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A mixed method survey to identify the views and opinions of Sri Lankan women in the UK about perinatal mental health

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Title Page

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Key words

Perinatal, Mental Health, Sri Lankan Women, South Asian, Migrant, Healthcare

Abbreviations

HCP- Healthcare professionals

PMH- Perinatal mental health

PMHI- Perinatal mental health issues

PPD- Postpartum depression

PPIE- Patient Public Engagement and Involvement

SA- South Asian

Conflict of interest

As the corresponding author of the paper, I can confirm that there is no conflict of interest.

Ethical Approval

Ethical approval was obtained from Health Research Ethics Committee (HREC) of Edge Hill University, UK (Ref no. **ETH2021-0191**)

Anonymous manuscripts

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Background

Mental health conditions among women in the perinatal period are a global issue and the most prevalent disorder during this stage (Fellmeth et al., 2017). Perinatal mental health issues (PMHI) increase morbidity and are the major causes of

direct maternal deaths in the UK (Watson et al, 2019; Knight, 2021). The phenomenon adversely effects families and the psychosocial development of offspring, leading to the socio-economic cost of 8.1 billion each year on British society (Bauer et al., 2022). South Asian (SA) women in the UK have elevated risks of developing PMHI (Smith et al., 2019) and this has been linked to language barriers, social stigma, isolation, differences in cultural values, poor knowledge and education on PMHI (Smith et al., 2019). Masood (2015) explained that a higher birth rate among SA women compared to the indigenous population, and a low female employment rate compared to other ethnicities in the UK, have contributed to higher levels of PMHI.

PMH has been a focus of interest in research and policy for many decades. However, this interest has mainly centred around PMH in large populations (Howard and Khalief, 2020) and there has been an under-representation of the concerns and experiences of SA women (Sihre et al., 2019). This is specifically the case for Sri Lankan women who have migrated to the UK. Language barriers and stigmatisation of PMHI within specific societies may have impeded the examination of SA women's experiences of PMHI and their access to health services (Bandyopadhay et al., 2010; Nilaweera et al., 2014; Nilaweera et al., 2016). Studies carried out on Sri Lankan women have largely been on English speaking Sinhalese women in High Income Countries (HIC) (Lansakara et al., 2010; Navodani et al., 2019), and it is important to understand that the Sri Lankan community is multi-ethnic and includes populations that speak different languages such as Tamil, English and Malay (David, 2012). There is a clear gap in the literature to help midwives and other healthcare professionals' (HCP) care for the perinatal mental health needs of English and non-English speaking Sri Lankan women in the UK. Therefore, to have a greater understanding of PMHI for

this population, this study aimed to examine the views and opinions of Sri Lankan women who lived in the UK about PMH.

Methods

Design

We used a mixed-methods online survey where both quantitative and qualitative data were collected simultaneously, analysed separately and synthesised to develop the findings (Creswell and Creswell, 2018). Four SA women acted as Patient and Public Involvement and Engagement (PPIE) advisors to guide the development of the study through feedback on the proposed design, recruitment approach and materials. The online survey, which was advised as an appropriate data collection method, was pre-tested by the PPIE advisors, and the wording of questions and responses altered accordingly, some wording and imagery on the flyers were also amended.

Participants

Sri Lankan women above 16 years of age living in the UK who were pregnant, had given birth or had a miscarriage/stillbirth in the last 24 months and were literate in English/Sinhalese were eligible to participate in the study.

Recruitment

A flyer about the study was placed in local Buddhist temples and Sri Lankan community groups in the UK and the same information was placed on social media (Facebook, Twitter). The flyer contained some brief information about the study and a link to the online survey.

Data Collection

An anonymous survey using Online Surveys captured women's responses to 12 closed and 12 open-ended questions. The questionnaire was grouped into four sections relating to; demographic data, Sri Lankan women's opinions about PMH, Sri Lankan women's views and opinions about accessing information about PMH and Sri Lankan women's opinions of accessing support services (Appendix 1). As suggested in the literature (Dörnyei, 2007; Dewaele, 2018), it was hoped that an anonymous online survey would elicit honest and less inhibited information from this group of women around what could be perceived as a sensitive topic. Data were collected between the 3rd of August and the 17th of September 2021.

Data analysis

The quantitative responses from the online survey were transferred into an excel database and analysed using frequencies and percentages. Sub-group analysis was not conducted due to the small sample size and variability within the respondent characteristics. The open text qualitative data were analysed using thematic analysis involving Braun and Clarke's (2006) six-phase guide. The qualitative and quantitative data were merged and interpreted using a convergent mixed method framework (Creswell and Creswell, 2018), and are presented alongside each other.

Ethical considerations

The research project was reviewed and gained approval from the Health Research Ethics Committee (REF to be inserted after peer review). Key information about the study was positioned at the beginning of the survey and consent was

assumed by submission of the survey (Ennis and Wykes, 2016). Women were given the option to skip questions if they found them upsetting. Support links were provided at the end of the survey to signpost women who believed they have PMH concerns to appropriate support.

Results

Demographic data of the sample

In total, 34 responses were received. Thirty responses were submitted in English and four responses were submitted in Sinhalese. Of these, 15 women (44%) identified that they had given birth, eight women (24%) were pregnant, three (9%) reported they had experienced a miscarriage and one (3%) responded that they had experienced a stillbirth during the last 24 months. As shown in Table 1, the majority of respondents were Sinhalese women (*n*=25/74%) from 30 to 40 years of age (*n*=19/56%) and were educated (*n*=21/62%).

Table 1 Demographic data of the women who responded

Characteristics	Study sample (N=34/100%)
Ethnicity	
Sinhalese	25 (74%)
Tamil	3 (9%)
Muslim	2 (6%)
Burgher	2 (6%)
Age	
21-30	8 (24%)
31-40	19 (56%)
41-50	3 (9%)
≥50	2 (6%)
Education	
Primary	1 (3%)
Secondary	9 (26%)
Degree level or above	21 (62%)
Vocational training	1 (3%)

Employment	
Never worked	4 (12%)
Working full-time	6 (18%)
Working part-time	7 (21%)
On maternity leave	5 (15%)
Temporarily away from work	10 (29%)

The findings will be presented according to main themes which were developed through the synthesis of the quantitative and qualitative data. These themes are; perception of the importance of PMH, accessing information about PMH, access to professional and non-professional support, and sharing emotions about PMH.

Perception of the importance of PMH

Women who responded to the question about their own PMH (*n*=31) identified that their mental health had stayed the same (*n*=12/35%) or improved (*n*=10/25%) over the perinatal period. Nine (26%) women reported that their mental health was worse or much worse during their perinatal stage.

When asked about who mental health should be discussed with, women stated a woman's partner *(n=26/76%),* with other responses identifying that PMHI could be shared within families (*n*=20/59%) or with friends (*n*=16/47%).

Accessing information about PMH

Women were asked to report if they had received information about PMH; twenty-two (65%) women reported receiving information about PMH from a HCP while 12 women (35%) in the study had not received any information through health services during their perinatal stage. Women reported that of the HCP they had seen, midwives

had had the highest involvement in providing them with information during their perinatal period (*n*=14/41% during pregnancy and *n*=9/26% after giving birth), followed by health visitors (*n*=8/24% during pregnancy and *n*=12/35% after giving birth). Of those who reported receiving PMH information, 11 (32%) out of the 22 women found the information they received useful. Nine women (26%) out of 11 women who provided additional information in the open text space, reported that information was useful to help increase awareness of PMH and receiving information encouraged them to speak more about the topic.

> *"Though I have not used the services they have recommended, I was pleased to know that my mental condition was recognised and that encourages me to access services if I ever needed" (R- 11)*

When women were asked how access to formal information could be improved, nine women (26%) emphasised there was a need to make Sri Lankan women aware of PMH support services by making information available in a range of formats, in addition to the provision of booklets. The role of midwives in the provision of information was emphasised by four (12%) women, an example of a comment made is highlighted below:

> *"Women should be given information at antenatal clinics, and this information should be well explained by the midwife" (R-14)*

Access to professional and non-professional support

The women were asked what factors they thought maintained good PMH. An emphasis on family support was highlighted by many of the respondents (n=18/53%):

"Based on my experience of going through postnatal depression, my opinion is that it is good to have parents around and get emotional support through them" (R- 13)

Many women (*n*=22/65%) reported that they did not need to access professional support for PMH, with only a small proportion (*n*=8/24%) reporting that they had accessed support. Four women (12%) identified that they had not been able to access support even when they had needed it. When respondents were asked what could improve professional PMH support, five women (15%) reported that professionals needed to tailor support for individual needs.

"Frequent contacts of the midwives and provide extra support for women who did not receive any help" (R- 6)

Sharing emotions about PMH

The women explained that sharing emotions with family and friends was important to them. Some women provided additional explanation in the open text that sharing feelings with their primary social group could help to overcome emotional stresses:

"Sharing emotions helps me to release tensions in my mind, and it also helps me to improve better communication with my family. Also, my distresses could be easily understood by my family and friends" (R- 10)

Twelve of the women (35%) emphasised barriers to sharing emotions and accessing support and these included difficulties in accepting PMHI within Sri Lankan cultures, due to social stigma and that this can prevent women accessing support. This is described below by one participant:

> *"Mental health is such a pivotal part in a woman, whether they have had a pregnancy or not. It is less well discussed in our own country due to age-old taboos. However, in a nation where mental health plays a key role in societal well-being, we should take the opportunity to discuss our own mental health and promote this back home in Sri Lanka as well" (R-16*)

Discussion

This study examined the views and opinions of Sri Lankan women who were living in the UK about PMH, to our knowledge this was the first study to focus on PMHI and Sri Lankan women in the UK. The survey findings mirrored similar reports of worsening PMH during the perinatal stage as shown in larger studies (Palfreyman 2021, Insan et al. 2020) and indicated that PMHI may differ across Sri Lankan ethnic minorities (Tamil, Muslim, Sinhalese and Burgher). These cultural differences have been highlighted in previous work by Beiser et al. (2015) and Kanagaratnem et al. (2020) who showed a higher incidence of depression, anxiety disorders and post-traumatic stress disorders in Sri Lankan Tamil refugees residing in Canada. However, these studies did not predominantly focus on women at the perinatal stage. Whilst there is developing evidence to show that tensions exist in the provisions of PMH services to women from other cultures in the UK (Watson et al, 2019; Smith et al, 2019; Jankovic et al, 2020), it is less known about the specific needs and concerns about Sri Lankan women.

The women respondents in this study who received information from midwives and HCPs reported this was useful in increasing awareness about PMH and such information encouraged them to speak about the topic of PMH. According to Hapangama (2021), PMH services remain largely neglected within Sri Lankan

healthcare systems and have been given a wider recognition within the British healthcare system, creating potentially different expectations around PMH information and support. Whilst written leaflets can be a useful tool to share information, the respondents in our study stated that the information would have been more useful if it had been offered in different formats including verbally and by signposting to other services. Similar concerns have been previously identified by Noonan et al. (2017) and Pinar et al. (2022) who highlighted that despite readable information routinely provided, offering practical support and signposting women to appropriate support seemed to be poor among midwives.

In this study, there was a strong emphasis on respondents relying more on non-professional support received by family and friends for mental health support during their perinatal stage. This reliance on family seems to reflect the Sri Lankan tradition where a new mother's family is expected to guide, care and support them throughout the perinatal stage (Lansakara et al., 2010; Nilaweera et al., 2016; Kandasamy et al., 2020) and mothers divulging their feelings and psychological concerns with someone outside their comfort zone is an act which is often frowned upon by SA societies (Prajapati and Liebling, 2021). The systematic review conducted by McCarthy et al. (2021) on the experience and perception of anxiety and stress during perinatal stage among women in general, further recognised the importance of sharing emotions between close social networks and identified that the understanding behaviour of partner, family and friends significantly reduced the levels of stress and anxiety of women during their perinatal stage.

The dominant barrier in sharing emotional stresses and PMHI was attributed to the social stigma pertaining to mental health among the Sri Lankan society. Stigma

may help to explain why 718 women accessed this survey and only 34 took part. Similar barriers were identified by a cross-sectional survey study conducted on stigma and perception on postpartum depression (PPD) in a rural suburb in Sri Lanka (Amarasinghe et al., 2019). In this study the majority of women (*n*=374/61%) strongly believed that they were not susceptible to PMHI and 56% (*n*=280) normalised symptoms of PPD and 50% (*n*=260) normalised suicidal ideation. Similarly, their study identified that some women (*n*=108/18%) did not wish to be a friend of an affected women due to stigma pertaining in Sri Lankan society (Amarasinghe et al, 2019).

Strengths and limitations

The strengths of the study include, that the surveys were translated into Sinhalese language and therefore this research was able to approach some 'less heard' Sri Lankan women in the UK. By conducting an anonymous online survey, the identity of the participants was protected, this aimed to facilitate the women to feel able to report their feelings and opinions. A further strength was the PPIE consultation with Sri Lankan women advisors to inform the development of the study design, sample, data collection and ethical considerations.

However, the study was small and therefore findings cannot be generalised. Women who participated were asked to encourage others within their own networks to take part, and hence the snowball sample created a potential self-selecting bias. The survey was only available to women who could read English and Sinhalese, the surveys were not translated into Tamil and Malay languages. The survey could only be accessed by women with access to the internet and who were computer literate, which may have limited the survey respondents.

Conclusion

This study identified that some Sri Lankan women did not receive any information about PMHI, despite identifying that their PMH had worsened. Women identified the need for information to be shared verbally as well as in written format and include signposting. Therefore, midwives need to ensure that PMH is discussed sensitively with all Sri Lankan women, recognising that the subject can be taboo in Sri Lankan culture. Any health care interactions or information provision needs to recognise the important roles of family members and partners in the support of women's PMH in Sri Lankan societies. Future quantitative research related to Sri Lankan women in the UK needs to examine if tools to detect PMHI are culturally sensitive and qualitative research needs to include partners, families and offspring to explore how best to care for this population during perinatal stage.

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Conflict of interest

The author declares no conflict of interest

Key points

- One-in-four Sri Lankan women reported they had PMHI during the perinatal phase
- One-in-three Sri Lankan women reported not receiving any formal or informal information about PMHI
- Midwives and other HCPs need to ask all Sri Lankan women about PMHI by increasing verbal explanations and signposts.
- Sri Lankan women in the UK are more reliant on non-professional support received from primary social groups
- Sharing emotions during the perinatal stage was important to women but social stigma was identified as the dominant barrier for Sri Lankan women to sharing

Reflective questions

- How would you open up sensitive conversations with Sri Lankan women in the perinatal stage about PMHI?
- What information is available to share with Sri Lankan women about PMHI?
- How would you signpost a woman to other HCPs if they disclosed or shared PMHI?

Tables

Table 1 Demographic data of the women who responded

Characteristics	Study sample (N=34/100%)
Ethnicity	
Sinhalese	25 (74%)
Tamil	3 (9%)
Muslim	2 (6%)
Burgher	2 (6%)
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≥50	2 (6%)
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Primary	1 (3%)
Secondary	9 (26%)
Degree level or above	21 (62%)
Vocational training	1 (3%)
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Additional Data (Appendix 1)