. For example, one respondent (Husband) reported that his wife was tensed due to her expectation for a boy baby. He quoted,

"*They were very upset during the fourth pregnancy because they already have three daughters. If it is repeated, what will happen then? This made them anxious.*"

Most of the respondents said (service user) that there are no mental service providers in our primary and secondary level hospitals in the health system in Bangladesh. Only one respondent out of twenty-one sought maternal mental healthcare from a gynecologist in a private hospital.

From the supply side perspective, at the community level, the service provider (CHCP) mentioned that they do not have any guidelines and knowledge to provide maternal mental disorders in the perinatal period of women. One respondent shared her experiences,

"When I was pregnant, I felt apprehension or dread, tense about my delivery, and panicked regularly. Then I shared it with my husband. He told me to go to CC for taking counseling but Apa (CHCP), could not provide any suggestions on these."

A few respondents (services providers and stakeholders) opined that unintended pregnancies happened in most cases at the community level in our country, making pregnant women mentally depressed.

Delivery care-seeking

In terms of physical health, most of the respondents reported that they sought treatment during the delivery period from a private hospital, clinic, or Mother & Child Welfare Centre (*MCWC*) which is popularly known as "maternity" at the district level. A few respondents also revealed that they also went Upazila Health Complex for delivery purposes during the delivery period. Very few respondents informed that they sought delivery care from the district hospital. Among all the respondents, only one respondent went to Faridpur Medical College and Hospital, a tertiary level hospital for delivery care seeking due to prolonged labor pain. In terms of mental health care seeking,most of the respondents said that they felt tensed and became frustrated over the danger signs, fatigue, hopelessness, body pain, and labor pain during the delivery period. For these types of maternal mental crisis during the delivery period, they did not seek doctors' treatment. They seem that it is a more natural process for human beings and will be cured naturally. Several respondents said that they are the follower of *Atrashi pak Darbar Sharif (religious and spiritual place)*; they get talisman (spiritual healer) from this *Darber Sharif* for any kind mental health problems during the delivery period. Another two respondents opined that they took *pani pora* (blessed water) from the Imam (Muslim religious leader) of the mosque to cure worries during the delivery period.

Post-natal (6 weeks or 42 days after delivery) care-seeking

Most community service providers reported that they do not have any formal knowledge and treatment guidelines to deal with post-natal mental disorders such as depression, anxiety, stress, post-partum

psychosis, post-partum blue, and related symptoms during the post-natal period in any way. Even if they have no idea that poor mental health conditions may lead to increased risk in childbirth followed by post-partum depression. One respondent said,

"*I think maternal mental disorders have seen in the perinatal period, especially after delivery due to her physical poor health conditions and new kid's crying and disturbance."* (Age: 18 years female, Education: SSC, Occupation: Housewife)

On the other hand, a few respondents said that they have experienced mental health problems during the post-natal period although they did not seek treatment. One mother reported that she thought of seeking mental health treatment during the post-natal period but she did not know where to go for the treatment. Only one respondent involved in the teaching profession revealed that depression, anxiety, postpartum blue, and psychosis are the most common mental health problems in the post-natal period but treatment management is not available in the community level facility.

Socio-cultural influencing factors

In the study area, most of the respondents revealed that healthcare-seeking behavior had been influenced by many confounding factors furthermore some factors have more significant influences on maternal mental disorders treatment seeking as follows; socio-cultural and religious beliefs, practices, taboos, and restrictions during the perinatal period of women. These factors have been elaborated by respondents' experience below.

Beliefs and practices

most community people have different beliefs in social and religious entities on maternal health and mental health issues during the perinatal period. Often the traditional healers, religious leaders, folk, and spiritual healers are referred to as the sources for treatment-seeking. Some respondents revealed that they did not go to the doctor for seeking mental healthcare during the pregnancy period because the doctors might give tests for pregnant women that might be harmful to the unborn fetus. Besides, it was also costly to go to doctors. In that case, they had to abide by their mother-in-law and husband's decision that led them to go to the religious leaders for spiritual blessings. Three respondents said that they sought treatment from *Joli didi (Sasto Kormi (Health worker) of BRAC)* because they knew her and took care of community people through household visits.

Support from neighborhood

Most of the respondents agreed on this common issue that social capital was a leading social determinant to motivate maternal mental healthcare-seeking behavior in the perinatal period of women. Through this relationship, a person gets support to improve the mental well-being of women in the perinatal period. Most pregnant women who participated in this study explained that they usually got help from their neighbors during pregnancy and in any critical situation. One pregnant woman said,

"*I felt severe pain in the lower abdomen when the eighth month of my pregnancy was running. I did not find any way. I shared with my husband but he did not make it clear to me; then I went to my neighbors. She told me that it is very usual in the pregnancy. I got relief after hearing this"*. (Age: 28 years female, Education: class seven, Occupation: Housewife)

Another female respondent who has one year's child said,

"*When I conceived, I did not know who will be better for medication at that period. My neighbor said to me to go to either Rabeya clinic or Maternity in Rajbari Sadar. After that, I went to maternity and got checked by Dr. Sumi Apa."* (Age: 18 years female, Education: class seven, Occupation: Housewife)

Most respondents opined that husbands' support is the most trusted and closest support than female relatives and friends. So, his support is considered to be the most important support during pregnancy. Besides, the intimacy in the husband-wife relationship seemed to have a central role in social support received, and their sense of togetherness.

Discussion

Healthcare-seeking behavior regarding maternal health and mental health disorders during the perinatal period has a huge impact not only on the lives of women but also on the development of their children. Moreover, the wide range of study participants (e.g., pregnant women, community service providers like CHCP, HA, FWA, FWV and SACMO, women who are mothers of children and community stakeholders) mentioned that healthcare-seeking practice is like a process which begins in the community level and ends with the specialized doctor in the sub-district or the district level.

This study found that they did not usually seek treatment for physical health and mental health problems during the perinatal period in the study area. Similarly, some studies show that parents are reluctant to seek mental health issues (23). Even, 78% of parents sought 'no care' for their preterm newborn (24). On the other arm, they (women) do not seek medication for any maternal mental health disorders during the perinatal period of women (25).

An almost similar result was also described in a study conducted in the coastal area of Bangladesh where 35.2% of respondents sought self-care or home remedy as to the first attempt whereas 22.1% of sought formal service providers. On the other hand, 41.5% sought treatment from the informal service providers for the second attempt during child illness, whereas, another 44.4% of mothers sought medication from qualified *allopaths* (26). In another study, community people seek medication from community health care providers locally called 'Shasto apa' and homeopathic practitioners. They also take medicine from a pharmacist or an unqualified medical practitioner depending upon availability and affordability. They also seek qualified medical practitioners for severe health problems during the pregnancy period. Besides, they also seek treatment from folk and traditional medicine and spiritual healing for any complication during pregnancy. In terms of individual level, married pregnant adolescent girls usually avoid health facility for pregnancy and delivery care because of their perception that

pregnancy is a natural phenomenon and there is no need to receive pregnancy care and other medical supports (27). Sometimes, shyness is seen for male service providers and some women are found to be afraid of instrumental delivery and surgical intervention if needed. In interpersonal and family-level factors, they pointed out that decision-makers (husband, mother-in-law, senior family members, and relatives) play an essential role in their use of skilled maternal health services (28). On the other hand, there is still a big concern over to what extent pregnant mothers seek care for mental health problems, especially in low and middle-income country settings. Evidence suggests, only 13.6% of women have sought help for their depressive symptoms (9).

One study reported a high prevalence of antenatal depression among rural women, who rarely seek treatment for their depression which goes with our study findings (7). Another study revealed that 14% of women with depression admitted that they felt like doing self-harm during their current pregnancy (29). Even, our research found that some women went to discuss with the community service providers but not got any fruitful treatment on mental health problems during the perinatal period as the service providers are not oriented about the perinatal mental health problems. So, the healthcare providers at the community level need to know the proper guidelines for the initial management of mental health problems and appropriate referrals.

Other studies found that most of the respondents seek healthcare from traditional birth attendants (TBA) and NFP during the delivery period. Similar types of finding are shown in many other pieces of literature that delivery usually takes place at home and attended by TBA (30, 31). On the other hand, a national survey in Bangladesh found that the health facility delivery rate is very low (32) which is similar to this study's findings. Findings show that most mothers stated that they felt panicked, phobia, stress, physical aches, and pains during the delivery period but there are no people to give mental support. So, they think it is a natural process, it obvious in life. But they felt a need for mental support during the delivery period (36)

Our study found that the religious beliefs and practice of family influence care-seeking. Almost similar findings were found from a study that showed women sought seek faith-based medication from '*local religious leaders* 'along with formal Healthcare services (10). Likewise, another study found that women receive pregnancy-related care from multiple sources based on the nature and type of threats they associate with their pregnancy (33). Moreover, there is an influence of social capital on healthcare-seeking behaviors on maternal health and mental health. From the same aspect, Ahmad R, et al, found a strong influence of healthcare-seeking behaviors during the perinatal period of women. This study found that social networks of women help to seek treatment as need (34). In another study by Yakong, V N et al found that the healthcare-seeking behavior of mothers during the perinatal period was influenced by interpersonal communication between providers and patient parties. That study further showed that women received treatment surreptitiously for mental health-related disease but some patients experience a lack of privacy during treatment-seeking (35). Besides, women's help-seeking was influenced by their expectations and experience of healthcare professionals and the healthcare system's structural factors (9).

We found in this study, community health care service providers had no necessary training as well as a guideline for the patient's management who has mental health problems during the perinatal period. That's why perinatal women cannot get adequate services to meet the requirements regarding mental health problems. This is also found in another study that inadequate service provider and their management guidelines are the vital barriers to providing services for mentally disorders women during this period and hampers the quality of life of people in developing countries (36).

Conclusion

This study documented the healthcare-seeking behavior on maternal mental health during the perinatal period of women in rural Bangladesh. Despite having the positive significance of mental health during the perinatal period, this service is not yet available in community-level public health facilities in Bangladesh. Some socio-cultural factors influence healthcare-seeking during the perinatal period. Usually, the senior family members decide on treatment-seeking. At the same time, half of the respondents do not seek treatment, and the rest of the one portion seeks treatment based on the severity of complications. For those who seek treatment for maternal mental health complications, most of them go to NFP and then some women go to community healthcare providers. Due to social stigma, women were found not to disclose mental health problems, let alone seeking treatment from any formal providers. There are some supply-side barriers as well to provide maternal mental health services in the community-level health facilities. As found, community-level health providers do not have the knowledge and skills set to provide mental health support during this time nor do they have proper guidelines and training. Therefore, it can safely be stated that treatment-seeking for a maternal mental disorder during the perinatal period impacts on maternal mental and child health and their well-being. The existing health services should be strengthened for providing mental health services during this period and promoted through community mobilization for improving maternal mental health in rural settings of Bangladesh. Besides, these study findings may also help the policymakers and program implementers to formulate appropriate policies addressing the community level peoples' knowledge and service gaps identified in this study.

List Of Abbreviations

ANC- Antenatal Care; BDHS- Bangladesh Demographic Health System; BRAC- Bangladesh Rural Advancement Committee; CBA- Community Birth Attendant; CC- Community Clinic; CHCP- Community Healthcare Provider; ECD- Early Childhood Development; FWA- Family Welfare Assistant; FWC- Family & Welfare Centre; FWV- Family Welfare Visitor; HA- Health Assistant; HSC- Higher Secondary School Certificate; IDI- In-Depth Interview; FGD- Focus Group Discussion; NFP- Non-Formal Practitioner; PNC- Prenatal Care; SACMO- Sub-Assistant Community Medical Officer; SK- Shasthya Kormi; SSC- Secondary School Certificate; TBA- Traditional Birth Attendant; UHC- Upazila Health Complex; USC- Union Sub-Center; WHO- World Health Organization

Declarations

Ethics approval and consent to participate

Ethical approval to conduct the study was obtained from IRB (Institutional Review Board), of International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b). In addition, we took written consent from participants during data collection and followed ethical guide line in every step of this study.

Consent for publication

Consent to publish was obtained from icddr,b.

Availability of data and materials

All data used in this study is readily available by request through the corresponding author. These are qualitative transcripts majorly.

Competing interests

The authors declared that they have no competing of interest.

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Authors' contributions

GKD, TKB and HUA were responsible for the development of research question and study design of this study. GKD, DSB and MR are responsible for data extraction, synthesis and analysis rigorously. GKD and MR are responsible for drafting the manuscript. TKB, HUA, BKS and DSB were reviewed the manuscript rigorously to finalized and approved the manuscript.

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