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Voices and lived experiences of perinatal women recovering from mental illness and informal caregivers regarding quality of maternal mental health care in south western Uganda

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ABSTRACT

Background

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Maternal mental illness (MMI) contributes significantly to maternal morbidity, particularly in low-resource settings. Although policies support integrating maternal mental health into routine maternity care, assessments of care quality have largely focused on health workers' perspectives rather than women's lived experiences. This study explored the quality of maternal mental health care as experienced by women recovering from MMI and family caregivers.

Methods

A phenomenological qualitative study was conducted between November 2022 and February 2023. Nineteen participants were purposively recruited from two regional referral hospitals in southwestern Uganda. We included women who had recovered from MMI and family caregivers. Following REC and hospital approvals, participants were contacted by telephone and after consent, appointments for the interviews were scheduled. Data were collected using in-depth interview guide until saturation was reached and manual thematic analysis done, guided by a hybrid coding approach.

Results

Most participants were female with male caregivers being husbands, rural residents, and self-employed. Women were aged 23–37 and caregivers 28–65 years. Five interrelated themes emerged: perceived causes of MMI; clinical presentation and healthcare experiences; challenges, recommendations, and future hopes; community perceptions and stigma; and social support and family dynamics. These inform that sociocultural beliefs, health-system responsiveness, and family support shape perceptions of care quality. Recovery and satisfaction were mainly attributed to hospital-based mental health services, often accessed through self-referral after maternity discharge.

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Conclusion

Despite some positive experiences, maternal mental health care quality remained limited by experienced challenges. Interventions should focus on community education, integrating mental health screening and management into maternity services, improving medicine availability and addressing stigma through culturally appropriate approaches.

Keywords: Maternal mental illness, perinatal mental health, quality of care, recovered women, family caregivers, Uganda, health systems

1 Background

Maternal mental illness (MMI) remains a public health concern, affecting women during pregnancy and up to one year postpartum. It has far-reaching consequences for mothers, infants, and families[1]. Informal caregivers, most commonly partners, mothers, and other close relatives, play a critical role in supporting the affected women and facilitating engagement with health services. These act as intermediaries between families and health care providers[2]. The burden of MMI is pronounced in low- and middle-income countries (LMICs), where maternity care systems are frequently ill equipped to identify and manage MMI in the perinatal period[3-5].

Globally, an estimated 10%-20% of women experience a mental health disorder during pregnancy or postpartum period, with prevalence rates higher in LMICs[6]. Maternal mental illnesses, include; perinatal depression, anxiety disorders, and puerperal psychosis. These are associated with maternal and infant adverse outcomes as well as caregiver shortfalls. Maternal adverse outcomes include; impaired maternal functioning, stigma, and increased risk of maternal suicide. Poor infant outcomes like; low birth weight, suboptimal mother-infant bonding, and infanticide may result [7-10]. Informal caregivers

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also face emotional, financial, and physical burdens, often compounded by limited knowledge of MMI and exclusion from care processes [11, 12]. Common perinatal stressors include; sleep deprivation, complicated labour, pregnancy loss, and breastfeeding difficulties. These contribute to onset or exacerbation of MMI, yet these factors are frequently under-recognized within maternity care confines [3, 11, 13].

World Health Organization (WHO), through the mental health Gap Action Program (mhGAP) has designed guidelines which emphasize family caregiver involvement in planning, needs assessment, promoting dignity and continuity of care [14]. Similarly, National Institute for Health and Care Excellence (NICE) guidelines recommend coordinated care pathways that recognize the central role of caregivers and highlight the impact of MMI on family relationships [12, 15]. Despite their pivotal role in recovery, caregivers often receive limited psychological support [11, 16, 17].

In Uganda, shortages of mental health professionals and poor integration into maternity services result in having women treated in psychiatric units, and not within maternity settings, leading to disrupted bonding with the infant [10, 18, 19]. This contrasts with care models in high-income countries with specialized mother-baby units [20].

Although national policies support integrated care, implementation gaps persist [21, 22]. Evidence from LMICs remains limited, highlighting the need to explore experiences of women and caregivers that would define quality from their perspectives. Therefore, this study explored quality of maternal mental health care from women recovering from MMI and their informal caregivers' perspectives in south-western Uganda. Findings would inform culturally appropriate interventions and improve care quality thus meeting the needs of women and their families.

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2 Methods

2.1 Study Design and Setting

This is a qualitative phenomenological study which elicited women and caregivers' experiences regarding care received, a key highlight of their definition of quality of care from their perspectives. Specifically, using the interpretive phenomenology,

Open ended interview questions aimed capturing participants' most meaningful experiences [21]. This was considered appropriate because the study sought not only to describe experiences but also to interpret the meanings participants attached to those experiences within their social and personal contexts regarding the care received. The study was conducted from two regional referral hospitals, Kabale and Mbarara, which serve south-western Uganda. These facilities provide specialized maternity and mental health services and act as referral centers for surrounding districts[22].

2.2 Study Population and Eligibility Criteria

The study population comprised women who had recovered from MMI between January 2012 and December 2022 and their informal caregivers. Caregivers included partners, parents, in-laws, or other close relatives involved in supporting the woman during the illness. All participants were aged 18 years or older, consistent with the legal age of informed consent in Uganda. Women were eligible for inclusion if they had experienced MMI during the recent 10 years (November 2022 to February 2023). The MMIs were considered if they had occurred during pregnancy or within one year postpartum. The women were considered to have recovered from MI, if they were mentally stable and not on any psychiatric medications. We considered those who were willing and able to share their experiences in either English or the local language (Runyankore-Rukiga dialect),

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and could be contacted through active telephone numbers recorded in hospital records. Women with documented pre-existing mental illness prior to pregnancy and or those who were on antipsychotic treatment before pregnancy on the basis of patient records were excluded because they were already in an active stage of mental illness before pregnancy. Potential participants who met eligibility criteria but could not be reached during the data collection period were also excluded.

2.3 Sampling Strategy and Sample Size

Purposive sampling strategy was used to recruit participants who met the inclusion criteria. These provided rich, relevant insights into experiences of maternal mental health care. Recruitment continued until data saturation was achieved, which indicated that at this point, no new information emerged from successive interviews. Saturation was reached at 19 in-depth interviews (8 women who recovered and 11 family caregivers).

2.4 Participant recruitment and data collection procedure

Following ethical approval from relevant Research Ethics Committees and administrative clearance from hospital authorities, the research team accessed psychiatry and maternity departments at the respective hospitals. Notably, maternity department records contained limited documentation on maternal mental health care incidents despite them reporting having received victims. This was attributed to routine referral of women with maternal mental illness (MMI) from maternity units to psychiatry services, lack of provision for documentation of reported mental cases and their management in the maternity HIMS register and frequent self-referrals to mental health units after discharge from maternity care, as reported anecdotally by maternity staff in June 2022.

2.4.1 Access to hospital records

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With support from the maternity and psychiatry ward in-charges, hospital Health Information Management Systems (HIMS) were searched to identify women's records, diagnosed with MMI between January 2012 and December 2022. From these, we obtained diagnosis, patient file numbers and names which were fundamental in accessing participant files. From the files, we extracted patient biography including the telephone contacts, and clinical information relevant to describe participant characteristics as well as eligibility. Eligible participants whose phone contacts could be reached were contacted and a total of twelve eligible patient case files were used (Figure 1). These records corresponded to twelve women who had recovered and 12 informal caregivers.

2.4.2. Involvement of staff

Initial contact with potential participants was made through informal caregivers whose telephone contacts were available in-patient files. Contact was facilitated by hospital staff members who was also part of the health care team in the same department and research assistants (LJ at MRRH) and AF at KRRH). These had the necessary qualifications required (LJ is a male psychiatric nurse while AF is a female psychiatric clinical officer). The research assistants have specialized training in Mental Health, with LJ having training in Mental health Nursing, and AF in diploma in psychiatric clinical medicine. They too have vast experience in mental health practice as well as research. Both research assistants were not necessarily selected because they knew the clients personally or they personally managed them during the illness, but because they work within that setting where they had been managed from. This would easily associate them to their prior care or follow up care hence easy rapport.

2.4.3. Consent

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Caregivers were provided with detailed information about the study aims and procedures and were invited to participate. They were updated regarding their freedom to participate or withdraw at any time but as well emphasizing the benefit of the study. Those who provided verbal consent were asked to connect the research team to the women they had cared for to also be given information and seek for their consent. Written informed consent was obtained from participants who were interviewed physically. Interviews were conducted in private rooms within the hospital setting to ensure confidentiality and no non-participants in the private room at the time of the interview. Two interviews were conducted by telephone due to geographical constraints and these consented verbally.

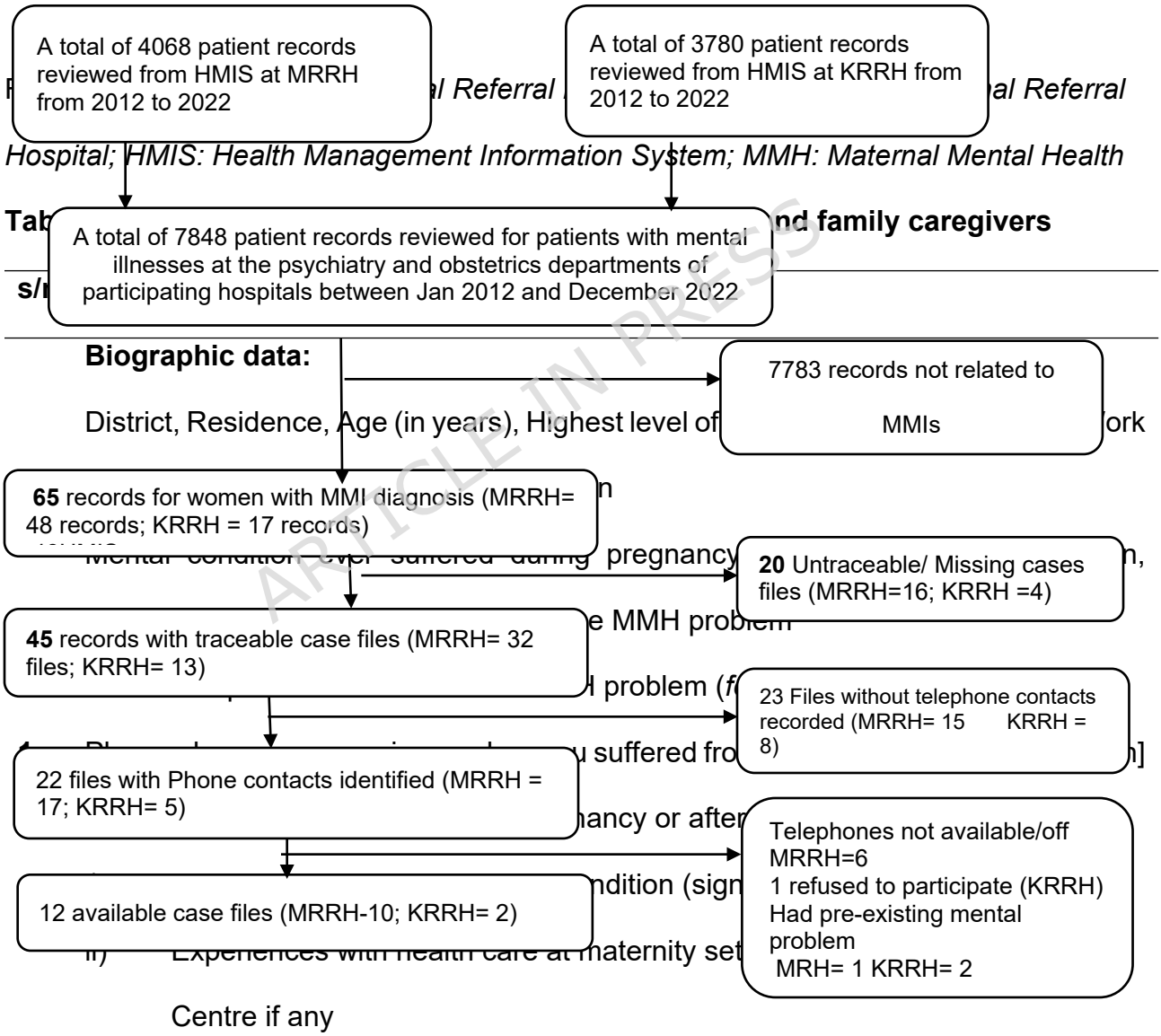
2.4.4. Data collection

Data were collected using in-depth interview guide developed in accordance with the study objectives (Table 1). The in-depth interview guide allowed participants to freely describe their experiences in their own words with open-ended questions which encouraged detailed narratives and reflections. Interviews were conducted in either English or the participant's preferred local language, lasted approximately 45- 60 minutes, and were audio-recorded with participants' permission. Field notes were taken during interviews to capture non-verbal cues and contextual information to supplement the audio recordings. The first two interviews were conducted as part of pilot testing to refine the interview guide. Since only minor modifications were made and the interviews generated relevant data aligned with the study objectives, they were included in the final analysis. One to three interviews were conducted per day, depending on participants' set appointments for the interviews. This was done until data saturation was reached. We ensured accuracy of information by recapping participants' responses to confirm whether

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what has been captured is what they had reported during the interview before conclusion. We also ensured peer debriefing through regular meetings, audit trails, and thick description of participants' experiences. This ensured that intended participants' meanings and interpretations are accurately represented while reducing researcher bias.

Figure 1: Participant recruitment flow chart (from records of patients with Mental Illness from participating hospitals)



Hospital; HMIS: Health Management Information System; MMH: Maternal Mental Health

Tab **nd family caregivers**

S/	
	Biographic data: District, Residence, Age (in years), Highest level of ork
	n
	pregnancy n,
	e MMH problem
	l problem (*f*
	u suffered fro n]
	nancy or after
	ndition (sign
ii)	Experiences with health care at maternity set Centre if any

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2. Kindly tell me the forms of health care or support you expected to receive from the health care workers in the maternity care settings in care of the maternal mental problems (depression or anxiety). i) Physical needs and psychological support ii) Others
3. What needs were not met by the health care providers in the maternity care settings for the maternal mental problems (depression or anxiety)?
4. What are the challenges encountered to access maternal mental care (treatment)?

2.5 Data Management and Analysis

Manual coding analysis was conducted. The data were transcribed verbatim, cleaned, and cross-checked against the audio recordings to ensure accuracy. A bilingual expert then translated the transcripts from the local language to English. Data analysis followed Creswell's six-step model[23]. All authors read the translated transcripts repeatedly to familiarize themselves with the data and ensure its representativeness as well as identifying relevant responses related to the study objectives [24]. In each transcript, responses with recurring expressions were identified and color-coded for easy categorization.

Each author (GN, RK, JM, EK) independently developed codes and categories from the data, after which a joint coding framework was established through consensus by discussion among the authors. This was applied to code all transcripts systematically. Subsequently, all authors conducted an initial analysis, sharing and discussing emerging categories to refine interpretations (subthemes and themes) while ensuring they truly described the participants' views.

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Hybrid coding, combining deductive and inductive approaches, was employed to analyze data by thematic analysis. While initial codes were derived from the data collection tool, additional themes and sub-themes were introduced throughout the analysis to capture the full depth of data. Interpretation involved moving between individual parts of the transcripts and the whole narrative. Continuous self-reflection was used throughout the study to enhance transparency and minimize undue influence on data interpretation. Verbatim quotes were used to illustrate the most significant aspects of emerging themes.

2.6 Ethical and Administrative Approvals

Ethical approval was obtained from the Research Ethics Committees of; University of Ibadan, Nigeria (Approval No. 22/0018), where the primary author was a PhD student; Mbarara University of Science and Technology, Uganda (Approval No. MUST-2022-414), serving as the supervising REC in southwestern Uganda where the study was conducted; and Uganda National Council for Science and Technology (Approval No. SS1362ES), the national regulatory body.

Administrative permissions were also obtained from the hospital authorities. Written informed consent was obtained from all participants prior to enrollment, and the study was conducted in accordance with the Declaration of Helsinki.

To ensure confidentiality, all participant information was coded and only accessible to the research team. Any published work or manuscript does not include information traceable to individual participants.

3 RESULTS

Nineteen in-depth interviews were conducted with women who had recovered from maternal mental illness (8) and their informal caregivers (11) in south-western Uganda.

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The women's age range was 23–37 years, while caregivers ranged from 28–65 years. Most participants were female, lived in rural settings, and relied on subsistence farming or small-scale self-employment for income. The majority reported that MMI developed during the postpartum period, with puerperal psychosis and postpartum depression being the most commonly described conditions. Other MMIs were; antepartum and postpartum anxiety, antepartum depression, and bipolar affective disorder during pregnancy. Caregivers were primarily close family members, including husbands, mothers, sisters, and in-laws, who played a central role in care-seeking and daily support during the illness. Five interrelated themes emerged from the hybrid coding analysis; three of which were apriori (perceived causes of MMI; clinical presentation and health care experiences; and challenges, recommendations, and future hopes) and two emerged during the research process (community perceptions and stigma; social support and family dynamics).

3.1 Perceived causes of maternal mental illness

Participants described multiple and overlapping explanations for the onset of MMI. Many women and caregivers attributed the illness to witchcraft, spiritual disturbance, or curses arising from strained family relationships. One woman stated,

> "After delivery, my neighbor brought me millet porridge and put Cham [witchcraft] in it… I was bewitched and I actually know the people who did it. We went to the witch healers to tell me what has happened" (WR003, KRRH).

Similarly, a caregiver explained,

> "Before getting sick, she said she saw her husband's spirit moving and they told her that it's her husband spirit disturbing her" (FCG002, KRRH).

Another woman associated her illness with parental disapproval for marriage, noting,

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> "…my father not being happy with us because my husband has never visited my home" (WR004, MRRH).

In addition to spiritual explanations, participants frequently linked MMI to psychosocial stressors and socioeconomic hardship. Experiences of intimate partner violence, financial insecurity, bereavement, and fear about coping after childbirth were commonly cited. One caregiver recounted,

> "She was tortured by her husband, he could beat her so much and she even lost her child after birth" (FCG003, MRRH).

Women described overwhelming worry and uncertainty, particularly in the context of poverty and illness, as illustrated by the statement,

> "The thoughts were too many, we didn't have money, the baby was admitted… I thought through all that is money to be paid" (WR007, MRRH).

Additional stressors included pain following caesarean section, delivery of a child of an undesired sex, and prior experiences of sexual violence. As one caregiver noted,

> "She wanted a boy but instead got a girl" (FCG010, MRRH), while another stated,
>
> "…she also earlier suffered from rape of unknown people" (FCG010, MRRH).

Some participants also described biomedical explanations for MMI, often emerging after interaction with health services. These included perceived effects of anesthesia, malaria, or HIV. One woman reflected,

> "…I also think this anesthesia they gave me… maybe it contributed" (WR007, MRRH).

A caregiver explained,

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> “They said fever [malaria] could have reached the brain. They advised us to take her to hospital” (FCG010, MRRH).

Most of the beliefs on causes framed MMI as an externally imposed condition and strongly influenced care-seeking decisions and the biomedical explanations were more associated with hospital care choices.

3.2 Community Perceptions and Stigma

Following the onset of MMI, many women experienced stigma, social isolation, and judgment from their communities and, at times, from family members. Women described being labelled as “mad” or bewitched, which exacerbated emotional distress and confusion. One participant shared,

> **“**When they got to know..., they isolated me… they even said that I’m bewitched…This even caused me to be more confused” (WR013, MRRH).

Another added,

> “They say you’re mad… they keep wondering what went wrong with you” (WR013, MRRH).

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Judgment and gossip were also common, particularly accusations of immoral behavior during pregnancy. A woman explained,

> “They speak badly…many words keep coming…they said that I was promiscuous during pregnancy…” (WR007, MRRH).

From these participants’ reports, the negative community talks and stigma, make them more stressed and confused, lose their sense of dignity, esteem and hope for support during illness. These can also delay assistance to seek for appropriate care.

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3.3 Clinical Presentation and Health Care Experiences

Women with MMI presented with a range of symptoms, including aggression, wandering, hallucinations, suspiciousness, and disorganized speech. Caregivers often described frightening behavioral changes, such as,

> "She was very aggressive, fighting everyone, and wanted to cut people with panga" (FCG008, MRRH).

Women also described perceptual disturbances and fear, for example,

> "When I was sleeping… something touched my eyes telling me to go" (WR003, MRRH).

Self-neglect, refusal to eat or bathe, insomnia, and difficulties with breastfeeding were also commonly reported. One caregiver observed,

> "She refused to eat… refused even to breastfeed baby" (FCG005, MRRH).

Regarding health care experiences, care-seeking pathways were often pluralistic. Some women were taken directly to hospitals, while others initially sought spiritual or traditional healing and only accessed hospital care after these approaches failed. One woman explained,

> "I was first taken to church for prayer… when things didn't work, they decided to take me to hospital" (WR001, MRRH).

Hospital care was frequently aimed at restoring sleep and behavioural control, as noted by a caregiver:

> "The management from hospital was to make her sleep" (FCG002, KRRH).

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Experiences with health care services were mixed. Some women described compassionate, timely, and effective care, which they strongly associated with recovery. One woman stated,

> “I appreciate the health workers… they gave me treatment, they cared for me. Indeed, I recovered” (WR013, MRRH).

Others, however, reported limited communication, lack of counselling, and unexpected costs for medications and food. A caregiver explained,

> **“**The health workers never talked to us… and after they discharged” (FCG002, KRRH), while another woman noted, **“**I thought we could get medicines from the hospital pharmacy without buying… but it wasn’t true” (WR006, MRRH).

Some clinical presentations represented severe form of MI and were mainly identified by caregivers, who subsequently made choices to seek for help using pluralistic pathways. Some report good health care experiences yet others seemed unsatisfied with the care from the health care workers.

3.4 Social Support and Family Dynamics

During the acute phase of illness, women often lacked awareness of their condition and relied heavily on caregivers to make decisions and provide care. As one woman stated,

> “My husband knows this better because me I wasn’t understanding anything” (WR013, MRRH).

While some families provided strong support, others experienced mistrust and conflict. One participant expressed distress, saying,

> “She wants to put a bad name on me… at home I was really mistreated” (WR003, KRRH).

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3.5 Challenges, Recommendations, and Future Hopes

Participants identified significant challenges affecting the quality of care, including shortages of mental health medications, adverse drug effects, fear of violence in mental health wards, separation from infants, and abandonment by partners. One woman shared,

> "My husband left me… everything was very difficult**"** (WR004, MRRH), while another described medication side effects, stating, "My hands were heavy… walking was hard**"** (WR002, MRRH). One caregiver reported; *"…*some mentally ill patients [would] find you in some room, they want to beat you but somehow you find a way out…" (FCG 004)

Despite these challenges, participants emphasized the importance of early medical intervention, affordable access to medications, faith, and community education. Women expressed hope for improved awareness and timely support, noting the need for guidance from health workers and understanding from communities.

"…health facilities should have medicines for women even if they have no money**…"** (WR006)

"…Indeed, I recovered. Because I was getting treatment in time… the medicine they gave me healed me. I thank God..." (WR013).

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4 Discussion

This qualitative study explored the quality of care for maternal mental illness (MMI) as experienced and voiced by recovering women and their informal caregivers in south-western Uganda. The findings show that women's experiences were shaped by sociocultural beliefs about illness causation, community responses and stigma, clinical

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encounters within health facilities, and the availability of family and social support. Although hospital-based care was ultimately perceived as effective for recovery, the overall quality of care was constrained by delayed care-seeking, limited communication, medication shortages, and socioeconomic barriers. These findings reinforce the need to view quality maternal mental health care as multidimensional, extending beyond symptom [25].

Women and caregivers described MMI using spiritual, psychosocial, and biomedical descriptions. Beliefs in witchcraft, ancestral spirits, and curses were prominent and often led families to seek care from religious institutions or traditional healers before accessing formal health care services. Similarly, this has been documented in Uganda and other sub-Saharan African settings, where mental illness, particularly psychosis and postpartum disorders, is frequently understood in spiritual terms[19, 26]. These beliefs delay timely access to effective treatment, despite evidence that MMI is highly treatable with early detection and appropriate care[1, 27].

At the same time, participants strongly associated MMI with psychosocial stressors, including intimate partner violence, poverty, bereavement, rape, and traumatic childbirth experiences. This aligns with prior research showing that women often interpret perinatal mental illness as a response to adverse life events rather than biological vulnerability alone[18, 28-30].

Our study findings uniquely highlight the fact that women and caregivers interpreted illness through overlapping spiritual, psychosocial, and biomedical frameworks rather that viewing them as mutually exclusive. The movement between traditional healers, prayer, and hospitals suggests that quality care was not judged entirely by biomedical

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effectiveness but also by whether services aligned with women's and families' beliefs about illness causation. This emphasizes the need for culturally sensitive communication and psychoeducation as components of quality maternal mental healthcare. Secondly, integrating psychosocial assessment and support into routine antenatal and postnatal care, particularly for women exposed to known risk factors would be of importance.

Stigma and negative community perceptions emerged as major influences on women's experiences of MMI. Participants described isolation, labelling, gossip, and moral judgment, which often compounded psychological distress and undermined recovery. Similar patterns of stigma surrounding maternal mental illness have been reported across low- and middle-income countries and are known to reduce help-seeking and adherence to care[31, 32]. However, our findings strongly underline how women's accounts of being isolated, labelled "mad," or accused of immoral behavior, worsened distress, and potentially delayed care-seeking. This meant that women perceived quality care not only as clinical improvement but also respect, emotional safety, and social acceptance. These findings suggest that high-quality maternal mental healthcare should incorporate community awareness and anti-stigma interventions.

Regarding clinical care experiences and health system responsiveness, our study findings distinctively showed that quality care was evaluated by women and caregivers through health workers' responsiveness, observable recovery, and compassionate care. Respectful treatment, good communication, and availability of medications were also key markers of good quality care. Conversely, poor communication, lack of counselling, and unexpected out-of-pocket expenses negatively affected perceptions of care quality.

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Similar gaps in provider patient communication and continuity of care have been reported in maternal mental health services across resource-constrained settings [33, 34].

The findings on family dynamics show that caregivers were essential to maternal mental healthcare implying that quality care was experienced not only individually but collectively within family relationships. Supportive caregiving facilitated treatment access and recovery, while mistrust, conflict, and mistreatment negatively affected women's experiences of illness and care. This highlights the importance of family-inclusive maternal mental healthcare approaches that acknowledge caregivers' decision-making roles while also protecting women from emotional harm and preserving their dignity.

The voiced structural and socio-economic challenges reveal important dimensions of perceived quality of maternal mental healthcare which further undermines trust in the health system and place a financial burden on families. These reflect broader challenges in mental health service delivery in Uganda and highlight the need for stronger integration of mental health services into maternal and reproductive health systems with well supported systems [10, 14]. Similar challenges have been widely documented in maternal mental health research and are recognized determinants of poor outcomes in low-income settings[33, 35]. Addressing these structural barriers requires multisectoral approaches, including social protection, livelihood support, and decentralization of mental health services to primary maternity care and community levels.

Our findings imply that women and caregivers associated quality care with timely treatment, availability of affordable medicines, physical safety within mental health wards, emotional support, and continuity of care after discharge.

The women and caregivers' recommendations suggest that quality maternal mental healthcare must address both structural health system gaps and psychosocial needs.

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Informal caregivers played a central role in care-seeking, decision-making, and daily support, particularly during acute illness when women often lacked insight into their condition. While caregiving was described as essential to recovery, it was also associated with emotional distress due to uncertainties, and financial strain. These findings are consistent with evidence showing that family caregivers of individuals with severe mental illness experience significant burden, particularly in low-resource settings with limited formal[11, 32, 36].

Quality maternal mental health care should therefore adopt a family-centred approach that acknowledges caregivers as key partners in care. Providing caregivers with information, counselling, and psychosocial support may enhance women's recovery while reducing caregiver burden.

4.1. Implications of the study

The findings suggest that improving the quality of maternal mental health care in south-western Uganda requires integrated, person and family-centred maternal mental health services that strengthen provider communication, psychosocial support, continuity of care, affordability, and meaningful caregiver involvement.

In health care practice, health services should strengthen respectful communication, psychosocial support, and caregiver inclusion. Antenatal and postnatal services should offer critical opportunities for mental health screening, education, and early intervention. Training maternity care providers in mental health care, counselling, and respectful communication is essential to improving women's experiences and outcomes.

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In research, future studies may be necessary to explore culturally grounded and community-based models of care, including strategies to reduce stigma and improve caregiver support.

Policymakers may consider incorporating women's lived experiences into health system planning and policy development to advance equitable, acceptable, and effective maternal mental health care in Uganda and other resource-constrained settings [25, 37]. They too can prioritize increasing investment in maternal mental health, ensure consistent availability of essential medicines and services, and integrate maternal mental health into routine maternity care.

4.2. Strength and limitations

This study's primary strength lies in its qualitative design, which enabled in-depth exploration of women's and caregivers' lived experiences, beliefs, and care pathways. The use of individual in-depth interviews allowed participants to share sensitive experiences in detail, generating rich contextual insights into perceptions of maternal mental illness and quality of care. Inclusion of both women and informal caregivers strengthened the analysis by capturing multiple perspectives across the care continuum from the informal perspective.

However, several limitations should be acknowledged. The study was conducted in a specific geographical and cultural context, and findings may not be generalizable to other settings. As with all qualitative research, causal inferences cannot be drawn. Additionally, reliance on self-reported experiences as well as the long recall period (past 10 years), may be subject to recall or social desirability bias. In addition, potential selection bias

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would be likely due to reliance on hospital records leaving out those who never had hospital admission. However, given the fact that we intended to ascertain participants' experiences regarding care, findings would still provide reliable evidence regarding hospital care received by women who recovered from MMI. There is also a possibility of power dynamics due to involvement of hospital staff as research assistants and this could have affected participants' responses but affirmation of the importance of the study and their right to participate or withdraw at any time, would improve their freedom during the interview hence minimizing the effect. Despite these limitations, the study provides valuable, contextually grounded evidence that can inform service improvement, policy development, and future research on improving maternal mental health care in similar low-resource settings.

4.3. Conclusion

This study highlights critical gaps and strengths in the quality of maternal mental health care in south-western Uganda as experienced by women recovering from maternal mental illness and their informal caregivers. Women's care trajectories were shaped by sociocultural beliefs about causation, community stigma, and health system responsiveness. Although hospital-based care was ultimately associated with recovery, experienced challenges limited the perceived quality of care. The findings emphasize that high-quality maternal mental health care must be woman-centred, culturally responsive, and inclusive of caregivers.

Strengthening mental health literacy within maternal services, ensuring consistent availability of essential medications, supporting family caregivers, integrating mental

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health screening and counselling into routine antenatal and postnatal care are essential steps toward improving outcomes.

Declarations

Ethical considerations

Ethical approval was obtained from the Research Ethics Committees of; University of Ibadan, Nigeria (Approval No. 22/0018), where the primary author was a PhD student; Mbarara University of Science and Technology, Uganda (Approval No. MUST-2022-414), serving as the supervising REC in southwestern Uganda where the study was conducted; and Uganda National Council for Science and Technology (Approval No. SS1362ES), the national regulatory body.

Administrative permissions were also obtained from the relevant district and hospital authorities.

Consent to participate: Written informed consent was obtained from all participants prior to enrollment, and they were assured of their right to withdraw at any time. Participant privacy and the confidentiality of the information provided were assured given the fact all participant information was coded and only accessible to the research team. Any published work does not include information traceable to individual participants. The study was conducted in accordance with the Declaration of Helsinki.

Consent to publish: Not applicable.

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Availability of data and materials

The data sets used for this study are available from the corresponding author upon reasonable request.

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Declaration of interests; have no competing interest

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Authors' contributions

GN: Conceptualization, Methodology, Data curation, Formal analysis, Writing- original draft and review of the manuscript.

JFM: Conceptualization, Methodology, Data curation, & review of manuscript

EK: Conceptualization, Methodology, Data curation, & review of the manuscript approval of the manuscript.

RK: Methodology, Data curation, review & editing. Finally, all authors have read and approved the final manuscript.

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