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Helping or Heightening Vulnerability? Midwives as Arbiters of Risk for Women Experiencing Self-Directed Violence in Urban Sri Lanka

Alexis Palfreyman¹

Abstract

The response of midwives to women engaging in self-directed violence (SDV) may affect women's care and outcomes. The author explored midwives' understanding of SDV through semi-structured focus groups and in-depth interviews with 11 Public Health Midwives in urban Sri Lanka. Thematic analysis identified four key themes: (a) perceived dimensions of women's risk and vulnerability to SDV, (b) midwives as arbiters of risk, (c) representations of women engaging in SDV, and (d) midwives' perceived capacity to respond. Given their proximity to communities, trustworthiness as sites of disclosure, and respectability as women and guardians of ideal womanhood in Sri Lankan society, midwives occupy a powerful position in the health system through which to alleviate or reinforce women's risk to SDV. Yet, investment in developing their skills and role to respond to the growing phenomenon of SDV among women in Sri Lanka must consider the context within which midwives assess and select their responses.

Keywords

midwives, health providers, women, suicide, attitudes, responses, Sri Lanka, LMIC, qualitative, semi-structured focus groups, in-depth interviews

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Introduction

Low- and middle-income countries (LMIC) face the greatest and growing burden of suicides, accounting for nearly 80% of self-inflicted deaths globally (World Health Organization [WHO], 2017). These deaths represent the most extreme outcome on a continuum of self-directed violence (SDV). SDV includes ideations, planning and preparatory behavior, and/or acts of self-harm, both fatal and nonfatal, which may or may not be suicidal in their intent (Crosby, Ortega, & Melanson, 2011). Suicide is now the leading cause of death among girls aged 15 to 19 years globally (Petroni, Patel, & Patton, 2015), fourth leading cause of death among women aged 15 to 49, and occurs at higher rates among younger women than their male counterparts in some LMIC regions including Southeast Asia. Nonfatal SDV including thoughts and behaviors—whether suicidally intended or not—is disproportionately observed in females globally (WHO, 2014).

Women's SDV in its various forms can lead to contact with the health system—often at a point of crisis. Health providers are an essential part of, with potentially crucial roles in, the nexus of circumstances within which self-harming women find themselves. The attitudes and practices of health providers interacting with those engaging in SDV have affected care and treatment in high-income countries (HIC), with negative responses (re)producing stigma and feelings of rejection (Anderson & Standen, 2007). In LMIC, stigma between health providers and patients may be worse (Hagaman et al., 2013). Evidence from those who have survived episodes of SDV but received negative reactions to their disclosure finds they are less likely to disclose in future, consequently affecting help-seeking behaviors (Frey, Fulginiti, Lezine, & Cerel,

2018). In LMIC, where help-seeking through health services and disclosure rates are both thought to be lower compared with HIC (Hagaman et al., 2013), women without alternative sources of support or with poor experiences with the health system may be more vulnerable to subsequent episodes of SDV. Thus, LMIC health providers' understanding of the phenomenon, attitudes toward, and experiences of working with SDV-practicing women are critical to informing local health system responses, thus, affecting the health of women engaged in SDV.

The majority of previous research on health providers' understandings, attitudes, and responses to SDV is quantitative, using knowledge, attitude, and practice (KAP) questionnaires, which were not developed in nor adapted for LMIC settings. Only one existing attitudinal scale was developed from a LMIC perspective, and no HIC tools have been formally validated prior to use in LMIC (Ghasemi, Shaghghi, & Allahverdipour, 2015). Current tools do not allow for a gendered perspective to better understand health providers' attitudes and responses, fail to take into account perceived competence that may impact provider attitudes, and restrict opportunities to understand why providers respond as they do. Qualitative methodologies are needed to generate emic cultural and gender-relevant perspectives (Jones, Krishna, Rajendra, & Keenan, 2015). There is also a paucity of data from LMIC. Hagaman et al. (2013) note that, "lay and clinical interpretations of suicidal ideation and intent determine the availability and type of support for persons reporting suicidal thoughts" (p. 61), which applies to the spectrum of SDV. Existing health provider research primarily focuses on professional groups in HIC with frequent contact with self-harming patients, including doctors and nurses in Accident and Emergency Rooms and mental health practitioners. The latest systematic review on provider KAP toward SDV identified only three studies from LMIC (Saunders, Hawton, Fortune, & Farrell, 2012).

Additional evidence has been generated since, but with comparatively few contributions from LMIC contexts (Jones et al., 2015), and deeper insights into the role of local cultural and religious beliefs on negatively skewed KAP observed among LMIC health providers are needed (Saunders et al., 2012).

In LMIC, the perspectives of community health workers who facilitate access to care, and can take primary and preventive services directly to community members, may be more insightful than specialized facility-based providers. However, literature incorporating community health workers' perceptions of SDV is sparse (Hagaman et al., 2013). Evidence on community health workers as "non-specialists" in responding to mental health needs in LMIC communities has sometimes framed SDV as one of many mental health issues they may address (van Ginneken et al., 2013), while at other times has overlooked SDV and its potential relationship with mental health in low resource settings (Surjaningrum, Minas, Jorm, & Kakuma, 2018). The positioning of SDV as a matter of mental health, however, remains contentious in LMIC where nonsuicidal self-harm and suicidal behaviors are less commonly preceded by psychopathology (WHO, 2014).

For LMIC women, the role of midwives as providers of both community and facility-based care may be particularly relevant to the prevention of and response to SDV for several reasons. First, midwife-led antenatal care is often the first and/or principal mechanism linking women with LMIC health systems (Metheny & Stephenson, 2017), after which women may continue to be under the care of or in contact with midwives for postnatal and early childhood interventions. Midwives also increasingly play a role in health promotion outside of the perinatal period globally (WHO, 2016). Third, as suicide has undergone revised classification as a cause of maternal death by WHO, several LMIC

have identified perinatal suicides as a new category of maternal mortality demanding attention (Fuhr et al., 2014). The potential role of midwives in prevention of maternal suicides has been highlighted in HIC, but restricted to discussions of improved mental health assessment and referral (Holland, 2018). WHO (2016) recently emphasized the need to document midwives' perspectives and experiences providing care on a range of issues, although mental health and SDV were not included in their own global consultation. Mental health's role in maternal suicides, however, is debated in LMIC (WHO, 2014), preventing the transferability of already insufficient evidence on midwives' attitudes toward managing mental disorders in perinatal women from HIC (McCauley, Elsom, Muir-Cochrane, & Lyneham, 2011). Limited research has explored midwives' attitudes toward suicide using survey methodologies, however, these studies exclude the fuller range of SDV experiences, originate from high-income contexts, and do not extend to exploring midwives' practices (Brunero, Smith, Bates, & Fairbrother, 2008; Lau, McCauley, Barnfield, Moss, & Cross, 2015). Finally, recent research suggests those with a history of SDV report a disinclination to disclose past or potential risk within close social networks of family and friends, and, thus, may look for confidantes beyond this (Frey et al., 2018). Midwives may already be providing support for women experiencing SDV, however, no data document the extent to which this may be happening in any setting nor the lived reality of midwives encountering it in their roles. This study, using the case of Sri Lanka and its Public Health Midwives (PHM), is the first to report midwives' understandings of, attitudes toward, and responses to SDV among women.

Aims of the Research

This study uses Sri Lankan midwives' narratives to answer three questions:

1. How do midwives understand risk and vulnerability among women experiencing SDV?
2. How do midwives respond to women's SDV, and why?
3. How do midwives perceive their capacity and role to respond to women engaging in or at risk of SDV?

The Sri Lankan Context

Sri Lanka is home to 20.3 million people and has enduringly high suicide rates with roughly 7% of households reporting at least one lifetime suicide attempt (Knipe et al., 2018). Although total suicides have decreased substantially since their peak in the mid-1990s, reductions in suicides among women have stalled, and hospital admissions data suggest a growing burden of self-harm among young women (under 21 years; Knipe, Padmanathan, Muthuwatta, Metcalfe, & Gunnell, 2017). These data represent the tip of an iceberg, where the proportion of SDV events that do not result in contact with health services remains unknown. Police data recorded 677 female suicides in 2017, and maternal suicides are a recognized public health challenge (Agampodi et al., 2014; Sri Lanka Police, 2017). Despite a national body of suicide research, the broader spectrum of SDV has received less attention in Sri Lanka with the exception of new evidence on household-level suicide attempts from one rural district, which suggests similar risk in females as males (22.3 per 1,000; Knipe et al., 2018).

Sri Lanka's midwives form the bedrock of its National Health Service and are responsible for family health at the community level free of charge, including family planning, ante- and postnatal care, child health for under 5 year olds, and some health

promotion (Family Health Bureau, 2018). PHM are all women, recruited from age 18 onward who receive approximately 18 months of training, qualifying them as midlevel health providers. Midwives reside in the communities they serve, covering roughly 750 households each (2,000–5,000 residents; Jayatilleke et al., 2015). Sri Lanka outperforms regional neighbors on a number of health and social indicators, and much of this success has been attributed to the contribution of PHM to improving community health outcomes (Jayatilleke et al., 2015). PHM are viewed as one of Sri Lanka's greatest healthcare assets.

Method

Study Setting: Gampaha District

Gampaha District, north of Sri Lanka's capital, was purposefully selected for this research for two reasons. First, with 2.4 million people, it has a more urban and industrial population than elsewhere in the country. Second, hosting three Free Trade Zones (FTZ) as well as the country's international airport, Gampaha has high migration levels and large concentrated populations of young and unaccompanied women travelling to and from the district for employment there or abroad (Family Health Bureau, 2018). Its FTZs house hundreds of factories, dominated by the garment industry, and operate on 80% female labor. Living conditions for FTZ workers can be challenging, and Gampaha's towns offer lifestyles quite different to those of village life, although parts of the district are classified as rural (Jordal, Wijewardena, Ohman, Essen, & Olsson, 2015). This local demography has not featured in previous Sri Lankan research on SDV, which has concentrated on rural, farming populations affected by pesticide poisoning (Pearson et al., 2014). In 2016, Gampaha District had 702 PHM

delivering services from 184 community clinics, public hospitals, and/or through home visiting (Ministry of Health, 2016). Recent estimates report that 0.4% of households in Gampaha have experienced at least one suicide attempt in the previous year (Department of Census and Statistics & Ministry of Health, Nutrition and Indigenous Medicine, 2017b), while lifetime household levels are unavailable. Data on prevalence of other dimensions of SDV are limited to one recent study, which found that one in four pregnant women in Gampaha District reported a lifetime experience of suicidal ideation, suicidal behavior, or both, while 7.4% of women reported these experiences in their current pregnancy (Palfreyman, 2018).

Sampling and Data Collection

PHM were identified through a three-step process. First, four of the district's 16 Ministry of Health areas were purposefully selected to ensure (a) representation of Gampaha's urban-rural mix, (b) that at least one FTZ was captured, and (c) that one Ministry of Health area hosted a hospital from which to recruit as community- and hospital-based PHM serve different populations. Within each Ministry of Health area, one antenatal clinic was randomly selected to approach midwives. Three antenatal clinics operate in the study hospital, but only one clinic was selected. As women were assigned to the hospital clinics randomly, the PHM serving the selected clinic would not have been receiving a biased patient pool. Finally, all PHM assigned to the four chosen clinics were invited to take part; all PHM accepted and, in total, 11 participated between March and October 2016. Midwives were given the option to participate individually or in group discussions, three clinic teams selecting the latter, citing comfort with one another and efficiency as primary reasons. The hospital-based PHM, working solo, took part in a face-to-face, in-depth interview.

Focus group discussions ($n = 3$) and the interview ($n = 1$) occurred on-site at times convenient for midwives that engendered privacy and minimal interruption. All PHM operated primarily in Sinhala, and discussions were bilingual, transitioning from English to Sinhala between the author as facilitator, and the midwives. The author has extensive experience working in maternal and mental health across a number of LMIC including Sri Lanka, and data collection was guided by key values of feminist research, including equity and awareness of power and relational dynamics throughout the research process. She was present for 4 months in the field prior to commencing data collection, which fostered rapport preceding discussions. This pre-data collection engagement supported trust and candidness between midwives and the research team, and this likely led to richer discussions than had time not been invested outside of these data collection moments. The author was present at all discussions, which were supported by a research assistant acting in the role of interpreter. The research assistant was a nursing graduate with specialist midwifery training from the study district and was, therefore, familiar with the local context and profession. All discussions were audio-recorded, with notes taken by the author, and lasted until information redundancy was reached—usually between 1 and 2 hours (Carminati, 2018).

Research Instrument

Discussions were guided by a semi-structured topic guide developed by the author. Drawing on core issues evidenced in the SDV KAP literature, additional items were selected to address context-specific issues in Sri Lanka as well as those requiring further evidence, such as PHM's perceived capacity to respond to women's SDV. The tool was intentionally flexible, asking a mixture of descriptive, evaluative, and structural

questions, and allowed for unanticipated topics to emerge. It was translated from English to Sinhala and back-translated to assess accuracy of intended meaning and allow for linguistic variability. The research team piloted the guide inviting participants' feedback to challenge assumptions about meaning, and made minor amendments to improve conceptual and cultural translation of ideas, supporting validity (Willig, 2013).

Transcription and Translation

As discussions were bilingual, the author transcribed English segments verbatim, which contained her spoken words as well as portions of the research assistants'. Following this, two local professional bilingual transcriptionists reviewed the English segments and added all Sinhala portions, which were subsequently translated into English. All transcripts were quality checked by the author and swapped between translators to ensure accuracy and completeness.

Data Analysis

This study employed thematic analysis to explore providers' perspectives as it offers a theoretically flexible but rigorous approach to identifying and organizing patterns of meaning in qualitative data (Braun & Clarke, 2006). Data analysis was supported by the use of NVivo 11 Plus (QSR International, 2018). Following initial reading of transcripts, coding proceeded inductively; generated directly from recurrent issues and often the participants' own language (in vivo) and continued until no new codes were identified. Codes were applied to units of meaning, rather than line-by-line, and were refined into themes that permitted recognition of relationships between themes. Clusters and themes were constantly interrogated within and across cases to ensure they were grounded in these data. To support quality and data validation, cultivate reflexivity, and

minimize biases on the part of the author, key themes were discussed with the research assistant to verify or modify interpretations and incorporated Braun and Clarke's (2006) quality criteria for good thematic analysis.

Ethics

Ethical approval for this study was granted by the London School of Economics and the Faculty of Medicine, University of Kelaniya (Ref. P/135/08/2015). The research assistant was trained on ethical research behavior and interviewing best practice, and she and the independent transcriptionists were subject to confidentiality agreements. All midwives were given written informed consent forms in their preferred language (English or Sinhala), and forms were reviewed in detail with the research team. PHM had time to read the forms privately before consenting. No incentives were given for participating, and no deception was employed.

Findings

Midwives largely spoke in stories, offering rich, experiential accounts yielding four main themes: (a) perceived dimensions of women's risk and vulnerability to SDV, (b) midwives as arbiters of risk, (c) representations of women engaging in SDV, and (d) midwives' perceived capacity to respond. Themes and subthemes were often and necessarily interrelated. Findings begin with a brief overview of midwives' characteristics, awareness, and general exposure to SDV in women. Illustrative quotes are presented to accompany the author's interpretations, and anonymity of midwives and their catchment areas are maintained.

Background and Exposure to SDV in Women

Midwives ranged in age from 31 to 58 years ($M = 39.7$ years) with varying lengths of service (3 to 31 years). Eight of the 11 midwives had more than 15 years of service, and PHM had been in their current posts for the majority or entirety of their careers. All 11 were married, and 10 were mothers, while one midwife was pregnant with her first child. All midwives lived in their communities of service, some of them for their whole lives. Their length of service and residency suggested PHM were very familiar with local populations and cultures.

The research team asked whether midwives had previous knowledge and/or exposure to women's SDV in their communities, as no evidence was available to suggest whether this provider role had contact with women experiencing SDV. All 11 midwives were aware of incidents of SDV among women in catchment areas other than their own, and each midwife had direct experience within the past 5 years. Most midwives recounted stories of affected women throughout their careers, some vividly from as early as 1990, which highlighted that, for them, SDV among women was not a new or emerging issue. However, there was a general consensus among midwives that SDV "has increased" among women and is, therefore, a growing issue for them personally and professionally.

The full spectrum of SDV had been encountered by all midwives, from ideations, to preparatory behaviors such as "carry[ing] with her a bottle of poison wherever she went to kill herself at any time," multiple experiences with suicide attempts, and deaths by suicide. The methods reported by midwives were variable, from self-poisoning ("recently [I] met a mother who drank Lysol"), to more violent means, such as, "jumping to the train," jumping into wells and dams, hanging, and multiple reports of self-immolation. Midwives encountered women at different life stages in the community, including perinatal and nonperinatal women, and often reported long-standing

provider-patient relationships with SDV-affected women. The hospital PHM had several stories of maternal suicides, two of which were women under her care earlier in her career and the other in a neighboring catchment; all three occurred during pregnancy.

Community-based midwives encountered SDV more frequently than the hospital-based PHM, who reported few recent cases and reflected on the more common occurrence in her community-based years: “During my years at the field I had met a lot . . . and a lot of pregnant mothers who had set themselves on fire . . . I have come across many like that.” This is perhaps a reflection of the different dynamics of community-versus hospital-based clinics as she only sees perinatal women in the hospital context, which is busy, overcrowded, and frequented by husbands and other family members compared with the relative calm of community settings. It may also be that women accessing hospital disclose or engage with health providers in other departments instead of the midwife.

Perceived Dimensions of Risk and Vulnerability for SDV in Women

Multiple dimensions of risk rendering women more vulnerable to SDV were identified. Strained family dynamics, particularly those revolving around marriage or intimate partners, were recognized as primary sources of women’s vulnerability: “Most of the time [midwives are] . . . dealing with family problems—that’s the problem they’re having.” Estranged relations with parents or in-laws, often ascribed to disapproval of women’s romantic relationships, were cited as sources of tension. Parents and in-laws openly disapproved of women’s marriages, vocalized discontent, and in one case engaged in repeated dowry harassment: “When I talk to the boy, the boy said that their family tells him to don’t bring her home without a dowry [sic] . . . That’s another thing to fight [about].” Other women faced tremendous pressure to marry—including from

midwives themselves—primarily in circumstances of nonmarital pregnancy: “The girl was unmarried [and] I had to force the boy to marry her.”

Several midwives summarized women’s primary risk as being “because of their husbands.” Volatile relationships, violence including marital rape, and tension due, in part, to husband’s jealousy or insecurity were described:

I knew a family, where the husband was not educated. Wife was well educated. The husband felt that the wife would supersede him one day because of her education . . . Some days the husband would bring swords [large knives] to cut her [harm her].
(Rural clinic midwife)

Volatility and violence were explicitly linked to men’s substance abuse and both illegal drug use and alcohol abuse in men were perceived as common by midwives: “Alcoholism of the husband is . . . one of the key reasons for such behavior.” Drug addiction was viewed as a particular risk for women in Gampaha, which may not be found elsewhere: “In here many women are married to men who are addicted to drugs . . . Drug addicts are high in this area so mostly their family members are more vulnerable to [these] kinds of things.”

Infidelity on the part of husbands, and occasionally women themselves was seen as a common risk for subsequent SDV, and women’s infidelity was attributed to preexisting tensions in the home, the husband’s absence or neglect. Lack of social and familial support was the overarching feature in all midwives’ experiences with women affected by SDV. Neglectful or absent husbands, loss of parents to death, migration, or disapproval over personal relationships, and abandonment by boyfriends in critical periods such as pregnancy were seen as damaging to women’s well-being and

contributors to women's choices to self-harm: "When they haven't anyone to help they used to do this kind of thing"; "When they get pregnant, they have no one to speak with and they commit suicide."

Women's sexual and reproductive health and rights took center stage in midwives' stories. Pressure from family to have or continue pregnancies, women's anxieties about (potential) infertility or impending motherhood, sex and pregnancy outside of marriage, and unplanned and/or unwanted pregnancies were reported by multiple midwives as contributing to women's trajectories into SDV. PHM felt married women had knowledge about avoiding pregnancy ("they have been taught"), but that unmarried or adulterous women were less able to access contraception and information from them due to stigma. Abortion is highly stigmatized and illegal in Sri Lanka save risk to a mother's life (Jordal et al., 2015), yet abortion experiences frequently featured in midwives' accounts of women's SDV as a result of premarital or extramarital pregnancies or, in one case, rape:

The mother got pregnant because of the rape . . . She said she has nothing more to do, that she wants to take her life because if she has the baby she will not be able to face anyone. (Rural clinic midwife)

PHM reported abortion as prevalent in Gampaha District, in part because of the FTZs ("Now the illegal abortions are high. . . . there are many places which [are] doing these kinds of abortions around this area"). Finally, forced sex in the context of marriage was reported by two midwives' accounts of suicidal women:

He forces her to have sex with [him] unnecessarily . . . even when the children are at home he forces her to have sex with him. So because of it she is depressed and [it] makes her feel uncomfortable and she had said she wants to commit suicide. (Rural clinic midwife)

Marital rape is just one form of intimate partner violence (IPV) described by midwives, which was perceived as a significant and common precursor to women's SDV. All midwives reported experiences with self-harming women affected by IPV including sexual, physical, emotional, and financial abuses and other controlling behaviors, such as preventing women from working, restricting family contact, withholding money, and blaming women for family difficulties. IPV was viewed as both a direct and indirect risk for women's SDV. Indirectly, they reported it contributed to depression and other mental health problems in women, affected their attendance at antenatal clinics, and incited fear about the safety of pregnancies when partners were violent. Suicidal ideation was associated with these circumstances in midwives' views. Episodes of IPV were also presented as direct triggers for SDV, "so when they got [sic] abused . . . [women] try to do this kind of thing."

Mental health was raised by several midwives as a potential source of risk that could initiate or exacerbate preexisting difficulties with SDV. This was discussed in relation to women's own mental health, as well as their husbands and other family members as indirect causes of worry. PHM shared several accounts of women with preexisting psychiatric diagnoses, including perinatal women who should have been medicated, but were not consistently adhering due to lack of support and competing traditional treatments. Other examples demonstrated that midwives' perceived as-yet undiagnosed psychiatric disorders including postpartum psychosis as key in some women's SDV trajectories. Overall, however, while mental health disorders were identified in a few

cases, midwives felt their role was secondary as, “it’s not mainly dependent on psychiatric disorders.” Husbands’ mental health could encourage women’s consideration of SDV: “When I started visiting the home she said she has been facing this [husband’s ‘mental stress’] for a long time and now she couldn’t take it anymore.” Two midwives described how women’s trauma and anxieties over the impact of violence on their children’s mental health compounded their own thoughts of suicide.

The Gampaha context, with FTZs, and high migration within and outside of Sri Lanka, converged to construct what midwives perceived to be a risk environment not seen elsewhere in Sri Lanka: “This is a very different area due to the Free Trade Zone. All those problems arrived because of that. Here we are having [the] most migrant population.” That many of the women they encountered with SDV were young and lacking in education and life experience was seen as a consequence of the female migration from rural villages to Gampaha. Youth and its presumed naïveté were presented as vulnerabilities: “When under 18, children come to work [and] they haven’t any idea about the society so they are easily trapping to these problems.” Separation from family, and, specifically, lack of guardianship from caring adults, rendered women susceptible to risky relationships with men, negative consequences of sex outside of marriage, exploitation, and violence. FTZ workers were perceived to be at particular risk of SDV:

Most of them are in very young age and they live in boarding places. They don’t have any guardian in there. So when they got [sic] abused or got pregnant without marrying, they try to do this kind of thing. (Semi-urban and FTZ-serving clinic midwife)

The dimensions of risk noted above were, for midwives, amplified in boarding house settings. According to one clinic's midwives, the transitory nature of boarding house living attracts women from elsewhere in the country and returning from overseas who wish to hide unwanted pregnancies, contributing additional cases at "higher risk" of SDV to their services.

Public Health Midwives as Arbiters of Risk

Midwives emerged as providing a critical social role in local communities, not restricted to health, and in relation to women experiencing SDV. PHM viewed themselves as first points of contact for women in distress and as embodied sites for trusted disclosure:

Midwife is a person who is in the field and closest to the people. People share most of the stories with the midwives . . . Those issues [SDV], they start in a home. And the home is visited by a midwife. (Hospital-based midwife)

Their stories revealed many instances of help-seeking by women directly—either during clinics or home visits; other times, community or family members approached PHM to help women at risk of or experiencing SDV or PHM-initiated probing when concerns arose.

Throughout midwives' accounts, their responses to women's SDV and their circumstances were described. All of the practices were presented by midwives as having been well-intended, and midwives appeared deeply committed to reducing risk and preventing SDV. These practices, however, reveal the significance of PHM in attending to women's SDV, as they could reduce or, conversely, heighten women's vulnerability to harm. Practices that appeared to support positive outcomes for women

included facilitating access to community health services—frequently antenatal care in the case of unplanned pregnancy—provision of health information and advice, referrals to a variety of services including psychiatric care, mothers’ groups, gender-based violence, and drug rehabilitation services. These efforts were sometimes reinforced by follow-up on women’s progress at the household level.

Considerable emphasis was placed on time spent talking, whether through perceived empathizing by sharing their own struggles with women, listening to women’s difficulties, or facilitating family mediation and couple’s counseling, albeit in informal ways as midwives are not formally tasked with this. Several PHM described this as providing “mental support.” There were, however, talking practices with potentially harmful unanticipated consequences for women. A woman who had disclosed suicidal ideation due to regular forced sex by her husband was advised by her midwife to stop refusing his sexual advances. The midwife first minimized the woman’s concerns by suggesting it would not happen too regularly due to the husband’s occupation, and upon learning it was a nearly daily occurrence, the PHM advised cooperation on the part of the woman. This was rationalized that otherwise the husband would seek sex outside the marriage, potentially putting the family unit at risk:

She has a problem of connecting with the husband [euphemism for sex]. She also visits me to talk about this and she feels like committing suicide at times . . . She visits me and says she feels like that . . . So I explained to her, if she refuses him, he will look for another woman. And that her three children will not have a mother. I explained it to her, and said not to do it. And after that she accepted it. (Rural clinic midwife)

Another midwife recounted the story of a young, unmarried FTZ worker who became pregnant by her violent boyfriend who was demanding an abortion. Upon finding out about the woman's situation through a retired midwife, this PHM phoned the boyfriend, impersonating a police officer, to inform him of the illegality of terminations and that should the abortion go ahead, he would be arrested. This tactic was repeated, and the midwife reported that she "forced him to marry the girl." Once married, IPV escalated, causing distress in the woman for the safety of the unborn baby. The midwife made multiple visits to the boarding house following abusive episodes:

When [I] got the news, [I] thoroughly advised to the husband by telling that if he had done something to her, [I was] going to have the legal actions against him. Also [I] had given the counseling for the boy telling that this pregnant lady should not be [treated] like this. (Semi-urban and FTZ-serving clinic midwife)

Following another fight that turned physically violent, the young woman attempted suicide by jumping into a well. Numerous examples highlighted the ethical and social complexity inherent in midwives' assessments of women's circumstances. At times, midwives appeared laden with the task of executing judgment as to how to respond to them. Keeping significant secrets such as women's infidelity, sexual assault, and unwanted pregnancy from partners and extended family was not uncommon. Their rationale for selecting particular responses seemed to be partly influenced by their perceptions of women's circumstances as blameless or transgressive and their capacities.

Representations of Women Engaging in SDV

Two opposing representations of women emerged from midwives' narratives. Some women were described in terms that suggest victimhood—"tearful," "quiet" women deserving of care, protection, and empathy, especially if their experiences were relatable to midwives'. Included were women with psychiatric diagnoses, those experiencing IPV, sexual violence, pregnancy and childlessness, and some FTZ workers were women to be pitied. Under these circumstances, PHM expressed a commitment to alleviating their distress: "I feel sorry. A woman when she comes to a position like that, they are helpless . . . So I want to help at times like that."

At other times, women's circumstances qualified them as female transgressors of social and gender norms. These women were described as shortsighted, impulsive, lacking in coping skills, "secretive," and unable to control themselves sexually, thus, ending up in precarious situations. A lack of tolerance for life's difficulties, especially in marriage, was identified by several midwives:

Most of the time today they go for the quick decisions . . . [I] wanted to save their marriage, to protect their marriage, but most of the women . . . just want to leave their husband and meet another one. (Rural clinic midwife)

Transgressions centered on standards of motherhood and female sexuality. A lack of willingness to endure in unhappy marriages was seen to jeopardize outcomes for children, thus, breaching the "sacrificial mother" role (Hemawanna, 2003), even when a husband's behavior was deeply problematic. Sex workers were a specific subpopulation well-known to one clinic serving an FTZ, and unwanted pregnancies were common; they constituted women that were "not so much good."

Women's representations invited both empathy and disapproval for their situations and the transgressions that facilitated them. This tension was best illustrated by the story of a young, unmarried pregnant woman deemed too problematic for her family who lived in a midwife's own home for 5 months:

She just wanted to commit suicide because she couldn't cope with it [pregnancy]. Then I was also feeling really bad so I took her home . . . it was becoming an issue for my children . . . I feared that they might get influenced . . . What I did was wrong. I could have lost my job . . . I tried to take her home and support and realized I couldn't.
(Hospital-based midwife)

Midwives expressed general views that SDV was morally wrong under all circumstances and religiously prohibited, and in one focus group discussion, midwives believed suicide was illegal. While accepting solutions may be difficult to identify, all PHM felt that, "every problem has a solution" and that women did not have a right to take their lives.

Midwives' Perceived Capacity and Role in Responding to Women's SDV

Midwives were asked about when they first encountered issues of SDV in women, whether they had expected this as part of their professional roles and been given any professional preparation. PHM with long service recalled attending 2-week, on-site psychiatry training in the late 1980s and early 1990s at what is now the National Institute of Mental Health. However, trainings were restricted to identifying signs of psychiatric conditions in mothers—not social and interpersonal difficulties—and none had received refresher training despite perinatal mental health evolving in the past 30 years. Younger midwives did not receive psychiatric training at all as it was reportedly

cut from pre-service curriculum, and only three midwives recalled having a one-off session on IPV. Overall, PHM felt they had not received sufficient preparation to respond to SDV and the concomitant distress present in women experiencing it. Midwives had no consistent guidelines or treatment pathways to follow, resulting in reactive strategies reliant on individual midwives' judgment: "We are doing just what we think, it's not the professional way."

Additional barriers to providing optimal care and support included patient, provider, and health systems challenges such as unsupportive family members, women's resistance to certain interventions, limitations to making direct referrals extending women's care pathway, and lack of local counseling and gender-based violence services. However, the most significant barrier for most midwives was high patient load and lack of time to build rapport with women:

Our issue is that we don't have the time to spend with such people . . . And only if we can become friends with them they would open up . . . No matter what workshop we are offered, if we are limited in time then we have a problem. We like to be [in] the field to talk, to build those relationships, but we don't have that opportunity. (Urban clinic midwife)

All PHM vocalized confidence that on a number of occasions they had "saved" women's lives and "stop[ed] them from suicide." They all expressed a willingness and sense of responsibility for attending to women at risk of or experiencing SDV: "Absolutely it's our responsibility; we are directly involved [in] these kinds of matters. We do maximally what we can do." This responsibility extended beyond their duty as a midwife for some and was a source of satisfaction: "This is more than a duty. We are

having so much pleasure when someone gets solutions for their problems.” For others, it was a reflection of their commitment to being a “good” Buddhist: “We want to do something good. Because if we do good in this life then in our next life it will be good.” Most of the midwives believed their role was critical to prevention of SDV in women, and some expressed a woman-centered approach to reducing risk:

We must focus on her as much as possible, and get her the help. There are social service institutes even that you could get her the support she needs. We can build an environment to prevent her from self-harm. (Hospital-based midwife)

All 11 PHM felt strongly that their role deserved investment and support, to build their capacity to identify and respond to women at risk of SDV. This reasoning was based on the common perception that women’s risk stemmed largely from their living environment, and that as *the* grassroots health provider, they were uniquely positioned to address SDV and its drivers. They shared numerous suggestions for capacity building, including pre- and in-service training that was both theoretical and practical on mental health, and specifically developing skills and confidence to deliver professionalized counseling as this would be more convenient for women and reduce the need for onward referral. They stressed the need for other levels of the health system to listen and engage with them, for referral systems to be improved so they could more easily track women’s progress, and for adjustments to be made to allow for the critical resource of time to be more available for these time-intensive cases:

We do share these same things, but not many listen to us. With the knowledge we have, the scale of work we can do is less. It is reducing with time. Make use of us. Give us the knowledge and make use of us. (Urban clinic midwife)

Discussion

This study is the first to present midwives' experiences of working with women at risk of or engaging in self-directed violence, and considers the reasons midwives in a LMIC context respond to the phenomenon as they do. The Sri Lankan midwives who participated all had multiple encounters with SDV-affected women, who were at various life stages including, but not limited to, the perinatal period. These contacts occurred throughout their careers highlighting that, for them, SDV is not a new phenomenon. Crucially, however, and although this study was not assessing knowledge, midwives' perception that SDV is rising among women is substantiated by global evidence (WHO, 2014).

Marital and family tension and IPV were core issues perceived to engender vulnerability in women, both of which have been documented as risk factors elsewhere (WHO, 2014). In Sri Lanka, between 25% and 35% of ever-married women have experienced IPV (Guruge, Jayasuriya-Illesinghe, Gunawardena, & Perera, 2015), while only 9.2% of affected women report seeking help from public health providers including midwives in Gampaha District itself (Department of Census and Statistics & Ministry of Health, Nutrition and Indigenous Medicine, 2017a). Women's perspectives on help-seeking for IPV and possible deterrent or enabling factors to approaching midwives in this context such as fear or assurance of nonjudgmental support are needed (Ivany et al., 2018). Evidence on prevalence, forms, and help-seeking for IPV among unmarried women is lacking, however, one recent study of both married and unmarried pregnant women in Gampaha District found nearly 54% experienced at least one form of IPV in their most recent partnership (Palfreyman, 2018). Women's sexual and reproductive

health and rights appeared central to vulnerability in midwives' narratives, including impacts of (marital) rape, motherhood status, unwanted pregnancy, and abortion. Although these issues are common to the lives of women globally, they have received scant attention in SDV research and prevention efforts. This study reiterates the importance of exploring SDV with a gender perspective to ensure critical dimensions of risk are not overlooked or minimized. While psychiatric disorders were recognized as risks in certain cases, midwives perceived them as rare and secondary to women's social circumstances, challenging the global- and perinatal mental health movements' framing of SDV as a mental health issue (McCauley et al., 2011; WHO, 2014). According to these midwives, overemphasizing the role of mental disorders would risk missing the most vulnerable of women, and not offer appropriate solutions. While screening for common mental disorders is encouraged for perinatal women by midwives in certain HIC (McCauley et al., 2011), this study suggests more comprehensive assessment of psychosocial issues—including IPV—is warranted (Jayatilleke et al., 2015; Palfreyman, 2018), and should not be confined to perinatal women only.

Community-based PHM are essential social actors in responding to women experiencing SDV. Seemingly trusted as early ports of call by families, community members, and women themselves, responding to SDV is an addition to the already extensive list of issues for which they are formally responsible (Jayatilleke et al., 2015). The nature of their responses demonstrates a position of influence that could mitigate or worsen women's outcomes.

Their responses were, in part, shaped by their capacities in terms of knowledge, skills, relevant training, awareness of, and confidence in utilizing referral mechanisms and social and health services. None of the midwives felt sufficiently knowledgeable or prepared to professionally address SDV, nor potentially related issues of mental health,

and there are no government-issued guidelines facilitating clear and consistent health system- and provider-level responses to SDV. While their duties include screening postnatal women for depression—a step toward formalizing mental health in their role—this is rarely implemented (Agampodi et al., 2014). In practice, this means midwives relied on their own judgment or that of other midwives in seeking appropriate solutions. Recognizing the potential of midwives to respond to women's SDV and prevent its escalation to higher levels of the health system, as has recently begun in some HIC (Holland, 2018), LMIC may consider investing in specialized training and development of complementary guidelines suited to their context. Models from HIC such as introducing a dedicated mental health midwife role into each local health area may offer inspiration (Holland, 2018). Existing training packages for PHM on IPV were successfully piloted in Sri Lanka, and, although they have stalled in their scale-up, they may offer a blueprint from which to broaden training to cover women's SDV (Jayatilleke et al., 2015). As IPV and SDV are intimately linked in this context, this study underscores the importance of following-through on promising interventions. Midwives stressed, however, that without the resource of time, additional trainings would do little to facilitate their care for women at risk of self-harm.

Perhaps more influential to midwives' responses than structural capacities, however, were their perceptions of the extent to which women experiencing SDV achieved or transgressed “respectable womanhood.” Ideals of respectable womanhood in Sri Lanka reflect a hybrid Victorian Buddhism prizing qualities of, “shyness, naivety, docility, helplessness and chastity, virginity” (Jordal et al., 2015, p. 2) and ignorance of sexual knowledge until marriage, against which all women are measured (Hemawanna, 2003). The concept of “shame-fear” (*lajja-baya*) is well recognized in Sri Lankan culture as a necessary and beneficial virtue into which all women should be socialized from a young

age, encouraging obedience (Jordal et al., 2015). Transgressions such as premarital or extramarital sex, pregnancy outside marriage, disregard for parents' marriage preferences, and sex work are heavily stigmatized, subject to social ridicule, and call into question a woman's morality (Hemawanna, 2003).

This moral burden is amplified for rural women charged with preserving tradition, thus, those migrating to the FTZs who are subsequently socialized into new "urban" lifestyles are seen as particularly shameful in their transgressions, transitioning "from innocent to disrespectable" (Jordal et al., 2015, p. 6). For midwives, the FTZs epitomized all that renders women vulnerable to self-directed violence. Midwives' reflected that women in the FTZs were faced with an almost impossible task of performing the role of both urban worker and village girl simultaneously, and that their vulnerability and resultant SDV was a consequence of the "freedom" and lack of supervision of urban life. PHM endorsed the popular social perception that FTZs are sites of "cultural decay," and portrayed women as deserving of pity, disapproval, or both depending on the degree to which PHM appeared to believe women deployed agency in creating their transgressive circumstances (Hemawanna, 2003).

Health providers, including midwives, must constantly navigate and manage the cultural expectations and pressures of their roles, institutions, and that of the external societies from which they and their patients originate. Previous research has observed this challenge among maternal health specialists as well as those providing treatment for SDV in hospital-based settings in LMIC (Mselle et al., 2017; Senarathna, Hunter, Dawson, & Dibley, 2013). Midwives, being female, have all been socialized into the same cultural and gender norms as the women they described, with a powerful internalized sense of what it is to be a respectable woman in Sri Lanka. Tasked with performing "respectability" themselves, their responses to women's circumstances

were shaped. PHM are the ultimate stewards for Sri Lankan women into acceptable sexuality, as their professionally sanctioned duty is to support women transitioning into marriage and the cultural expectation to become a wife and mother. When faced with women experiencing SDV, midwives assessed women's circumstances, and arbitrated risk based on the solution that would best support a woman's ability to achieve or maintain respectability. Reinforcing the role of "sacrificial wife/mother" meant midwives sometimes heightened women's vulnerability rather than minimizing it (Hemawanna, 2003). This was most vivid in the accounts of instructing women to tolerate forced sex by a husband as this was preferable to his infidelity, and pressuring marriage to a known perpetrator of IPV because unmarried motherhood would have been worse than spousal abuse. At other times, their responses buoyed women's agency to find acceptable solutions that did not appear to compromise safety.

Conclusion

Although this study does not include the direct insights of women experiencing SDV in this context, it reveals PHM to be critical in the identification of and response to SDV in women. As a qualitative study, it recognizes the findings are connected to the study context and does not presuppose the same experiences would be observed among all PHM operating in Sri Lanka (Carminati, 2018). Further research in other parts of the country would, therefore, contribute to an evidence base on midwives' role and potential in addressing the growing phenomenon of SDV among women in Sri Lanka. Their proximity to communities, trustworthiness as sites of disclosure, and respectability as women and guardians of ideal womanhood in Sri Lankan society, PHM occupy a powerful position in the health system through which to alleviate or reinforce

women's risk to SDV. The midwives in this study vocalized a deep commitment to supporting women in their distress, and a confidence that with the right training and systemic support, they would be able to provide a health system's response for women that, to date, has not been considered or prioritized. Yet, as actors embedded in their communities and socialized into local cultural norms, any such capacity building must take into account the context within which PHM make decisions and offer context-specific guidance that strives to facilitate the agency and safety of women affected by SDV.

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