

Exploring Knowledge, Attitudes and Care-Seeking Practices Related to Postpartum Depression Among Marginalized Mothers in Rajshahi, Bangladesh: An Exploratory Qualitative Study

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Abstract: Limited awareness, cultural attitudes and lack of access to care influence whether marginalized women are identified and supported after delivery, in the context of postpartum depression (PPD) which is not well recognized. This study focuses on the understanding, interpretation and reactions of the marginalized mothers towards postpartum emotional and psychological distress in relation to PPD in the slum community of low-income group in Rajshahi District. The design of the research was exploratory qualitative. This study analyzed 75 mothers who gave birth within the last five years using 70 semi-structured interviews and 5 in-depth case studies. The data was collected in Bengali from October to November 2025 and thematically analyzed with coded frequencies, which were used descriptively to show the distribution of frequented accounts across the sample not as indicators of the prevalence of these accounts in the population. The knowledge domain in most cases PPD was not seen as a separate condition and in many cases, mothers lacked a shared language for their experience because they were illiterate and could not access the community health outreach. Families, in their turn, tended to blame distress on supernatural or spiritual factors, they were less likely to openly discuss their emotions, and a stronger preference for sons influenced family reactions to the suffering of mothers in the attitude's realm. Only 17 out of 75 mothers received any postnatal checkup in the domain of the practice, many families depended on amulets and spiritual remedies rather than medical intervention and mothers took up heavy workloads in the house and in work to support their families shortly after giving birth. The three gaps seem to reinforce each other. The results indicate that a community-based awareness and structural and economic support for marginalized mothers might be more effective with clinical screening.

Keywords: Postpartum Depression; Postpartum Distress; Knowledge, Attitudes and Practices; Care-Seeking; Marginalized Women; Bangladesh; Qualitative Research.

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I. INTRODUCTION

Motherhood is considered one of life's most fulfilling experiences, but for a significant number of women, the postpartum phase is a time of psychological distress [1]. Although clinically studied, there is less empirical research on women's experiences of postpartum emotional and psychological distress in low-resource, marginalized settings; and research on how women interpret and react to emotional and psychological challenges after childbirth is still in its

early stages [2], [3]. One out of every five women is thought to suffer from common perinatal mental disorders in low and lower-middle income countries, such as Bangladesh, and formal recognition and treatment for these disorders is uncommon [4].

This problem is best solved by adopting a knowledge, attitudes, and practices (KAP) approach because PPD is a clinical problem as well as a social problem. A woman's distress may be named, tolerated, stigmatized, or treated

depending on what her community knows about the condition, the way it is culturally understood and talked about, and the community's expectations for behaviors in seeking care [5]. While poverty, illiteracy and limited access to services constrain all three domains among marginalized groups such as people of the informal settlements in urban and peri-urban areas in Bangladesh [6]. Previous Bangladeshi studies have documented perinatal mental distress in rural areas and, more recently, among slum residents in Dhaka [8], [9], [25], however, not much is known about how women in the periphery of the city experience respond to postpartum distress or how the lack of knowledge, attitudes, and practices work together rather than independently. Studies of these issues of marginalized women in slum communities in the district of Rajshahi specifically are apparently limited. This study aims to fill this gap by analyzing and reinterpreting the qualitative fieldwork done in the original study of women's postpartum experience in the slum area of Simla, near Laxmipur, in the district of Rajshahi.

This research examines the experience of postpartum distress from the perspective of the mothers and how their family and cultural experiences affect the nature in which they understand postpartum distress and how they seek care for it. As a result, it sees PPD as a socially constructed experience, as well as a clinical condition that can be diagnosed, and as such considers gender relations, family authority, poverty, stigma, and access to care. The guiding questions are: What is the gap in knowledge, attitude and practice (KAP) of marginalized mothers related to PPD in this context, and how is the interaction between the gap in knowledge, attitude and practice (KAP)?

II. LITERATURE REVIEW

➤ *The Burden and Recognition Gap*

The prevalence of PPD depends on the context and is estimated to vary greatly, in part due to varying definitions of PPD, screening methods, and how symptoms are expressed culturally [7], [8]. Depressive symptoms have been reported in about 18% of women in rural Bangladesh during pregnancy and as high as 32% at six to eight months after delivery [9], and a study of women in slums in Dhaka found nearly one in five mothers suffered from depressive symptoms during the first year after giving birth [25]. For Bengali women, screening tools that rely on western symptom expression, like those that ask if life is worth living, are not relevant; they tend to somatize distress, express it using local idioms like "tension" or simply not see it as a discrete condition [10], [11], [27]. It is not just a question of what mothers and their communities can name and recognize but also what they may not be able to identify and measure. Researchers need to consider what communities know and their inability to recognize and evaluate their own experiences.

➤ *Cultural Attitudes and Stigma*

Postpartum rituals can either reinforce or alienate the mother and either help or make help worse [12], [13]. While the traditional postpartum confinement period is meant to

ensure rest and support for the new mother, [14], [15]; in some parts of Bangladesh, it also restricts her movement and voice within the home, and in different ways and intensities in different regions, classes and households, and should not be considered a uniform Bangladeshi norm. Stigma against mental illness in general deters disclosure of emotional challenge [16], [17], and gendered family dynamics such as high son preference have been associated in some communities to greater stigma faced by mothers who give birth to girls [18]. Such patterns of attitude are important for the knowledge domain because they influence what kinds of explanations for distress are shared within a household, and in the practice domain because they influence the riskiness of disclosure of the distress, including whether it results in care-seeking.

➤ *Practices and Barriers to Care*

Accepting care, even when mothers are aware of their distress, is influenced by costs, transport, household decisions regarding spending, and services available [19], [20], [26]. Around the time of childbirth, IPV is reported as a correlate of depressive symptoms, and as a practice-level barrier: controlling partners could limit mothers' access to support [21], [22]. The evidence from various national surveys also indicates that formal mental health seeking among Bangladeshi women of reproductive age is relatively low, even in the presence of mental health issues, and that informal networks are responsible for most of the assistance provided [28]. The existing literature indicates that the problem of limited recognition, stigmatizing interpretation, and limited practical access to PPD in the marginalized communities in Bangladesh is not likely to be solved by any single intervention, as each of these factors and their interlinkages will reinforce the other.

➤ *Toward an Interconnected KAP Framework*

The current literature largely views knowledge, attitude and practices as distinct and independent variables, and prevalence of knowledge, cultural beliefs or barriers to service use are reported as concurrent but separate findings. There is a dearth of research, especially outside of Dhaka, that documents interactions between these three domains in one marginalized community: how what these women and families know (or don't know) about PPD influences their attitude, and how their attitude influences what is considered possible or not in the area of practice. This study aims to fill that void by considering the three KAP domains as interrelated rather than as discrete areas, and least of all as discrete areas, in a neglected slum community in the town of Rajshahi District, which has been hardly attended by any special qualitative study so far.

III. METHODOLOGY

➤ *Research Design*

This study was conducted in an exploratory qualitative format which aimed to capture mothers' experiences of the emotional and psychological issues of the postpartum period and the social significance attributed to these, rather than relying on predetermined diagnostic categories. Studies related to these concerns in the context of marginalized

women in slum communities of Rajshahi District were not seen to be very much, hence, the exploratory qualitative method was selected which was able to detect the knowledge, attitude and practice pattern in the slum women, that could not be captured by a structured survey instrument or the same may be mis-specified.

➤ *Setting*

The data was collected in the slum area of Simla, near Laxmipur area of Rajshahi District, in Bangladesh, which is an informal low-income slum area with poor access of formal health and social services.

➤ *Participants and Sampling*

The mothers were selected by purposive, non-probability sampling for mothers with previous 5-year delivery history. A total sample of 75 mothers was interviewed using semi-structured interviews (70 mothers) and in-depth case studies (5 mothers). The five case-study participants were purposively selected because their narratives enabled these coded themes to be brought into particularly rich focus through the nature of the situation they encountered, for example being survivors of documented intimate partner violence or having complex post-surgical recovery processes. Their accounts were used only to complement and extend the thematic patterns that emerged in the broader sample and were not intended to replace them. There was no reliable record of the total population of the study area, and therefore no possibility of a probability sample. Thematic saturation was achieved with 75 participants, and recruitment continued until this point.

➤ *Data Collection*

In September and November 2025, face-to-face and semi-structured interviews were conducted in Bengali to collect primary data. Interviews were conducted for about 45-60 minutes. Oral informed consent was sought prior to each interview, and audio recording was conducted using a smartphone with explicit consent from each participant. Any newspaper, web or government documents that were used as secondary were used only for contextualization purposes and were not used as part of the primary qualitative data and used to develop themes or codes to the analysis.

➤ *Interview Guide*

The interview guide covered three general topics: main causes of postpartum distress; impact of cultural attitudes and fear of stigma on postpartum distress; and mothers' perceptions and practices surrounding seeking medical care. Questions were open-ended and did not include words of a

diagnostic or offensive nature so that mothers could give their experience in their own terms.

➤ *Data Analysis*

All the recordings were transcribed in Bengali, translated into English and checked for accuracy. Thematic analysis was used to find common themes in mothers' stories. For the purposes of this paper, the themes that emerged in the initial coding were grouped under the three KAP domains listed in Table 1 as opposed to creating an inventory of stressors following the birth of a child. The simple frequencies for those participants who had an account with a specific coded theme were descriptive to show the frequency of the theme within the sample. The counts for each should not be interpreted as prevalence for mothers who met clinical criteria for depression.

➤ *Credibility and Trustworthiness*

The credibility of the analysis was supported by a few standard qualitative approaches: That the translation of the original Bengali language recordings was checked against the transcripts; that each code was accompanied by illustrative excerpts of the recordings and that re-mapping the original eight themes to the three KAP domains was done not just with a summary of the original coding, but by referring back to the original transcriptions.

➤ *Ethical Considerations*

The mothers participated voluntarily and they were told that if they did not want to answer any question or withdraw from it at any time, there was no consequence. Due to the varied levels of literacy within the study community, informed oral consent for the purpose of the study, the voluntary nature of participation and the use of audio recording was obtained from each participant prior to the interview.

All participants' names were anonymized, and the identities of other participants were not disclosed during the process of data collection, transcription or reporting, even when using quotations from anonymous participants. The interview guide used did not include language that might offend or discriminate against participants and interviews were held in a confidential setting to minimize the risk of participants' answers being overheard by others in their household, particularly regarding the issue of intimate partner violence and family conflict sensitivity. The researcher ensured that the research participants were not deceived about the purpose of the research and was objective in collecting and analyzing data.

Table 1 Mapping Original Thematic Codes onto KAP Domains

KAP Domain	Original Theme(s)	Illustrative Code(s)
Knowledge	Lack of knowledge; illiteracy (from socio-economic factors)	No familiarity with the term 'postpartum depression'; no exposure to health-worker or NGO outreach
Attitudes	Cultural attitudes and fear of stigma; culture of superstition; negligence towards mother's feelings; cultural attitudes of family members; psychological issues	Belief in spiritual causation; stigma around expressing distress; devaluation of daughters; normalization of anger directed at children
Practices	Attitude towards medical care; physical challenges;	Low uptake of postnatal check-ups; reliance on amulets

	intimate partner violence; socio-economic factors	and holy water instead of clinical care; resumption of paid and domestic labor immediately postpartum
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Source: Authors' Re-analysis of Original Interview Data.

IV. FINDINGS

Data is presented by KAP domain. Reported frequencies are the number of mothers in the 75 mothers with whom the authors spoke and who were included in the qualitative sample who had a given coded theme discussed in the interview or case study report and should not be interpreted as clinical prevalence rates as no standardized diagnostic assessment was used.

➤ Knowledge Domain: An Unnamed Condition

In the sample, postpartum depression was rarely identified as an identifiable 'condition' at all. Mothers talked about physical fatigue, mood swings and psychological distress, but they did not have a common language for them as a syndrome and no one within the household, including husbands, knew them in that language. All the mothers reported mental and physical problems after birth, but the term postpartum depression was not known to them. No health workers and non-governmental organizations (NGOs) had come to the slum to create awareness on postpartum mental health. Most mothers could not read and write, further restricting their access to print health information if it were available. This lack of knowledge was exacerbated by poverty. Several mothers attributed their failure to seek information or care to the survival day to day rather than to lack of sensitivity or indifference. One mother said that she had known poverty before she became pregnant: After giving birth, she was even poorer, and worry is a life-long condition, not a treatable one.

➤ Attitudes Domain: Superstition, Stigma, and Gendered Devaluation

Many families saw mothers' symptoms as spiritual or superstitious without having a medical diagnosis of what was causing them. 33 out of 75 mothers stated that their family members believed that they were possessed by evil spirits that caused their physical and hormonal symptoms. These families resorted to amulets and to the use of certain diets which were not medical consultations.

"My mother-in-law gave me an amulet, and for three days I was not allowed to eat any food, only holy water."

Gendered attitudes also influenced the way families were able to receive mothers' distresses. Of the 75 mothers, 63 said there was a negative response from family members after their child was born a daughter, with some reports of verbal abuse and/or pressure for a male child, and in some cases, the use of herbal remedies for sex change.

"After giving birth to two female babies, my mother-in-law, husband, and sister-in-law beat me almost every day. They addressed me as a curse on their family."

Emotional expression was another aspect of life regulated by stigma. Some mothers reported that they

concealed their distress to look happy to their husbands and that this increased their distress. The 75 mothers were asked if their families were emotionally neglectful of them after the child was born and treated the child's needs more seriously than their own personal needs, 53 mothers answered in the affirmative.

➤ Practices Domain: Limited Care-Seeking and Reliance on Non-Medical Remedies

There was a limited uptake of formal postnatal care-seeking, reflecting the above-described gaps in knowledge and attitude. The postoperative checkup was performed on only 17 of the 75 mothers. Others indicated financial constraints as the primary obstacle: husbands were not willing or able to pay for the mother's care. Of the 75 mothers, 47 were C-sect, and a few mentioned the physical effects of the c-section that were not addressed by follow-up care, for example, back pain, and changed skin tone from meds.

"After giving birth to my baby, I had a tumor on my waist, so I had an operation and there are 16 stitches, so now I cannot do any hard work. I am a burden for them."

Many households resorted to informal spiritual healing rather than seeking clinical attention and mothers were expected to soon resume physical labor, whether for the household or for income, after giving birth. One mother, whose family depended on her to work both in the home and on the street as a beggar, was forced back to work within weeks of her giving birth and was denied a period of rest.

IPV was prominently mentioned in attitudes and practices. 63 of the 75 mothers indicated that they had experienced IPV during their postpartum period, often related to accounts of the partner's unemployment, drug use, or their dissatisfaction with the sex of the child. The qualitative, cross-sectional nature of this research design does not allow us to determine the causal direction or strength of any association between IPV and diminished ability to communicate their own needs for care, but there was a close and consistent relationship between the two in the mothers' narratives.

V. DISCUSSION

The community level knowledge, attitude and practice gaps regarding postpartum depression seem not to be independent but rather reinforcing experiences were shared by participants. The knowledge gap is the lack of recognition of PPD as a discrete condition, the attitude gap is the superstitious and stigmatized interpretations by families of their distress, and the practice gap is a tendency to seek spiritual remedies and to return to work as soon as possible. This is in line with previous studies that found that beliefs about illness influence both the expression of perinatal distress and seeking help behaviors in women [23], [24].

➤ *Medicalization and Naming*

Not having a familiar term for PPD is not just a lack of familiarity with a clinical diagnosis, it is also a sociological factor. If there is no common term for a condition, such as among mothers in this study who experienced no word for what they were going through, it's more difficult to see that condition as a legitimate health problem rather than a private affliction to be borne. This is similar to the findings of other urban slum-dwelling adults in Bangladesh, who talk about their distress in terms of local idioms of "tension" rather than diagnostic categories and who react accordingly in terms of seeking help [27]. Medicalization in this context is a social process as well, since it makes it necessary for a community to first "categorize" a cluster of experiences as a named, addressable category.

➤ *Gender and Household Power*

In this study, son preference, emotional neglect, IPV, and lack of gender equality in household spending are better understood as manifestations of gendered household power that influence the recognition of a mother's distress and her capacity to take action on her own health needs. These mothers who reported more severe treatment after the birth of the daughter or violence related to a partner's dissatisfaction were not only reporting depressive symptoms but were reporting restrictions of voice and mobility within the household. The dynamics observed are consistent with others from other Bangladeshi contexts that have found links between IPV and less maternal seeking of care [18], [21], [22].

➤ *Poverty and Agency*

Lacking use of postnatal care was often as much a result of women's lack of practical access to money, time, and transport to seek care, as it was because of their being unaware that care was available. Many mothers talked about the daily struggle for survival that did not allow them to find room for dealing with their own suffering separately from the struggle for survival. This implies that raising awareness without acknowledging the economic barriers participants identified will not be sufficient to lead to increased formal mental health support seeking; a pattern also found in national survey data, which indicate low rates of formal mental health support seeking among Bangladeshi women [28].

➤ *KAP as a Cycle*

The results collectively indicate a reinforcing and/or cyclic relationship between the three KAP domains, as opposed to a series of barriers. The lack of a clearly defined and widely accepted term for PPD, because of cultural and religious interpretation, limits the types of care-seeking approaches that mothers and families consider viable and appropriate. Without the formal care, however, there are no routine interactions with health providers, clinics, or peers that might lead to the creation of new terms and ways of understanding postpartum distress within the household and in the wider community. Each of the three domains in turn influences the other: knowledge leads to attitude, and attitude leads to practice; a lack of practice leads to a lack of knowledge. In such a cycle, efforts to intervene in any single

domain could be more effective than efforts to intervene in any single domain alone, because a change that occurs at one point in the cycle could have an impact on the dynamics of the other points. Appropriate caution is warranted, however, in this interpretation, because of the qualitative, cross-sectional nature of the design used in this study, which would not lend itself to the statistical determination or certainty of direction, strength, or temporal sequence of these relationships. Therefore, the cyclical model offered here should be understood not as an empirically tested causal model, but rather as an interpretive framework, based on participants' own accounts, which is built inductively.

VI. LIMITATIONS

There are a number of limitations of this study. The study results are not statistically generalizable to the Rajshahi District or to Bangladesh, and transferability is limited to the single slum community from which the purposive, non-probability sample was drawn; the results are only a detailed description of the experience in the community in question, and not an estimate of KAP gaps across the District or the entire population of Bangladesh. The data was based on a retrospective self-report starting from the time of the interview and extended 5 years back, which could lead to recall bias, and translation of the Bengali to English could introduce additional layers of interpretation and nuances. The frequencies reported for sub-themes in the attitudes and practices domains like attribution to spiritual causes, negative treatment after the birth of a daughter, caesarean delivery and IPV represent the number of times a theme occurred in the coded responses to the interviews and do not represent an estimate of the population prevalence but should be interpreted as epidemiological figures. The present study did not involve using a clinical test (including the Edinburgh Postnatal Depression Scale) to diagnose depression; therefore, all findings presented here should be understood as mothers' postpartum distress, interpretations and awareness of postpartum experiences that could be related to depression. Last but not the least, since it is a qualitative and exploratory study, it is impossible to conclude with statistical certainty the relative size of the knowledge, attitude and practice gaps in the population; a follow-up study based on the survey and/or mixed methods approach that involves a larger and more representative sample of the population and a validated screening tool would be necessary to do that.

VII. CONCLUSION AND RECOMMENDATIONS

In this slum community, PPD has not been adequately acknowledged by the women who suffer from it and is often blamed on witchcraft, sorcery, or spiritual issues, and less often on formal treatment especially by a physician. This is not a clinical prevalence or diagnosis of PPD in this population, but rather an observation of how mothers know, think and act about PPD and how these gaps in knowledge, attitudes and practices can be further exacerbated by poverty, illiteracy, gendered family dynamics and IPV. The implications of these findings are measures that are offered in the form of suggestions for intervention, but not

interventions for which this study provides evidence of effectiveness. There are some recommendations:

- Increase community based mental health outreach efforts such as health workers in the field and mental health awareness sessions (in both written and non-written forms) for low literacy groups.
- Support the government and/or NGOs to create or strengthen maternal health clinics/birthing centers located in/around slum communities and provide more and better postnatal care.
- Provide frontline health workers with skills to identify and non-judgmentally challenge common misconceptions that arise following birth (e.g. spiritual causation) while respecting families' cultural context.
- Use existing maternal and child health points to incorporate messages on postpartum mental health because mothers in this study were more likely to seek treatment for an unwell infant than for themselves.
- Ensure that awareness programmes are accompanied by economic and social support for example, providing short term income support and protection from IPV to ensure that improved knowledge and attitudes are likely to translate into behavior change.
- Increase the number of peer education models that enable mothers who have suffered post-partum distress to share their experience and accurate information with those in the community.

DECLARATIONS

➤ *Author Contributions*

Mst. Nusrat Jahan Suchi designed the study, led data collection, performed the initial data analysis and drafted the original manuscript. Md. Abu Obaida Rafi helped develop the study methodology and data interpretation, helped with data collection, and critically reviewed and revised the manuscript for important intellectual content. Both authors read and approved the final manuscript and guarantee to be accountable for all aspects of the work.

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➤ *Competing Interests*

The authors declare that they have no competing interests.

➤ *Ethical Approval and Consent to Participate*

This study has been done with the permission of Bangladesh University of Professionals (BUP) obtained before the data collection process. Relevant institutional authorities were obtained and informed consent was obtained from all participants. The study was completely voluntary, and all data was carefully and strictly handled as confidential.

➤ *Data Availability*

Data used for the results of this study are included in aggregated form in the original thesis. The respondent-level

dataset was not part of the manuscript materials and so is not publicly available.

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