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SOCIAL SUPPORT, COPING STRATEGIES AND HEALTHCARE EXPERIENCES AMONG WOMEN WITH POSTPARTUM MENTAL HEALTH CHALLENGES IN SOUTHEAST NIGERIA: A QUALITATIVE STUDY

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Abstract

Postpartum mental health disorders are among the leading contributors to maternal morbidity worldwide and represent a growing public health concern in low- and middle-income countries. Despite increasing recognition of postpartum depression and related mental health challenges, access to appropriate care remains limited in many parts of sub-Saharan Africa. In Nigeria, sociocultural stigma, inadequate integration of mental health into maternal healthcare, and weak referral systems continue to hinder timely identification and management of affected women. This study explored the social support systems, coping strategies, and healthcare experiences of postpartum mothers in Southeast Nigeria, with particular emphasis on health system gaps and utilization of maternal mental health services. A qualitative descriptive study was conducted in 2024 among 36 postpartum mothers attending Life International Hospital, Awka, Anambra State, Nigeria**.** Participants were purposively recruited from women within six months postpartum. Data were collected through four focus group discussions using a semi-structured interview guide. Discussions were audio-recorded with participants' consent, transcribed verbatim, and analyzed thematically following Braun and Clarke's approach. The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ). Three interconnected themes emerged from the analysis. First, participants relied primarily on informal social support from spouses, mothers, relatives, and close friends, although unsupportive family interactions frequently intensified emotional distress. Second, mothers adopted various coping strategies, including prayer, emotional suppression, social withdrawal, music, and peer support, reflecting both personal resilience and prevailing cultural expectations regarding motherhood. Third, participants described important shortcomings within the healthcare system, including limited routine screening for maternal mental health conditions, inadequate counselling services,

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insufficient provider engagement, and weak referral pathways. Most mothers reported that healthcare providers rarely enquired about their emotional wellbeing during postnatal visits, while stigma further discouraged disclosure of psychological distress. Women who received empathetic counselling and professional reassurance reported greater emotional relief and acceptance of their experiences. Postpartum mental health challenges among women in Southeast Nigeria are strongly influenced by the availability of social support, culturally shaped coping mechanisms, and deficiencies within maternal healthcare services. Integrating routine mental health screening into postnatal care, strengthening provider capacity to deliver culturally responsive psychosocial support, improving referral pathways, and promoting family-centred interventions may enhance service utilization and improve maternal mental health outcomes. These findings provide context-specific evidence to inform maternal mental health policy, service planning, and healthcare delivery in Nigeria.

Keywords: Postpartum mental health; Postpartum depression; Social support; Coping strategies; Maternal health services; Health system strengthening; Qualitative research; Nigeria.

Background

Postpartum mental health disorders are among the leading causes of maternal morbidity worldwide and represent an important but frequently neglected component of maternal healthcare. Among these disorders, postpartum depression (PPD) is the most common, affecting women's emotional wellbeing, maternal functioning, and the health and development of their infants. PPD is characterized by persistent sadness, loss of interest in daily activities, feelings of guilt or worthlessness, anxiety, fatigue, sleep disturbances, and impaired mother–infant bonding occurring within the first year after childbirth. Beyond its effects on mothers, untreated PPD has been associated with poor infant growth and development, impaired cognitive and emotional outcomes, disrupted family relationships, and reduced quality of life for affected families (Howard & Khalifeh, 2020; Slomian et al., 2019; World Health Organization [WHO], 2022).

Globally, postpartum depression affects approximately one in seven women, although prevalence estimates vary across countries because of differences in screening methods, diagnostic criteria, and sociocultural contexts (Shorey et al., 2018; Wang et al., 2021). The burden is disproportionately higher in low- and middle-income countries (LMICs), where women frequently experience poverty, limited access to healthcare, inadequate social protection, and persistent stigma surrounding mental illness (Gelaye et al., 2016). Despite increasing recognition of maternal mental health as a public health priority, access to timely diagnosis and appropriate treatment remains inadequate in many LMICs, where maternal healthcare services continue to focus predominantly on physical rather than psychological wellbeing (WHO, 2022).

Nigeria experiences a substantial burden of postpartum depression, with studies reporting prevalence estimates ranging from approximately 10% to over 30%, depending on the population studied and the screening instruments used (Agbaje et al., 2019). Maternal mental health in Nigeria is influenced by a complex interaction of socioeconomic hardship, financial insecurity, marital

relationships, childcare responsibilities, and limited availability of specialized mental health services. Cultural expectations that women should demonstrate strength, resilience, and gratitude following childbirth further discourage many mothers from acknowledging emotional distress or seeking professional support (Oladeji & Gureje, 2019). Consequently, many women experience psychological symptoms without receiving appropriate assessment or treatment, increasing the likelihood of prolonged illness and adverse maternal and infant outcomes.

Although considerable research has documented the prevalence and determinants of postpartum depression in Nigeria, comparatively little attention has been paid to women's experiences of accessing maternal mental healthcare. Quantitative studies have identified important risk factors but provide limited insight into how women perceive available services, interact with healthcare providers, or navigate barriers to obtaining psychological support. Understanding these experiences is particularly important because healthcare utilization is influenced not only by the availability of services but also by women's perceptions of provider attitudes, cultural beliefs, family support, and previous healthcare experiences.

Health systems play a critical role in the early identification and management of postpartum mental health disorders. The World Health Organization recommends integrating mental health into primary healthcare and maternal health services to improve early detection, continuity of care, and equitable access to treatment (WHO, 2022). Routine screening during antenatal and postnatal care provides opportunities to identify women experiencing psychological distress before symptoms become severe. However, implementation of routine maternal mental health screening remains limited in many resource-constrained settings because of shortages of trained personnel, competing clinical priorities, inadequate referral systems, and limited availability of counselling services (Howard & Khalifeh, 2020).

Social support also represents an important determinant of maternal mental health and healthcare utilization. Emotional, informational, and practical assistance provided by spouses, relatives, friends, and community members may reduce psychological distress and facilitate help-seeking among postpartum women. Conversely, inadequate family support, interpersonal conflict, and negative social interactions have consistently been associated with an increased risk of postpartum depression and poorer maternal outcomes (Gelaye et al., 2016; Slomian et al., 2019). Within many Nigerian communities, family members are central participants in postpartum care and therefore influence women's decisions regarding whether, when, and where to seek professional healthcare. Understanding how women experience these family relationships is therefore essential for designing effective maternal mental health interventions.

Women employ a wide range of coping strategies to manage postpartum psychological distress. Some adopt adaptive strategies such as seeking emotional support, engaging in religious activities, participating in peer support groups, or consulting healthcare professionals. Others rely on emotional suppression, social withdrawal, or self-isolation because of fear of stigma or concerns about being judged by family members or healthcare providers. Although these coping mechanisms may temporarily reduce emotional distress, they may also delay professional help-

seeking and contribute to the persistence of depressive symptoms. Understanding these coping behaviours within their cultural context is important for developing interventions that are acceptable, culturally appropriate, and responsive to women's lived experiences.

The present study was informed by the Biopsychosocial Model**,** which proposes that health outcomes result from the interaction of biological, psychological, and social factors. In the context of postpartum mental health, biological changes associated with childbirth interact with psychological responses, including anxiety and depressive symptoms, while broader social influences such as family relationships, cultural expectations, stigma, and healthcare experiences shape women's ability to cope and access appropriate care. This framework provides a comprehensive understanding of maternal mental health and supports integrated approaches that combine clinical care, psychosocial support, and community engagement.

Despite growing recognition of maternal mental health as a priority, important evidence gaps remain regarding how postpartum women experience available healthcare services within the Nigerian health system. In particular, there is limited qualitative evidence describing how social support, coping strategies, and interactions with healthcare providers influence maternal mental health service utilization in Southeast Nigeria. Such evidence is essential for informing interventions that extend beyond identifying women with postpartum depression to ensuring that appropriate, accessible, and culturally responsive services are available.

This study therefore explored the social support systems, coping strategies, and healthcare experiences of postpartum mothers attending a private Hospital, Awka, Anambra State, Nigeria**,** in 2024. Specifically, the study examined how women experienced support from family and healthcare providers, the strategies they adopted to cope with postpartum psychological distress, and the health system factors influencing access to maternal mental health services. The findings provide context-specific evidence to inform the integration of maternal mental healthcare into routine postnatal services, strengthen provider capacity, and support the development of family-centred and culturally responsive interventions aimed at improving maternal wellbeing in Nigeria.

Methods

Study design

This study employed a qualitative descriptive design to explore the social support systems, coping strategies, and healthcare experiences of postpartum mothers experiencing mental health challenges in Southeast Nigeria. A qualitative approach was considered appropriate because it enabled an in-depth exploration of participants' perceptions, experiences, and interactions with family members and healthcare providers within their sociocultural context. The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.

Study setting

The study was conducted between May and August 2024 at a private Hospital, Awka**,** located in Awka South Local Government Area of Anambra State, Southeast Nigeria. Life International Hospital is a privately owned secondary healthcare facility that provides comprehensive maternal and child health services, including antenatal care, delivery services, postnatal care, child welfare clinics, and general outpatient services. Although routine maternal healthcare services are available, dedicated maternal mental health screening and counselling services are not routinely integrated into postnatal care.

Participants and recruitment

The study population comprised postpartum mothers attending postnatal and child welfare clinics at the hospital. Participants were recruited using purposive sampling to ensure the inclusion of women with diverse postpartum experiences.

Women were eligible to participate if they:

- were within six months postpartum;
- attended postnatal or child welfare services at Life International Hospital during the study period;
- were able to communicate in English or Igbo;
- were willing to share their experiences during focus group discussions; and
- provided written informed consent.

Mothers with severe physical illness or who were unable to participate in group discussions were excluded.

A total of 36 postpartum mothers participated in the study. Recruitment continued until data saturation was achieved, with no substantially new concepts emerging during the final focus group discussion.

Data collection

Data were collected through four focus group discussions (FGDs)**,** each comprising 8–10 participants**.** A semi-structured interview guide developed by the research team was used to facilitate discussions on participants' experiences of social support, coping strategies, interactions with healthcare providers, barriers to seeking psychological care, and perceptions of maternal mental health services.

The discussions were moderated by the principal researcher with support from a trained research assistant experienced in qualitative maternal health research. Sessions were conducted in either English or Igbo**,** depending on participants' language preference, and lasted approximately 60–90 minutes. All discussions were audio-recorded with participants' permission, while detailed field notes were maintained to document non-verbal communication, group dynamics, and contextual observations that supported interpretation of the findings.

Researcher reflexivity

The research team consisted of investigators with backgrounds in public health education, maternal health, and qualitative research. Before commencing data collection, the researchers reflected on their professional backgrounds and potential assumptions regarding postpartum mental health to minimise bias during data collection and interpretation. During the focus group discussions, moderators adopted a neutral, non-judgmental approach and encouraged participants to express their experiences freely. Reflexive discussions were conducted throughout the analytical process to ensure that emerging interpretations remained grounded in participants' accounts.

Data management and analysis

Audio recordings were transcribed verbatim immediately after each discussion. Interviews conducted in Igbo were translated into English by bilingual researchers familiar with both languages and the local cultural context. To ensure accuracy, translated transcripts were independently reviewed against the original recordings before analysis.

The transcripts were imported into NVivo 14 (QSR International, Melbourne, Australia) to facilitate data organisation and coding. Data were analysed using the six-phase thematic analysis framework described by Braun and Clarke, comprising familiarisation with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report.

Two members of the research team independently coded all transcripts before comparing coding frameworks. Differences in coding and theme development were discussed until consensus was achieved. Credibility of the findings was strengthened through investigator triangulation and member checking, whereby preliminary themes were discussed with a small group of participants to confirm that the interpretations accurately reflected their experiences. An audit trail documenting coding decisions and theme development was maintained throughout the analysis to enhance dependability and transparency.

Trustworthiness

The trustworthiness of the study was established using the criteria of credibility, dependability, confirmability, and transferability. Credibility was enhanced through prolonged engagement with participants, member checking, investigator triangulation, and the inclusion of verbatim quotations

to support the findings. Dependability was strengthened through consistent use of the semi-structured interview guide and maintenance of an audit trail throughout the research process. Confirmability was achieved through reflexive discussions among the research team and independent coding of transcripts. Transferability was supported by providing detailed descriptions of the study setting, participants, recruitment procedures, and analytical processes to enable readers to determine the applicability of the findings to similar contexts.

Ethical considerations

Administrative approval to conduct the study was obtained from the management of a private Hospital, Awka**,** before commencement of data collection. All participants received detailed information about the purpose of the study, study procedures, voluntary participation, confidentiality, and their right to withdraw from the study at any stage without consequences. Written informed consent was obtained from all participants before participation in the focus group discussions.

Participants' anonymity was protected by removing all identifying information from the interview transcripts and assigning pseudonyms during data analysis and reporting. Audio recordings and transcripts were stored securely and were accessible only to the research team. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki and reported in line with the COREQ guidelines for qualitative research.

Results

Participant characteristics

Thirty-six postpartum mothers participated in the study through four focus group discussions (FGDs), with each discussion comprising between eight and ten participants. Participants represented diverse socio-demographic backgrounds with respect to age, parity, educational attainment, occupation, marital status, and postpartum duration. Most participants were married, had completed at least secondary education, and were within six months postpartum. The diversity of participants enriched the discussions by capturing a broad range of experiences relating to social support, coping strategies, and interactions with maternal healthcare services.

Table 1: Socio-demographic characteristics of participants (N = 36)

Characteristic	**Category**	**n (%)**
Age (years)	20–24	6 (16.7)
	25–29	12 (33.3)
	30–34	11 (30.6)
	≥35	7 (19.4)
Marital status	Married	31 (86.1)
	Single	5 (13.9)
Educational level	Primary	4 (11.1)
	Secondary	15 (41.7)

	Tertiary	17 (47.2)
Occupation	Civil servant	8 (22.2)
	Trader	11 (30.6)
	Self-employed	7 (19.4)
	Housewife	6 (16.7)
	Student	4 (11.1)
Parity	Primiparous	15 (41.7)
	Multiparous	21 (58.3)
Months postpartum	0–2 months	10 (27.8)
	3–4 months	13 (36.1)
	5–6 months	13 (36.1)

Thematic findings

Analysis of the focus group discussions generated **three interrelated themes** describing participants' experiences: **(1) social support**, **(2) coping strategies**, and **(3) healthcare experiences**. These themes illustrate how interpersonal relationships, cultural expectations, and characteristics of the healthcare system influenced women's psychological wellbeing and their use of maternal mental health services.

Theme 1: Social support

Participants consistently described social support as an important resource during the postpartum period. Support from spouses, relatives, and peers helped many women manage emotional distress, although unsupportive family relationships often intensified psychological difficulties.

Spousal support

Many participants identified their husbands as their primary source of emotional encouragement during the postpartum period. Emotional reassurance and practical assistance enhanced confidence and reduced feelings of isolation.

One participant explained:

"My husband encouraged me, saying I was doing well. That gave me strength." (FGD 1)

Women who described supportive spouses generally reported feeling more capable of coping with childcare responsibilities and emotional challenges.

Family support and criticism

Extended family members frequently provided practical assistance with household responsibilities and infant care. However, participants also described criticism from relatives, particularly older family members, which often worsened emotional distress.

One participant remarked:

"My sister told me I was lazy because I could not manage the baby alone. That made me feel worse." (FGD 2)

Another explained:

"My mother-in-law compared me to other women who seemed stronger. I felt ashamed." (FGD 3)

These experiences demonstrate that family involvement could function either as a protective factor or an additional source of emotional burden.

Peer support

Several mothers described interactions with other postpartum women attending clinic visits as an important source of reassurance. Sharing experiences with women facing similar challenges reduced feelings of loneliness and normalized emotional difficulties.

As one participant noted:

"Talking with other mothers helped me. I realized I was not alone." (FGD 4)

Peer support was therefore perceived as reducing isolation and encouraging emotional expression despite broader societal stigma.

Theme 2: Coping strategies

Participants described adopting a range of coping strategies to manage postpartum psychological distress. These strategies reflected personal beliefs, available support systems, and prevailing cultural expectations that mothers should remain emotionally resilient after childbirth.

Emotional suppression and silence

The most commonly reported coping strategy was deliberately concealing emotional distress from family members and healthcare providers.

One participant stated:

"I kept quiet because I did not want my family to think I was ungrateful." (FGD 1)

Many participants viewed silence as necessary to avoid criticism or being perceived as weak.

Religious coping

Prayer emerged as one of the most frequently described coping mechanisms. Participants viewed religious faith as a source of emotional comfort and resilience during periods of distress.

One mother explained:

"I prayed every night, asking God to give me strength. It was the only way I could cope." (FGD 2)

Religious practices appeared to provide hope and emotional stability, particularly among women who lacked access to professional psychological support.

Social withdrawal

Several participants reported intentionally withdrawing from social interactions because of sadness, fatigue, or fear of being judged.

As one participant explained:

"I stopped going to church because I did not want people to see me looking weak." (FGD 4)

Withdrawal often reduced opportunities for receiving social support and delayed professional help-seeking.

Selective disclosure

Although most women concealed their emotional struggles, a few participants described discussing their experiences with trusted healthcare workers or close friends.

One participant shared:

"When I spoke to the nurse, she told me it was normal. That gave me hope." (FGD 2)

These accounts suggest that supportive interpersonal relationships facilitated healthier coping and encouraged future help-seeking.

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Theme 3: Healthcare experiences

Participants consistently described healthcare services as concentrating primarily on physical recovery following childbirth, with limited attention given to maternal psychological wellbeing.

Limited mental health screening

Most participants reported that healthcare providers rarely asked about their emotional wellbeing during routine postnatal consultations.

One participant explained:

"They only asked about the baby's weight and my blood pressure. Nobody asked if I was feeling sad." (FGD 1)

The absence of routine mental health assessment meant that emotional difficulties frequently remained unidentified.

Limited counselling and support services

Participants also reported that formal counselling services addressing postpartum mental health were largely unavailable.

One mother reflected:

"If you say you are sad, they think you are not grateful for your baby." (FGD 3)

Fear of stigma, combined with the perceived absence of supportive services, discouraged many women from discussing psychological symptoms with healthcare professionals.

Positive provider interactions

Although relatively uncommon, participants who experienced supportive interactions with healthcare providers described these encounters as reassuring and emotionally beneficial.

One participant stated:

"The doctor told me it was normal to feel this way. That helped me accept myself." (FGD 2)

Another added:

"When the counsellor listened, I realized I was not alone. That gave me courage." (FGD 4)

These experiences suggest that empathetic communication and professional reassurance positively influenced participants' willingness to acknowledge emotional difficulties.

Overall, participants perceived maternal healthcare services as focusing predominantly on infant health and maternal physical recovery, while psychological wellbeing received comparatively little attention. Consequently, many women relied on informal support networks and personal coping strategies rather than professional mental health services.

Table 2: Summary of themes, subthemes and illustrative quotations

Theme	Subthemes	Illustrative quotation
Social support	Spousal encouragement; family assistance; criticism from relatives; peer support	*"My husband encouraged me, saying I was doing well."*; *"My sister told me I was lazy."*; *"Talking with other mothers helped me."*
Coping strategies	Emotional suppression; prayer; social withdrawal; selective disclosure	*"I kept quiet because I did not want my family to think I was ungrateful."*; *"I prayed every night."*; *"I stopped going to church."*
Healthcare experiences	Limited mental health screening; inadequate counselling; stigma; supportive provider interactions	*"Nobody asked if I was feeling sad."*; *"If you say you are sad, they think you are not grateful."*; *"The doctor told me it was normal."*

Summary of findings

The findings demonstrate that postpartum mothers attending a private hospital in Awka, Southeast Nigeria**,** relied predominantly on informal social support from spouses, relatives, and peers to manage emotional distress during the postpartum period. Coping strategies were strongly influenced by cultural expectations that encouraged emotional restraint, religious reliance, and limited disclosure of psychological symptoms. Participants also described important gaps within maternal healthcare services, including limited routine screening for postpartum mental health conditions, inadequate counselling services, and minimal provider engagement regarding emotional wellbeing. Although positive interactions with empathetic healthcare providers were uncommon, they were consistently described as validating and beneficial. Collectively, these findings highlight opportunities for strengthening maternal health services through the integration of routine mental health assessment, culturally responsive counselling, and family-centred support within postnatal care.

Discussion

This study explored the social support systems, coping strategies, and healthcare experiences of postpartum mothers attending a private hospital in Awka, Southeast Nigeria**.** Three interrelated themes emerged from the analysis: the central role of informal social support, coping strategies shaped by sociocultural expectations, and important gaps in the delivery of maternal mental healthcare services. Together, these findings demonstrate that postpartum mental health is influenced not only by individual psychological experiences but also by family relationships, cultural norms, and the responsiveness of the healthcare system. The findings reinforce growing evidence that strengthening maternal mental healthcare requires interventions at both the community and health system levels.

Social support as both a protective and risk factor

Social support was consistently identified as a major influence on participants' psychological wellbeing. Mothers described emotional encouragement from spouses and practical assistance from relatives as important sources of resilience during the postpartum period. These findings are consistent with previous Nigerian research showing that inadequate social support significantly increases the risk of postpartum depression and psychological distress among postpartum women (Agbaje et al., 2019). Similarly, systematic reviews from low- and middle-income countries have demonstrated that strong family and social support are among the most important protective factors against postpartum depression, whereas interpersonal conflict and social isolation substantially increase vulnerability (Gelaye et al., 2016; Slomian et al., 2019).

However, family relationships were not uniformly beneficial. Several participants reported criticism, comparisons with other mothers, and unrealistic expectations regarding childcare responsibilities. Rather than providing reassurance, these interactions intensified feelings of inadequacy, guilt, and emotional distress. This finding highlights the complexity of family involvement within postpartum care in Nigeria, where extended family members often play important caregiving roles but may also reinforce cultural expectations that discourage emotional vulnerability. Consequently, family involvement alone cannot be assumed to improve maternal wellbeing; the quality of interpersonal relationships appears to be equally important.

Peer support also emerged as an important source of emotional reassurance. Mothers who shared experiences with other postpartum women reported feeling understood and less isolated. These findings suggest that structured peer-support programmes integrated into postnatal care may complement formal healthcare services by reducing stigma, encouraging disclosure, and promoting emotional wellbeing.

Coping strategies and sociocultural influences

Participants described several coping strategies, including emotional suppression, prayer, social withdrawal, and selective disclosure. Emotional suppression was the most frequently reported

strategy, with many mothers choosing not to discuss their emotional difficulties because they feared criticism or being perceived as weak. Similar observations have been reported in studies examining mental health stigma in Nigeria, where cultural beliefs often discourage acknowledgement of psychological distress and delay professional help-seeking (Oladeji & Gureje, 2019).

Religious coping was another prominent finding. Prayer provided participants with emotional comfort, hope, and resilience during periods of distress. Religious beliefs have long been recognised as important coping resources within many African communities and may provide significant psychological benefits. Nevertheless, reliance on prayer alone may delay access to professional mental healthcare when symptoms become severe. Therefore, maternal mental health programmes should acknowledge the positive role of spirituality while promoting timely access to evidence-based psychological support.

Social withdrawal was also commonly described, with participants avoiding social gatherings because of sadness, fatigue, or fear of judgement. Although withdrawal may temporarily reduce exposure to criticism, it simultaneously limits opportunities for receiving emotional support and may contribute to worsening depressive symptoms. In contrast, participants who disclosed their experiences to trusted healthcare providers or close family members generally described these interactions positively, suggesting that supportive communication encourages help-seeking and emotional recovery.

Healthcare experiences and health system gaps

One of the most important findings of this study was the limited attention given to maternal mental health within routine postnatal services. Participants consistently reported that healthcare providers concentrated primarily on maternal physical recovery and infant wellbeing, while psychological health was rarely discussed. None of the participants described receiving routine mental health screening during postnatal consultations.

These findings reflect broader challenges in maternal mental healthcare reported across many low- and middle-income countries, where shortages of trained personnel, competing healthcare priorities, and limited mental health resources reduce opportunities for early identification and management of postpartum depression (Howard & Khalifeh, 2020; World Health Organization, 2022). Failure to identify women experiencing psychological distress during routine maternal healthcare represents a missed opportunity for early intervention and may contribute to prolonged illness and poorer maternal and infant outcomes.

Participants also described limited availability of counselling services and referral pathways for women experiencing emotional distress. In many cases, women perceived healthcare facilities as places where physical complications were treated, while emotional wellbeing received little attention. Consequently, participants relied predominantly on family support, religious practices, and personal coping strategies rather than professional mental healthcare.

Although relatively uncommon, positive interactions with empathetic healthcare providers had a substantial influence on participants' experiences. Women who received reassurance and emotional validation reported feeling understood, accepted, and more willing to acknowledge their psychological symptoms. These findings demonstrate that even brief supportive interactions between healthcare providers and postpartum women may improve help-seeking behaviour and reinforce the importance of patient-centred communication during postnatal care.

Comparison with existing literature

The present findings are consistent with international evidence demonstrating that postpartum mental health is shaped by interactions between individual, interpersonal, and health system factors. Systematic reviews have shown that untreated postpartum depression is associated with impaired maternal functioning, reduced mother–infant interaction, poorer child developmental outcomes, and diminished family wellbeing (Slomian et al., 2019; Wang et al., 2021). Similarly, Howard and Khalifeh (2020) emphasized that improving maternal mental health requires integration of psychological care into routine maternal health services rather than treating mental health as a separate specialty service.

Our findings extend this evidence by illustrating how sociocultural expectations surrounding motherhood influence healthcare utilization in Southeast Nigeria. Cultural expectations that mothers should remain emotionally strong and grateful following childbirth contributed to reluctance to disclose psychological symptoms, even when healthcare services were available. This suggests that improving maternal mental healthcare requires not only strengthening health services but also addressing cultural beliefs and stigma surrounding mental illness within families and communities.

Theoretical implications

The findings are well explained by the Biopsychosocial Model**,** which proposes that health outcomes arise from interactions between biological, psychological, and social factors. Participants' experiences illustrate how biological changes associated with childbirth interacted with emotional distress, while family relationships, cultural expectations, and healthcare experiences shaped coping behaviours and access to care. This multidimensional perspective supports integrated maternal healthcare approaches that address psychological wellbeing alongside physical recovery.

The findings also align with the Social Ecological Model, which recognizes that health behaviours are influenced by multiple interacting levels. Individual reluctance to disclose emotional distress, family attitudes toward mental illness, community stigma, and institutional limitations within healthcare services collectively influenced maternal mental health experiences. These findings suggest that interventions targeting only one level are unlikely to achieve sustained improvements without complementary changes at family, community, and health system levels.

Policy and practice implications

The findings have important implications for maternal healthcare policy and practice in Nigeria. First, routine screening for postpartum depression should be integrated into standard postnatal care using validated screening instruments to facilitate early identification of women requiring psychological support. Second, healthcare providers require additional training in maternal mental health assessment, counselling, and referral to improve confidence and competence in managing postpartum psychological disorders. Third, maternal mental health services should be incorporated into existing primary and secondary maternal healthcare programmes to ensure that emotional wellbeing receives the same priority as physical health. Finally, family-centred education and community awareness programmes are needed to reduce stigma, promote supportive family relationships, and encourage timely help-seeking among postpartum women.

Strengths and limitations

A major strength of this study is its qualitative design, which provided rich descriptions of postpartum mothers' experiences that are unlikely to be captured through quantitative surveys alone. The use of focus group discussions facilitated interaction among participants and generated detailed accounts of social support, coping behaviours, and healthcare experiences. Furthermore, adherence to the COREQ reporting guidelines enhanced the transparency and credibility of the study.

Nevertheless, several limitations should be acknowledged. The study was conducted among postpartum mothers attending a private hospital in Awka, and the findings may not be transferable to women receiving care in public health facilities or in other regions of Nigeria. Participants who did not attend healthcare facilities were not represented and may have different experiences of postpartum mental health and service utilization. In addition, the qualitative design was not intended to estimate prevalence or establish causal relationships. Future studies should include multiple healthcare settings across different geopolitical regions of Nigeria and consider mixed-methods or longitudinal designs to examine changes in maternal mental health experiences and healthcare utilization over time. The findings demonstrate that improving maternal mental health services in Nigeria requires strengthening routine screening, expanding access to culturally responsive counselling, enhancing provider capacity, and promoting supportive family and community environments. Addressing these interconnected factors will improve service utilization and contribute to better maternal and child health outcomes.

Conclusion

This study provides qualitative evidence on the social support systems, coping strategies, and healthcare experiences of postpartum mothers attending a private hospital in Awka, Southeast Nigeria. The findings demonstrate that maternal mental health is shaped by a complex interaction of family relationships, sociocultural expectations, individual coping behaviours, and the responsiveness of the healthcare system. While supportive spouses, relatives, and peers

contributed positively to women's emotional wellbeing, criticism, stigma, and expectations of maternal resilience often discouraged disclosure of psychological distress and delayed help-seeking. Participants also identified important gaps within routine postnatal care, including limited mental health screening, inadequate counselling services, and minimal provider engagement regarding emotional wellbeing.

These findings highlight the need to strengthen maternal mental healthcare within existing postnatal services. Integrating routine screening for postpartum mental health conditions, improving healthcare providers' capacity to identify and manage psychological distress, and establishing appropriate referral pathways may facilitate earlier recognition and timely intervention. In addition, culturally responsive counselling, family-centred education, and community-based stigma reduction initiatives have the potential to improve acceptance of maternal mental health services and encourage women to seek professional support.

This study contributes context-specific evidence that may inform maternal health policy and service delivery in Nigeria and similar resource-constrained settings. Future research should include multiple healthcare facilities across different regions of the country and examine the effectiveness of integrated maternal mental health interventions in improving service utilization, maternal wellbeing, and child health outcomes.

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