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Review Article

Mental Health Literacy and Barriers to Care among Rural Women: A Systematic Review

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Abstract

Background: Mental health literacy among rural women remains low in countries such as India, Bangladesh, Nigeria, Turkey, and Ghana. Limited awareness, stigma, and restrictive socio-cultural norms contribute to poor recognition, delayed help-seeking, and underutilization of services. Traditional beliefs, rigid gender roles, and poor access to professional care compound these issues, making rural women’s mental health an overlooked concern.

Objective: This systematic review examined levels of mental health literacy among rural women, explored socio-cultural influences on mental health perceptions, and identified barriers to care, with implications for behavioral science and policy in low- and middle-income countries.

Design and Methodology: Following PRISMA 2020 guidelines, five databases were searched, yielding 170 records. Twelve peer-reviewed studies published between 2008 and 2025 met inclusion criteria, with 2008 chosen as the launch of WHO’s mental health gap action programme. A thematic synthesis, guided by the health belief model and socio-ecological perspectives, integrated findings across quantitative, qualitative, and mixed-methods designs.

Results: Four major themes emerged. Firstly, mental health literacy was low, through regional variations were observed. Secondly, socio-cultural influences shaped perception, with stigma, supernatural attributions, and reliance on traditional treatments widely reported. Thirdly, barriers included poor access, somatic presentations, affordability, and gender-based restrictions. Finally, interventions such as community education, awareness campaigns, and integration of traditional and biomedical care improved knowledge and reduce stigma, through sustainability was limited.

Conclusion and Implications: Despite some progress, rural women face persistent disadvantages. Interventions must be culturally tailored, community-based, and theory-driven, while future research should emphasize sustainability, intersectional, and rigorous evaluation to strengthen policy impact.

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Mental health is a critical determinant of overall well-being and is explicitly linked to the United Nation’ sustainable development goals (SDGs), including SDG 3 (good health and well-being), SDG 5 (gender equality), and SDG 10 (reduced inequalities) (United Nation, 2015). Despite its importance, mental health remains under unprioritized in rural and low-resource contexts, where women face intersecting disadvantages such as poverty, early marriage, limited education, and poor healthcare infrastructure (Patel et al., 2018; Saxena et al., 2013). According to the World Health Organization [WHO] (2022), mental health literacy, defined as knowledge and beliefs that aid recognition and management of mental disorders (Jorm,

2012), is particularly low among rural women. This limited literacy contributes to delayed diagnosis, chronic distress, and reduced help-seeking behavior. Stigma and cultural misconceptions exacerbate these challenges, as conditions are often attributed to supernatural forces, personal weakness, or divine punishment (Kermode et al., 2009; Lauber & Rössler, 2007).

The global policy landscape shifted with the launch of the WHO's mental health gap action programme (mhGAP) in 2008, which emphasized task-shifting and community-based care in low- and middle-income countries (WHO, 2021). Since then, interventions such as lay health worker programs in South Africa (Petersen et al., 2011), school-based psychoeducation in India (Barry et al., 2013), and mobile health initiatives in Sub-Saharan Africa have demonstrated the potential of culturally sensitive, community-driven strategies. These efforts illustrate how integrated approaches, bridging traditional and biomedical systems, can address entrenched barriers and expand access to care for rural women.

From a behavioral science perspective, models such as the health belief model (Champion & Skinner, 2008; Rosenstock, 1974), theory of planned behavior (Ajzen, 1991), and socio-ecological frameworks (Bronfenbrenner, 1979) offer useful lenses to explain rural women's health-seeking behaviors. These models highlight the roles of perceived susceptibility and severity of illness, social norms, self-efficacy, and multilevel structural barriers in shaping decisions around mental health care. However, systematic syntheses focused exclusively on rural women remain scarce. Prior reviews, such as Ganasen et al. (2008) and Lauber and Rössler (2007), often combine male and female data or emphasize urban populations, overlooking the intersection of gender, culture, and rural disadvantage. This review therefore synthesizes peer-reviewed studies published 2008-2025. The start year (2008) was chosen because it coincides with the launch of the WHO's mhGAP, which marked a global policy shift toward scaling up mental health services in low- and middle-income countries (WHO, 2021). Guided by this context, the review addresses four research questions:

1. What levels of mental health literacy exist among rural women?
2. What socio-cultural perceptions influence their beliefs?
3. What barriers limit access to care?
4. Which interventions show effectiveness in reducing stigma and improving literacy?

Review Method

Design

This systematic review was conducted to examine the knowledge, attitudes, and perceptions (KAP) related to mental health among rural women, with a focus on factors shaping mental health literacy and barriers to care. The review followed the preferred reporting items for systematic reviews and meta-analyses (PRISMA 2020) guidelines to ensure a structured and transparent process of evidence synthesis across studies published between 2008 and 2025 (Page et al., 2021).

Search Strategy and Data Sources

A comprehensive literature search was conducted across five major academic databases: PubMed, PsycINFO, Scopus, Web of Science, and Google Scholar. Searches were limited to peer-reviewed articles published in English between 2008 and 2025. The start year (2008) was chosen because it aligns with the launch of the WHO's mhGAP, which marked a global shift toward scaling up mental health services in low- and middle-income countries (WHO, 2021). A Boolean search strategy combined the following key terms: ("mental health literacy" OR "mental health awareness" OR "knowledge of mental illness") AND ("attitudes toward mental illness" OR "perceptions of mental illness" OR "mental health stigma") AND ("rural women" OR "women in rural areas" OR "rural populations") AND ("barriers to care" OR "healthcare access" OR "help-seeking behavior")

To mitigate publication bias, reference lists of eligible studies were hand-searched, and targeted manual searches of key journals were conducted. Google Scholar was used only as a supplementary source, and results were screened up to the first 20 pages to ensure feasibility and reproducibility.

Eligibility Criteria and Study Selection

Inclusion Criteria

The inclusion criteria for this review were defined to ensure relevance and rigor. The population of interest was adult women aged eighteen years and above who were residing in rural or semi-rural settings. Eligible studies were those that examined aspects of mental health literacy, attitudes toward mental illness, perceptions, stigma, or barriers to accessing care. Only empirical research was included, encompassing quantitative, qualitative, or mixed-methods study designs. The geographic scope was limited to studies conducted in low- and middle-income countries (LMICs), with particular emphasis on South Asia and Sub-Saharan Africa. Furthermore, only peer-reviewed articles published in English were considered.

Exclusion Criteria

The exclusion criteria were equally well-defined. Studies were excluded if they lacked gender-disaggregated data or did not specifically address women. Research focusing exclusively on urban populations was not considered. Editorials, commentaries, and purely theoretical papers without empirical evidence were excluded, as were conference abstracts that did not have full-text availability. Exclusion decisions during the screening process were based on predefined criteria of irrelevance, such as studies examining unrelated populations, settings, or outcomes, as well as methodological limitations, including inadequate sampling or absence of a mental health focus.

Data Extraction

Data extraction was independently performed by two reviewers with expertise in psychology and public health research methods. Reasons for excluding full-text studies were carefully documented to maintain transparency. The PRISMA flow chart was used to illustrate the stages of study selection. A structured extraction form was created to systematically capture relevant information, including author(s), year, study location, design, population, measures, main findings, identified barriers, and suggested interventions.

Quality Appraisal

The methodological quality of the twelve included studies was appraised using established design-specific tools. Six quantitative cross-sectional designs and were assessed using the Joanna Briggs Institute (JBI) critical appraisal checklist (Moola et al., 2020). This tool contains eight items assessing aspects such as sample representativeness, clarity of inclusion criteria, measurement validity, and appropriateness of statistical analysis. Each study was scored item-by-item, with higher scores (6/8) reflecting stronger methodological rigor. Four qualitative studies were evaluated with the critical appraisal skills programme checklist (Critical Appraisal Skills Programme [CASP], 2018). This ten-item tool evaluates the clarity of research aims, appropriateness of methodology, recruitment strategy, data collection, ethical considerations, and rigor of analysis. Responses were recorded as “yes,” “no,” or “unclear” and overall judgments of quality were made accordingly.

One mixed-methods study was appraised using the mixed methods appraisal tool (MMAT; Hong et al., 2018). The MMAT applies five core criteria addressing the rationale for using mixed methods, integration of qualitative and quantitative findings, adequacy of each component, and coherence of interpretation. Finally, one pre-experimental study was assessed using the JBI critical appraisal checklist (Tufanaru et al., 2020), for quasi-experimental designs. This checklist includes nine items assessing clarity of cause–effect relationships, comparability of participants, outcome measurements, and reliability of follow-up.

Data Analysis and Synthesis

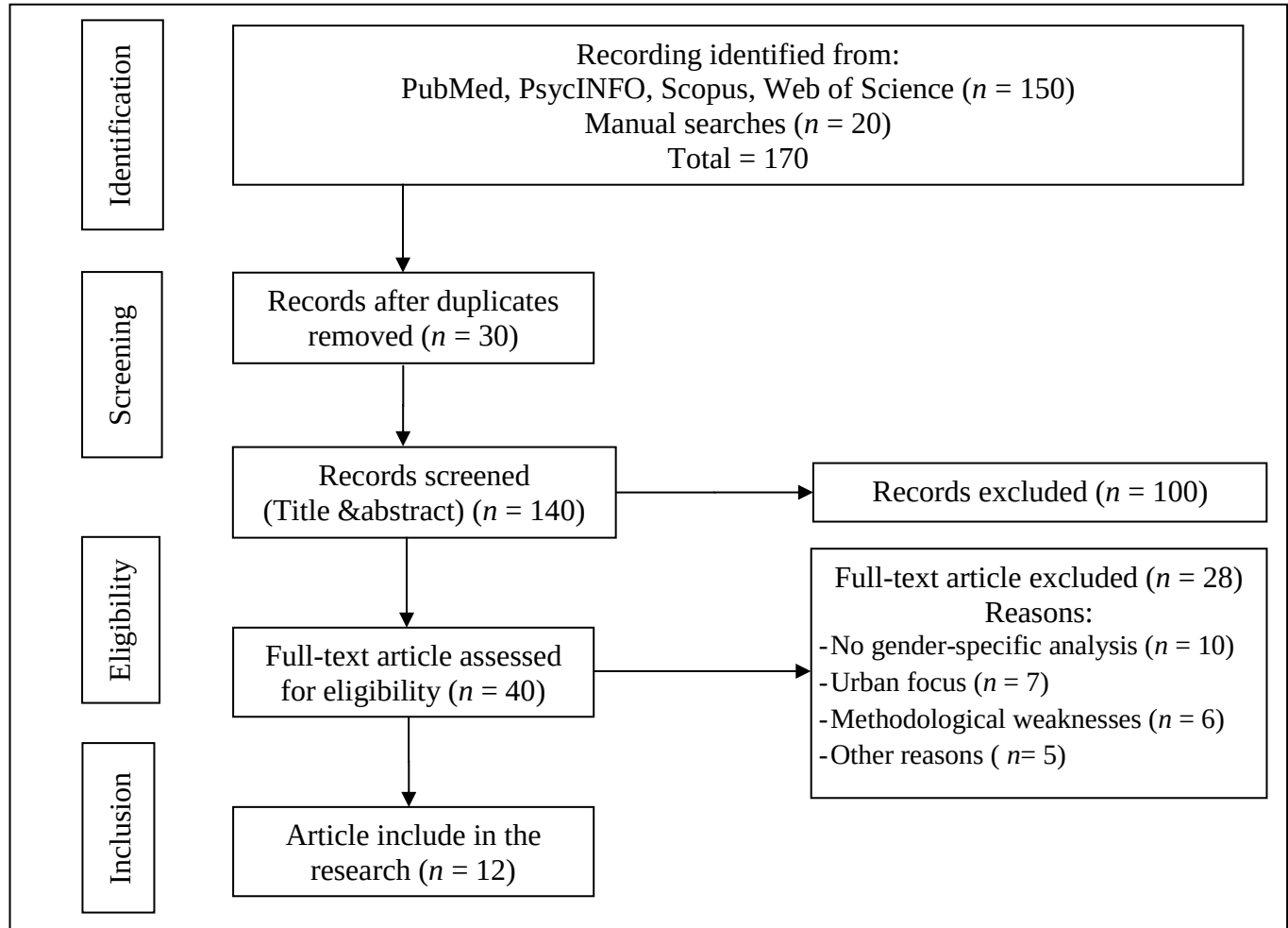
The data extracted from the 12 selected studies were systematically analyzed using thematic synthesis, following the guidelines of Thomas and Harden (2008). This approach was chosen to integrate qualitative, quantitative, and mixed-methods findings into coherent, policy-relevant insights.

Thematic Coding

Key concepts and patterns were identified inductively across studies. Line-by-line coding of extracted findings, development of descriptive themes across studies, generation of analytical themes that integrated findings with behavioral science frameworks. Coding was performed independently by two reviewers ($\kappa = .81$, NVivo software). The first reviewer holds a doctoral degree in psychology with training in systematic reviews, while the second reviewer has a master's degree in public health with experience in qualitative and quantitative data analysis. Any discrepancies between the two reviewers were resolved through discussion, and when necessary, consultation with a third senior reviewer was sought.

Figure 1

Inclusion Strategy Using PRISMA Guidelines



Results

Characteristics of Included Studies

The study selection followed the PRISMA 2020 guidelines (Figure 1). A total of 170 records were identified through database and manual searches. After removing duplicates and screening titles and abstracts, 40 full-text articles were assessed for eligibility. Of these, 12 studies met all inclusion criteria. Two independent reviewers evaluated eligibility at each stage, resolving discrepancies through discussion to ensure reliability and transparency (Moher et al., 2009).

Among the twelve studies included in this review (Table 1), six adopted a cross-sectional design (Bhalerao et al., 2008; Gur & Kucuk, 2016; Kutcher et al., 2016; Manjrekar & Patil, 2018; Okafor et al., 2022; Thakur & Sharma, 2025). These studies primarily assessed women's mental health awareness, stigma, and help-seeking patterns at a single time point. Four studies employed qualitative approaches,

including interviews and focus groups, to explore cultural perceptions and lived experiences of rural women (Dutta et al., 2022; Gala et al., 2024; Gawai & Tendolkar, 2019; Agyekum, 2023). One mixed-methods study (Iyer et al., 2023) integrated survey and interview data, while one pre-experimental study (Anitha & Jaikumar, 2017) evaluated the effectiveness of an information, education, and communication (IEC) package in raising awareness. This methodological diversity enriched the synthesis by capturing both breadth (quantitative prevalence) and depth (qualitative insights) across rural contexts.

Table 1*Summary of Searching Information and Screening Results*

Citation/ Country	Design & Method	Sample / Population	Measures / Focus	Key Findings	Barriers Identified	Interventions Suggested
Bhalerao et al. (2008) India	Cross-sectional	50 women, ages 25–35	Self-esteem, decision-making, parenting knowledge.	Economic dependence and societal expectations linked to poor mental health.	Economic dependence, gendered expectations.	Community-based interventions; empowerment programs.
Kutcher et al. (2016) India	Cross-sectional	140 women from 3 religious groups	Socio-religious influences.	Illness attributed to karma and spirits.	Religious beliefs, lack of infrastructure.	Faith healer inclusion in awareness campaigns.
Gur and Kucuk (2016) Turkey	Cross-sectional	387 women, ≥ 18 yrs	Attitudes toward mental illness.	Stigma and cultural norms shaped help-seeking.	Reliance on traditional healers, stigma.	Culturally sensitive awareness programs.
Anitha and Jaikumar (2017) India	Pre-experimental	60 women in self-help groups	IEC package effectiveness.	67.8% knowledge increase post-intervention.	Cultural stigma, misinformation.	Structured psychoeducation for rural women.
Manjrekar and Patil (2018) India	Cross-sectional	300 antenatal mothers, mean age 24 ($SD = 5$)	Perceptions of perinatal mental illness.	90% unaware of perinatal disorders; stigma high.	Lack of awareness, stigma.	Targeted literacy programs for antenatal women.
Gawai and Tendolkar (2019) India	Qualitative	Women ≥ 18 yrs	Coping and perceptions.	Patriarchal norms and misinformation hinder literacy.	Patriarchal control, low literacy.	Training for health workers to identify somatic signs.
Dutta et al. (2022) Bangladesh	Qualitative	Perinatal women (sample unspecified)	Help-seeking behavior.	Stigma and lack of awareness delay care.	Fear of stigma, poor access.	Community awareness campaigns; service integration.
Okafor et al. (2022) Nigeria	Cross-sectional	295 rural women, adults	Role of traditional beliefs.	Superstitions influence perception.	Belief in supernatural causes, stigma.	Integration of faith-based and medical care.
Iyer et al. (2023) India	Mixed methods	196 adults (18–60 yrs)	Awareness and attitudes.	Preference for traditional healers.	Traditional healer reliance.	Integration of traditional and modern services.
Agyekum (2023) Ghana	Qualitative	Women accessing maternal care.	Maternal mental health.	Underreported issues due to stigma.	Stigma, cultural beliefs.	Community-based, culturally sensitive interventions.
Gala et al. (2024) India	Qualitative	72 female entrepreneurs (age < 35– > 45)	Gendered perspectives.	Financial stress and gender roles drive distress.	Economic dependence, gender roles.	Economic empowerment and workshops.
Thakur and Sharma (2025) India	Cross-sectional	400 women, ages 26–35	Literacy, stigma, help-seeking.	Low awareness; spiritual attributions common.	Fear of stigma, reliance on traditional healers.	Training health workers, integrated awareness campaigns.

Risk of Bias Assessment

Across the twelve included studies, the overall risk of bias was assessed as moderate, though it varied depending on study design. The cross-sectional studies were generally strong in design, making use of structured instruments and adequate samples, yet several relied on convenience sampling and provided little control for confounding factors, which raises concerns of selection bias and limits generalizability. Self-reported measures were widely used, introducing the potential for measurement bias. Qualitative studies offered rich cultural and contextual insights and employed systematic thematic analysis; however, limited attention to reflexivity and small sample sizes meant that interpretive bias and restricted transferability could not be ruled out. Mixed-methods designs enhanced validity through triangulation, but the integration of qualitative and quantitative components was not always clearly articulated, which may have introduced reporting bias, and short follow-up periods reduced the ability to evaluate intervention sustainability. At the review level, restricting eligibility to English-language and peer-reviewed sources increased the likelihood of language and publication bias, particularly given that relevant evidence in LMICs is often reported in local-language or grey literature. Furthermore, differences in how constructs such as “mental health literacy” and “stigma” were operationalized across studies introduced a risk of outcome reporting bias. Taken together, while the evidence base was of moderate to high quality overall, these methodological constraints suggest that the findings should be interpreted with caution.

Thematic Synthesis

The analysis yielded four consistent themes across studies (Table 2).

Mental Health Literacy and Knowledge

Across settings, mental health literacy was generally low, with rural women often unfamiliar with common symptoms and conditions. For instance, 90% of antenatal mothers in rural India were unaware of perinatal mental health disorders (Manjrekar & Patil, 2018), while in Nigeria, only 35% demonstrated adequate knowledge (Okafor et al., 2022). However, targeted interventions such as structured psychoeducation (Anitha & Jaikumar, 2017) and mental health workshops (Gala et al., 2024) showed promise in improving awareness.

Socio-Cultural Influences and Stigma

Cultural and religious interpretations of mental illness strongly shaped attitudes. Illness was often attributed to karma, spirits, or supernatural causes (Kutcher et al., 2016; Okafor et al., 2022). Stigma was widespread and reinforced by community norms, though its association with education was mixed—some studies reported reduced stigma with higher education, while others found no significant effect (Gala et al., 2024; Gur & Kucuk, 2016;).

Healthcare-Seeking Behaviors and Barriers

Structural barriers such as affordability, lack of services, and gendered restrictions were consistently reported. Somatic symptom presentation was common, often masking psychological distress (Gawai & Tendolkar, 2019). Preference for traditional or faith-based healing was widespread across South Asian and African contexts (Dutta et al., 2022; Iyer et al., 2023; Okafor et al., 2022).

Intervention Strategies and Effectiveness

A small subset of studies evaluated interventions. Community-based education (Anitha & Jaikumar, 2017), economic empowerment programs (Gala et al., 2024), and integration of traditional healers into awareness campaigns (Kutcher et al., 2016) demonstrated potential. However, most interventions lacked long-term follow-up, scalability assessments, or rigorous evaluation frameworks, limiting generalizability.

Table 2*Thematic Overview of Findings across Studies*

Theme	Key Findings	Supporting Studies	Cultural Context
Mental health literacy and knowledge	Generally low literacy; interventions (IEC, psychoeducation, workshops) improved awareness in some cases.	Manjrekar and Patil (2018); Okafor et al. (2022); Dutta et al. (2022); Anitha and Jaikumar (2017); Gala et al. (2024)	Consistently low across South Asia and Sub-Saharan Africa
Socio-cultural influences and stigma	Religious and traditional beliefs central (karma, spirits, supernatural); stigma widespread; education effects mixed.	Kutcher et al. (2016); Gur and Kucuk (2016); Okafor et al. (2022); Gala et al. (2024)	Norms varied: strong religious framing in Nigeria & India; patriarchal framing in Turkey and India
Healthcare-seeking behaviors and barriers	Barriers included affordability, service scarcity, patriarchal restrictions; somatic presentations common; preference for faith healers.	Gawai and Tendolkar (2019); Dutta et al. (2022); Iyer et al. (2023); Okafor et al. (2022)	Similar barriers across LMICs; nuanced differences in South Asia vs. Africa
Intervention strategies and effectiveness	Community education, empowerment programs, and faith–biomedical collaborations improved knowledge; most lacked long-term evaluation.	Anitha and Jaikumar (2017); Kutcher et al. (2016); Gala et al. (2024)	Reported mainly in South Asia and Sub-Saharan Africa; culturally tailored approaches most successful

Discussion and Conclusion

Discussion of Main Results

This systematic review aimed to explore mental health literacy, stigma, and barriers to psychological care among rural women in diverse cultural contexts, focusing particularly on South Asia and sub-Saharan Africa. The findings highlight a complex interplay of limited awareness, entrenched socio-cultural beliefs, and structural barriers that hinder effective mental health care access for rural women. The four central themes identified mental health literacy and knowledge, socio-cultural influences and stigma, healthcare-seeking behaviors and barriers to access, intervention strategies and their effectiveness, offer a nuanced understanding of how these factors manifest and interact across different settings.

Mental Health Literacy and Knowledge

This review found that mental health literacy among rural women remains consistently low across regions, with limited recognition of symptoms, causes, and treatment options for common disorders (Dutta et al., 2022; Manjrekar & Patil, 2018; Okafor et al., 2022). Misattribution of distress to supernatural or spiritual causes was frequent (Anitha & Jaikumar, 2017), reinforcing stigma and delaying care. Encouragingly, community-based programs involving health workers and peer educators demonstrated measurable improvements in awareness (Dutta et al., 2022), echoing global evidence linking literacy with earlier help-seeking and reduced stigma (Jorm, 2012; Wei et al., 2015). Nonetheless, rural women are often excluded from outreach initiatives due to limited mobility, low education, and systemic neglect (Kutcher et al., 2016), highlighting a persistent gap in equitable access to knowledge resources.

Socio-cultural Influences on Mental Health Beliefs

Socio-cultural norms strongly shaped perceptions, with mental illness commonly linked to divine punishment, ancestral displeasure, or black magic (Okafor et al., 2022). Such beliefs perpetuated reliance on traditional healers and discouraged professional treatment (Iyer et al., 2023). The influence of education

was complex: while some studies linked schooling with reduced stigma (Kutcher et al., 2016), others found that higher education did not necessarily translate to acceptance of biomedical approaches (Gala et al., 2024). These mixed findings suggest that education alone may be insufficient unless it explicitly engages with local explanatory models. Interventions must therefore adopt culturally responsive approaches that build trust and incorporate, rather than dismiss, prevailing belief systems.

Barriers to Healthcare-Seeking Behavior

Barriers to accessing care emerged at both individual and structural levels. Stigma, fear of social exclusion, and preference for traditional remedies were recurrent obstacles (Dutta et al., 2022; Gawai & Tendolkar, 2019). Structural challenges, including affordability, distance to facilities, lack of female providers, and weak infrastructure, further constrained access (Iyer et al., 2023). The frequent somatization of distress, where psychological problems were expressed as physical symptoms, also delayed recognition and treatment (Anitha & Jaikumar, 2017). These findings resonate with broader research from collectivist societies, where emotional suffering is often minimized or reframed as bodily complaints (Patel et al., 2011). Addressing such barriers requires strengthening both health systems and community-level engagement to normalize help-seeking.

Intervention Strategies and Their Effectiveness

The review identified promising interventions, including psychoeducation, women's self-help group initiatives, and participatory awareness campaigns. Programs tailored to cultural and linguistic contexts reduced stigma and improved literacy (Barry et al., 2013; Kutcher et al., 2016; Petersen et al., 2011). Integrating traditional healers into referral networks, as demonstrated in South Africa (Petersen et al., 2011), respected local beliefs while strengthening formal care pathways. Creative communication methods such as street theatre and folk storytelling further enhanced acceptance (Gala et al., 2024). Despite these successes, most interventions lacked rigorous evaluation, long-term follow-up, and scalability beyond small pilot areas (Iyer et al., 2023; Okafor et al., 2022). Effective approaches consistently shared three features: cultural tailoring, community engagement through trusted actors, and multi-level integration of education, stigma reduction, and service linkage. Scaling such interventions requires embedding them within routine health infrastructure and ensuring sustainability through government and community partnerships rather than donor-driven projects.

Synthesis and theoretical framing taken together, the findings reveal how limited knowledge, socio-cultural beliefs, and structural barriers intersect to disadvantage rural women's mental health. Framing these findings within behavioral science models provides deeper explanatory power. The health belief model (Champion & Skinner, 2008; Rosenstock, 1974) explains how perceived severity and barriers influence help-seeking; the theory of planned behavior (Ajzen, 1991) highlights the role of subjective norms and perceived behavioral control, clarifying why stigma and low self-efficacy reduce help-seeking intentions. At a boarder level, the socio-ecological model (Bronfenbrenner, 1979) underscores how individual, interpersonal, community, and structural factors interact to constrain or enable mental health behaviors in rural contexts.

These frameworks not only illuminate why barriers persist but also guide the design of interventions that are culturally resonant, gender-sensitive, and scalable. However, the evidence base has limitations: most studies were cross-sectional, relied on self-report, or had small, non-representative samples, reducing both internal and external validity. Intervention studies often lacked long-term follow-up, making it difficult to assess sustainability and impact over time.

Limitations

This review has several limitations that should be acknowledged. First, restricting inclusion to English-language and peer-reviewed studies may have excluded relevant evidence published in local languages or grey literature, particularly in low- and middle-income countries. Second, methodological variability across the included studies, such as differences in sampling strategies, measurement tools, and definitions of key constructs like "mental health literacy" or "stigma," limited comparability.

Implications for Behavioral Science

This review underscores the importance of applying behavioral science frameworks to address rural women's mental health needs. The health belief model points to the necessity of enhancing women's perceived susceptibility and perceived benefits while reducing stigma-related barriers, whereas the theory of planned behavior highlights the role of shifting social norms and strengthening self-efficacy for help-seeking. At the same time, the socio-ecological model emphasizes the need for multi-level strategies that engage individual, household, community, and system factors simultaneously. Future research should prioritize intersectional analyses that account for domestic violence, disability, and digital exclusion; evaluate the sustainability of community-based interventions; and co-design culturally resonant strategies with rural women and local leaders. For policy and practice, embedding mental health literacy into maternal and child health services, training community health workers and traditional leaders as referral agents, and integrating mental health into primary care and digital platforms can together create scalable, culturally tailored solutions that bridge structural gaps and promote equitable access.

Conclusion

This systematic review highlights that rural women across diverse contexts continue to face low mental health literacy, strong socio-cultural barriers, and significant obstacles to accessing care. While community-based and culturally sensitive interventions show promise, methodological limitations and short-term evaluations constrain the evidence base. Addressing these gaps through theory-driven, gender-responsive, and sustainable strategies is essential. Strengthening behavioral science applications in this field has the potential to reduce stigma, improve early recognition, and expand access to care, thereby promoting equity in global mental health.

Declarations

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Conflicts of Interest: The authors declare no conflicts of interest

Ethical Approval Statement: As this study is a systematic review of previously published research, it did not involve the collection of primary data from human participants. Therefore, ethical approval was not required. All included studies were reviewed for ethical compliance as reported by their original authors. No primary data collection was involved.

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