




# Healthcare Professionals' Perspectives on Perinatal Mental Health Care in the United Arab Emirates: A Qualitative Study of Barriers and Facilitators at the Patient, Family, and Societal Levels

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**Introduction:** Perinatal mental disorders have a considerable impact on mothers, infants, and the overall well-being of society. The experiences of healthcare professionals (HCPs) addressing these challenges are under-researched. This study aimed to explore healthcare professionals' perspectives on the barriers and facilitators to perinatal mental health care at the patient, family, and societal levels in the UAE.

**Methods:** This qualitative research utilized a descriptive qualitative approach, gathering data through three focus group discussions and 28 individual interviews with 43 HCPs from Abu Dhabi, Dubai, and Al Ain between May and November 2023. The data were analyzed thematically using the MATRix framework, focusing on barriers and facilitators to perinatal mental health (PMH) care at the levels of the patient, family, and society.

**Results:** Key barriers identified included patient-level fear of stigma, family-level low mental health literacy and denial, and societal-level cultural taboos. Facilitators involved patients' psychological readiness to seek help, strong family and spousal support, and culturally ingrained postpartum care practices such as the traditional 40-day care period.

**Discussion:** Addressing PMH requires multi-level strategies, including family-focused mental health literacy interventions, public campaigns to reduce stigma, and policies supporting culturally sensitive postpartum care. This study offers context-specific insights that can be applied to diverse cultural populations.

**Plain Language Summary:** Mental health problems during pregnancy and after birth can affect mothers, babies, and families, yet many women do not receive the support they need. In the United Arab Emirates (UAE), little is known about how healthcare professionals experience providing perinatal mental health care (mental health during pregnancy and the year after birth). This study explored what helps or prevents women from accessing this care.

Researchers spoke with 43 healthcare professionals, including doctors, nurses, and midwives, from Abu Dhabi, Dubai, and Al Ain through focus groups and individual interviews. Their responses were analysed to identify key challenges and supportive factors at the level of the woman, her family, and wider society.

Healthcare professionals reported that fear of stigma and being judged often prevents women from seeking help. Families may lack awareness or deny the existence of mental health problems, while cultural taboos in society further discourage open discussion. At the same time, positive factors were identified. Women were more likely to seek support when they felt emotionally ready, had supportive partners and families, and benefited from traditional postpartum practices such as the 40-day care period.



These findings highlight the need for action at multiple levels, including improving mental health awareness, reducing stigma, and providing culturally sensitive care to better support women in the UAE.

**Keywords:** social determinants, perinatal mental health, healthcare professionals, qualitative research, barriers, facilitators

## Introduction

Perinatal mental health (PMH) significantly affects not just mothers and infants but also families and broader society.<sup>1</sup> Perinatal disorders such as depression and anxiety that occur during pregnancy and the postpartum period can negatively influence maternal well-being, family unity, and the developmental outcomes of children.<sup>2,3</sup> If these conditions go untreated, they can severely disrupt family dynamics, strain relationships, and increase societal challenges through rising healthcare expenses and productivity losses.<sup>4</sup> Recent studies estimate that between 24–35% of women in the UAE experience symptoms of perinatal depression and anxiety, with many remaining undiagnosed and untreated.<sup>5,6</sup> These prevalence rates are comparable to, and in some cases higher than, global estimates, particularly in low- and middle-income and Middle Eastern settings where perinatal mental health disorders remain underdiagnosed and undertreated.<sup>7,8</sup> This highlights the urgency of addressing PMH in the UAE while accounting for its unique sociocultural context.

Families and society must recognize, support, and manage issues related to perinatal mental disorders. Nevertheless, various obstacles like stigma, low mental health literacy, and insufficient family support consistently impede effective PMH care. The stigma associated with mental health conditions often makes mothers hesitant to seek assistance, primarily due to fears of judgment and adverse effects on their families and social connections.<sup>9</sup> Additionally, low mental health literacy in families contributes to delays in diagnosis and diminishes the availability of support, significantly negatively impacting maternal mental health outcomes.<sup>10</sup> These issues are compounded by cultural expectations surrounding motherhood, where societal norms that promote silence and resilience can dissuade women from discussing their difficulties openly, further postponing essential care.<sup>9</sup> Tackling these challenges necessitates a careful understanding of the family and societal contexts that influence PMH practices. Given these sociocultural constraints, women may face considerable difficulty in openly expressing mental health concerns or seeking timely support.<sup>9,10</sup> In this context, healthcare professionals are uniquely positioned to recognize, interpret, and respond to these challenges within clinical settings, making their perspectives essential for understanding how such barriers influence care delivery.

Healthcare professionals (HCPs) play a vital role in perinatal care, having a key role in the early identification, support, and referral processes.<sup>11,12</sup> In this study, we included a diverse group of healthcare professionals involved in perinatal care, including psychiatrists, obstetricians, paediatricians, family physicians, midwives, nurses, and lactation consultants. This multidisciplinary inclusion reflects the integrated nature of perinatal care, where responsibility for mental health identification, support, and referral is shared across providers. While specialists play a key role in managing more complex or diagnosed conditions, many non-specialist providers represent the first point of contact and maintain continuous engagement with women throughout pregnancy and the postpartum period, positioning them to identify early signs of distress and facilitate timely intervention.<sup>11,12</sup> However, while most UAE studies focus on prevalence among women, few explore how providers navigate systemic and cultural barriers. Specifically, there is limited evidence on how perinatal healthcare professionals perceive and respond to multi-level sociocultural barriers influencing perinatal mental health care in the UAE, highlighting a critical gap that this study seeks to address. A multilevel understanding that includes patient, family, and societal aspects is crucial for creating effective and sustainable interventions. This qualitative research aims to fill that gap by exploring healthcare professionals' perspectives on the challenges and supporting factors in delivering PMH care within the distinctive cultural and healthcare context of the UAE. The findings are expected to inform the development of culturally sensitive clinical practices, guide healthcare provider training, and support policy initiatives aimed at improving access to and quality of perinatal mental health care. While previous analyses of this dataset examined healthcare professionals' mental health literacy and lived clinical experiences,<sup>13</sup> the present study focuses on systemic and sociocultural determinants shaping the delivery of perinatal mental health care. This study had two objectives: to explore HCPs' perspectives on the multi-level barriers to PMH care,

and to identify their insights regarding multi-level facilitators. Through analysis, these factors were organized and understood within a framework of patient, family, and societal levels.

## Materials and Methods

### Study Design

This study employed a descriptive qualitative design using interpretive thematic analysis to explore healthcare professionals' perspectives on barriers and facilitators to perinatal mental health care. This approach was chosen because it allows for abductive approach and interpretive engagement with existing theoretical frameworks.<sup>14,15</sup> Data collection involved focus group discussions (FGDs) and semi-structured interviews with professionals from diverse backgrounds in perinatal care, enabling a comprehensive understanding of their viewpoints within the UAE healthcare context.

The data analysed in this study were collected as part of a broader doctoral research project that generated multiple analytically distinct qualitative studies. Some participant quotations are reused here where they most clearly illustrate the analytic focus of this paper. This manuscript reports the social determinants component (patient, family, and societal levels) of the broader analysis; complementary findings on healthcare system determinants (professional, organizational, and policy levels) have been reported separately.<sup>16</sup>

### Setting and Sample

The study was conducted across three major urban cities in the United Arab Emirates, Abu Dhabi, Dubai, and Al Ain, chosen to reflect variation in healthcare contexts and professional practice environments. Recruitment occurred between May and November 2023 and used a combination of targeted outreach and participant referral. Healthcare professionals were approached through outpatient and inpatient services, as well as through professional development activities such as Continuing Medical Education events and conferences.

Eligibility criteria required participants to be practising healthcare professionals with formal qualifications (diploma, bachelor's, or postgraduate degree) in disciplines relevant to perinatal care, including nursing, midwifery, lactation consulting, obstetrics, family medicine, pediatrics, psychiatry, or psychology. Participants were required to be at least 25 years of age and to have a minimum of two years of clinical experience. Individuals who were recently graduated or not actively practising were excluded.

In total, 59 healthcare professionals were invited to take part, of whom 43 consented and participated, resulting in a participation rate of 73%. Those who declined most cited limited time availability or lack of interest in research. All participants received detailed written and verbal information about the study procedures, ethical safeguards, and confidentiality prior to providing informed consent. No prior professional or personal relationships existed between participants and members of the research team.

### Data Collection

Data were generated using two complementary qualitative methods to enhance depth and triangulation. Three focus group discussions (FGDs) were conducted virtually using Microsoft Teams, involving a total of 15 participants (five per group), followed by 28 individual semi-structured interviews. Of these interviews, nine were carried out face to face in private settings within participants' workplaces, while nineteen were conducted via Microsoft Teams. Each participant took part in a single interview. Participants had no prior personal or professional relationship with the interviewers and were informed about the researchers' backgrounds and the purpose of the study. To ensure methodological consistency, all interviews were conducted by two experienced qualitative researchers. Reflexive practices were documented throughout data collection, including the maintenance of a reflexivity log to account for potential influences arising from the research team's backgrounds in public health, nursing, and psychology. These perspectives were regularly discussed during team meetings to support balanced interpretation.

The interview guide was developed by the research team to explore barriers and enablers to perinatal mental health practice based on participants' perceptions and experiences. Minor refinements were made following two pilot interviews

before the guide was used for the remaining data collection. Both FGDs and individual interviews followed the same interview guide, which addressed two core areas: participants' perceptions of perinatal mental health and the multi-level barriers and enablers influencing the implementation of PMH care, including factors related to individuals, families, and the wider community (Table 1).

After informed consent was obtained, participants' demographic characteristics, including age, gender, and professional experience, were collected via an online survey prior to the FGDs and interviews and are presented in Table 2. Focus group discussions lasted approximately 45–60 minutes, while individual interviews typically lasted 30–45 minutes.

**Table 1** Interview Guide

Areas of Inquiry	Description	Core Interview Questions
Facilitators and Barriers in Perinatal Mental Health Practice	Exploring multi-level factors (e.g., individual, relational, community) that enable or hinder perinatal healthcare professionals in implementing perinatal mental health care.	<ul style="list-style-type: none"> <li>• From your perspective, what multi-level factors (e.g., individual, relational, community) most effectively support the implementation of perinatal mental healthcare?</li> <li>• What challenges or barriers across different levels, from individual to societal, hinder the delivery of perinatal mental health services?</li> <li>• What changes across different levels of influence would improve perinatal mental health practices?</li> </ul>

**Table 2** Demographic Characteristics (N=43)

Items	n	%
<b>Specialties</b>		
Family Medicine	6	14
Lactation Consultant	6	14
Maternity Nurse	7	16
Obstetrician	6	14
Midwife	6	14
Psychiatric/Psychologist	6	14
Paediatrician	6	14
<b>Gender</b>		
Male	4	9
Female	39	91
<b>Nationality</b>		
UAE	6	14
Indian	4	9.5
Pakistan	4	9.5
Jordan	4	9.5
Sudan	3	7
Palestine	4	9.5
Egypt	3	6
Lebanon	2	5
South African	3	6
Syrian	3	6
Somalia	2	5
Poland	1	2.5
Philippines	2	5
France	1	2.5
Iraq	1	2.5

(Continued)

**Table 2** (Continued).

Items	n	%
<b>Educational Level</b>		
Doctorate Degree	3	7
Master's degree	16	37
Bachelor's degree	21	49
Diploma Degree	3	7
<b>Working Experience</b>		
> 15 years	17	39.5
10 to 15 years	16	37
5 to 9 years	10	23.5
<b>Working Sector</b>		
Public	30	70
Private	13	30
	<b>Mean</b>	<b>SD</b>
<b>Age</b>	41.70	10.05
<b>Number of Maternal Patients with Mental Disorders Cared for in the Last Year</b>	5.51	0.68

Probing questions were used to clarify responses and encourage further elaboration where needed.<sup>17</sup> All audio recordings were professionally transcribed verbatim and returned to participants for review. Participants confirmed the accuracy of the transcripts, and no major changes were requested. Data collection continued until no new information or themes emerged, with data saturation achieved after three focus group discussions and 28 individual interviews. Reflexivity was maintained throughout the study through ongoing critical self-reflection and regular team discussions.

## Data Analysis

Data analysis followed the six-phase reflexive thematic analysis approach described by Braun and Clarke.<sup>14,15</sup> Although the interview guide was designed to capture influences across multiple domains, participants' accounts consistently clustered around three primary levels of influence: patient, family, and societal. An abductive analytic stance was adopted, with transcripts coded in NVivo 14 (QSR International™) and reviewed iteratively to refine and consolidate categories into coherent themes. The Initial coding was conducted inductively across the dataset without predefined categories. Subsequently, emerging themes were interpreted and mapped onto patient-, family-, and societal-level domains in alignment with the MATRix framework, allowing for a holistic analysis followed by structured, theory-informed interpretation across levels. To strengthen interpretation, an additional theory-informed comparison was undertaken by aligning emergent themes with the MATRix framework.<sup>9</sup> This process situated identified barriers and facilitators within three interconnected domains: patient-level influences (eg., limited mental health awareness), family-related factors (eg., stigma and family attitudes), and societal-level influences (eg., cultural norms surrounding mental health). This comparative step enabled examination of both convergence and divergence between locally derived findings and broader international evidence.

Analytic work progressed through familiarization with the data, generation of initial codes, refinement and clustering of categories, and final theme development. Themes were clearly defined and named to reflect the underlying meanings expressed in participants' narratives. Findings were organized into a thematic map and illustrated with selected participant quotations to support analytic interpretation.<sup>15,18</sup>

## Rigor

Methodological rigor was supported by the research team's prior training and experience in qualitative methods and interview-based research. The interview guide was reviewed and endorsed by a psychologist and a mental health literacy specialist prior to data collection. To enhance credibility, participants were invited to review their interview transcripts and provide feedback, with

no substantive changes requested. Analytic reliability was strengthened through collaborative coding, whereby two researchers (RK and PK) conducted parallel coding and discussed interpretations, and a third researcher (IE) was consulted to resolve any areas of disagreement. Throughout the study, research procedures were conducted in accordance with relevant ethical and methodological standards. Reporting quality was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.<sup>19</sup>

## Results

### Demographic Data

A total of 43 healthcare professionals from seven clinical specialties participated in the study (Table 2), which summarizes participants' demographic characteristics, including age, gender, and professional experience. The sample was predominantly female (90.7%) and reflected a high level of professional experience, with over three-quarters of participants (76.5%) reporting ten or more years of practice. Participants represented 14 nationalities, including Emirati healthcare professionals (14%) as well as clinicians from India, Pakistan, Jordan, and Palestine (each 9.5%), highlighting the multinational composition of the workforce. Most participants were employed within the public healthcare sector (70%), and the majority held at least a bachelor's degree (86%). The mean age of participants was 41.70 years (SD = 10.05). On average, healthcare professionals reported caring for approximately five maternal patients with mental health conditions in the last year.

### Thematic Findings

The findings illustrate a multi-level framework of social determinants shaping perinatal mental health management (Table 3). At the patient level, barriers such as stigma and poor mental health literacy contrast with facilitators like growing awareness and psychological readiness. Family-level influences were distinctly dualistic, acting as both a source of debilitating stigma and a crucial foundation of support. Societally, deep-rooted cultural norms and faith-based interpretations often intensify stigma, yet traditional support practices and increasing public awareness present powerful avenues for positive change.

**Table 3** The Main Themes and Subthemes Emerging from Data Analysis

Social Determinant Factors	Barriers	Facilitators
Patient-level Factors	<p><b>Theme 1: Psychological Barriers</b></p> <ul style="list-style-type: none"> <li>Subtheme 1: Concealment of Mental Health Concerns</li> <li>Subtheme 2: Fear of Stigmatization</li> <li>Subtheme 3: Reluctance to Seek and Accept Help</li> <li>Subtheme 4: Restricted decision-making autonomy</li> </ul> <p><b>Theme 2: Knowledge and Awareness Barriers</b></p> <ul style="list-style-type: none"> <li>Subtheme 1: Low Mental Health Literacy</li> <li>Subtheme 2: Medication hesitancy</li> </ul>	<p><b>Theme 1: Psychological Readiness</b></p> <ul style="list-style-type: none"> <li>Subtheme 1: Help-Seeking Willingness</li> <li>Subtheme 2: Patient Willingness to Disclose</li> </ul> <p><b>Theme 2: Patient Mental Health Literacy</b></p> <p><b>Theme 3: Patient support groups</b></p>
Family-level Factors	<p><b>Theme 1: Low family PMH literacy</b></p> <ul style="list-style-type: none"> <li>Subtheme 1: Family Stigma</li> <li>Subtheme 2: Family PMH awareness</li> </ul> <p><b>Theme 2: Lack of Family Support</b></p>	<p><b>Theme 1: Family Support</b></p>
Societal-level Factors	<p><b>Theme 1: Cultural Beliefs</b></p> <ul style="list-style-type: none"> <li>Subtheme 1: Cultural Stigma</li> <li>Subtheme 2: Faith-Based Barriers to Psychological Care</li> </ul> <p><b>Theme 2: Societal Norms and Expectations</b></p> <ul style="list-style-type: none"> <li>Subtheme 1: Maternal Norms and Standards</li> <li>Subtheme 2: Societal Underestimation of Maternal Struggles</li> </ul> <p><b>Theme 3: Systemic Gaps in Awareness and Support</b></p> <ul style="list-style-type: none"> <li>Subtheme 1: Lack of Public Awareness</li> <li>Subtheme 2: Psychosocial Support Barriers</li> </ul>	<p><b>Theme 1: Culture and Awareness</b></p> <ul style="list-style-type: none"> <li>Subtheme 1: Increased Public Awareness of Perinatal Mental Health</li> <li>Subtheme 2: Cultural Postpartum Support</li> </ul>

## Patient-Level Factors

Healthcare professionals described a range of influences at the patient level, where significant internal and knowledge-based barriers were often counterbalanced by personal readiness and resources. Knowledge and awareness barriers emerged strongly, with limited understanding of PMH symptoms and misconceptions about treatment. For instance, one participant noted, “perinatal patients need to recognize and understand that they have a problem” (FM4, II, female). Misbeliefs around psychiatric medication was also widespread, with patients fearing addiction, as noted, “A challenge is whether perinatal patients will agree to take psychiatric medication for mental disorders during this period” (FM4, II, Female). Psychological barriers further hindered help-seeking, including fear of stigma, as one participant shared, “Some women fear that a psychiatric diagnosis before delivery could lead to divorce or being seen as an unfit mother, stopping disclosure and help-seeking” (OBS3, II, Female). The stigma attached to being labelled as a “mental health patient” creates a profound sense of shame, often intertwined with perceptions of maternal competence. Mothers navigate this stigma with heightened sensitivity due to their perceived responsibilities towards their children, leading to fears of being deemed incapable or unworthy. As another participant explained, “There is a sense of shame, especially for mothers, because they feel they should always be there for their children” (Psy4, II, female). This sense of shame serves as a barrier to seeking assistance and disclosing one’s experiences. Another barrier that delays diagnosis is the concealment of symptoms due to various reasons, as one participant noted, “They are very good at hiding what’s going on... it’s not easy for them to express those emotions” (MW1, FGD, female). Many women were also reluctant to seek or accept help, suffering silently, and some faced restricted decision-making autonomy due to family control, as shared by a participant, “Her husband refused, insisting she didn’t need it...as many women are denied treatment by their husbands or fathers” (Psy1, II, female).

Despite these barriers, facilitators were also reported. Some patients demonstrated good levels of mental health literacy, as evidenced by their awareness and understanding of the topic, as noted by an obstetrician, “A lot of them would be aware and heard about it [PMDs]. Sometimes they know what they’re talking about” (Obs5, II, male). Additionally, they showed psychological readiness, indicating a willingness to seek and accept support. For instance, a psychiatrist shared, “Most self-refer, sometimes following advice from a clinician” (Psy5, II, female), and some were prepared to disclose openly, as shared “Some patients will come and they will be ready to expose their feelings and emotions” (FM6, II, female). In addition, educational patient support groups and helplines were seen as valuable enablers, as one participant explained, “We started women’s groups and educational helplines, which really made a difference. We can help patients form support groups that improve overall care” (Obs2, II, female).

## Family-Level Factors

The analysis revealed that the family unit is a pivotal but complex influence, whose role can be decisively positive or negative, influencing PMH management and shaping women’s experiences of perinatal mental health (PMH). A major barrier was low family PMH literacy, with stigma and limited awareness leading to denial, misunderstanding, and poor support. As one participant noted,

The family often avoids discussing mental health issues due to stigma. They may hide the behavior, attributing it to things like the ‘evil eye,’ and refuse to share it with others. (LC4, FGD, female)

Families sometimes normalize perinatal distress, delaying recognition and care:

Family members may not recognize the first symptoms of depression... they might dismiss it as tiredness after delivery, due to low awareness of mental health issues. (Obs3, II, female)

Lack of family support was another key barrier, reflected in disengaged spouses and limited assistance, as one midwife shared, “I never saw the husband, not during the antenatal visits or follow-ups, and even when the patient was admitted to the antenatal ward several times” (MW4, II, female). Similarly, the absence of extended family support left some women isolated: “She was an expat and didn’t have family support, which made her feel lonely. She only had her husband, but he had to take care of their children” (Psy1, II, female).

Despite these barriers, family support was also identified as a crucial facilitator, creating an evident duality in its influence. This support was manifested through emotional, practical, and financial assistance. Family support played a particularly vital role, with healthcare providers noting its transformative impact, as one participant noted, “It doesn’t take long to improve their mental health. family support plays a crucial role in improving their mental well-being” (Obs6, II, Female). Spousal involvement was especially beneficial, as illustrated by one psychologist’s account, “her husband was very supportive in helping a patient overcome anxiety” (Psy1, II, Female). Extended family networks also proved valuable, with one pediatrician observing: “Involving the family by having the mother-in-law or mother care for the mother and child creates a supportive environment” (Ped5, II, Male, 30). However, providers acknowledged the complex dynamics of family involvement, noting that “The father or family members can act both as barriers or enablers” (Ped1, II, Female).

## Societal-Level Factors

Beyond the family, HCPs pointed to broader societal forces that set the context for perinatal mental health care, where deep-seated cultural norms both hinder and help. At the societal level, healthcare professionals highlighted how cultural beliefs, societal norms, and systemic gaps in awareness and support significantly impacted the implementation of perinatal mental healthcare in the UAE. Cultural stigma was identified as a major barrier, as one participant said,

Mental illnesses and emotions are still stigmatized in our culture. Women hesitate to disclose their feelings out of fear of being labeled with conditions like postpartum depression or anxiety. (FM2, II, Female)

Faith-based interpretations further intensified stigma, with another noting, “The stigma is stronger for pregnant women, as they are expected to be grateful to Allah and not show sadness or worry. If they do, it may be seen as unfaithful” (Psy3, II, Female). Traditional perinatal practices also shaped women’s behaviors, as one obstetrician explained,

After a cesarean, we encourage mothers to mobilize and eat, but social pressures, what to eat, how long to rest, or whether to move, often override medical advice and affect both mother and baby. (Obs6, II, Female)

Broader societal norms reinforced expectations of idealized motherhood, leading many women to suppress their struggles. As a psychologist explained, “Pregnancy is expected to be joyful, so women may feel they can’t admit to depression or anxiety” (Psy3, II, Female). Another participant echoed this,

People tend to underestimate a mother’s struggles... saying, ‘We’re all in the same situation.’ But not everyone is the same, and each person copes differently. (LC1, FGD, Female)

A notable barrier identified was the profound lack of psychosocial support, particularly for women without local family networks. As one maternity nurse observed,

Many pregnant women, especially those far from family, face this journey in emotional isolation. They have no one to confide in, no one to share their fears with, which heightens their anxiety. (MN, FGD, Female)

Systemic gaps in awareness also persisted, with one pediatrician stating, “Many mothers and fathers may experience mental disorders without realizing it. Educating the public is essential” (Ped3, II, Male).

Despite these challenges, facilitators were also noted, including growing awareness and supportive cultural practices. For example, one obstetrician observed, “Awareness of mental health is increasing, and patients are more open to discussing their issues with doctors” (Obs2, II, Female). Similarly, traditional postpartum support was seen as protective, as a pediatrician explained, “I advise new mothers not to sit alone, stay with family or neighbors. In our culture, this support strengthens mental well-being” (Ped6, II, Male).

## Discussion

This research explored the perspectives of healthcare professionals regarding the barriers and facilitators to perinatal mental health (PMH) care at the patient, family, and societal levels in the UAE. The results indicate a complex interaction of sociocultural norms, stigma, and health literacy that influences perinatal mental healthcare implementation. Significant

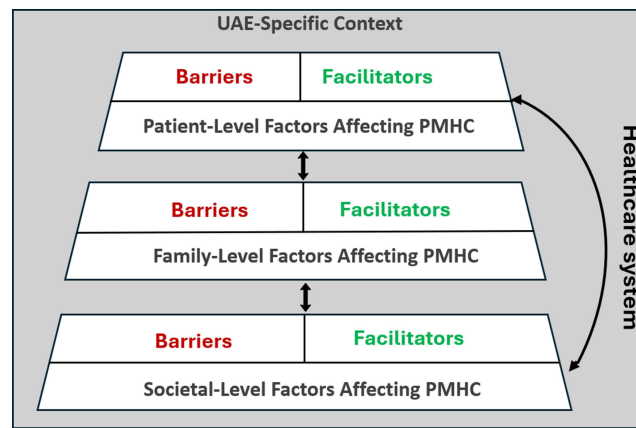
barriers include a lack of mental health literacy among patients and families, widespread stigma, and cultural taboos that discourage individuals from seeking help, often tied to concerns about judgment, marital consequences, or breaches of confidentiality. Family dynamics, such as a lack of involvement from spouses, restrictive gender norms, and pressures from in-laws, further exacerbate these issues. On the other hand, facilitators include patients' readiness to share symptoms, supportive involvement from family, and culturally rooted postpartum traditions that provide emotional and practical support. Findings presented here reflect the social determinants component (patient, family, and societal levels) of a broader qualitative analysis; healthcare system determinants (professional, organizational, and political levels) are reported separately.

These findings align with existing literature from both the region and internationally, which consistently points to stigma, cultural beliefs, and family influences as critical factors in PMH care. Research within the MENA region<sup>9,20</sup> shows high levels of stigma and limited mental health awareness, with a reliance on informal support systems such as family and religious practices delaying both diagnosis and treatment. Our results build on this evidence by illustrating how these barriers become evident in clinical settings, underscoring the necessity for interventions that tackle both public stigma and familial power dynamics. The noted link between education and positive attitudes reflects previous research,<sup>21</sup> emphasizing the importance of community education directed toward men and low-literacy populations.

In agreement with Al-Darmaki et al<sup>22</sup> participants observed patients' preference for religious coping mechanisms rather than professional care. However, avoidance related to stigma was more pronounced among perinatal women compared to the general population, likely due to societal pressures regarding maternal strength. These cultural and religious interpretations do not operate in isolation but are embedded within broader societal structures, including gender norms and patriarchal family systems that shape women's roles, autonomy, and help-seeking behaviors.<sup>23–26</sup> In such contexts, expectations of maternal resilience, obedience, and emotional self-regulation may limit women's ability to openly express psychological distress or seek care. Additionally, decision-making power within family hierarchies, often influenced by male partners or senior family members, can further restrict access to mental health services, reinforcing the interplay between cultural beliefs and structural constraints. Gendered patterns in help-seeking<sup>23</sup> were also observed, with male partners frequently serving as gatekeepers to care, a conclusion supported by studies across the UAE and the region.<sup>24–26</sup> Strong support from partners and in-laws was identified as protective, while its absence heightened the risk of perinatal depression and anxiety. Expatriate women, who lack familial support networks, were noted to be especially vulnerable, reinforcing the need for culturally tailored, non-familial support systems.<sup>27,28</sup> Our findings also align with insights on the protective benefits of traditional postpartum customs, such as the culturally important 40-day maternal care period,<sup>29</sup> and the potential to incorporate traditional healers (Mutawa) into PMH services.<sup>21,30</sup> These findings present opportunities to integrate biomedical practices with culturally relevant approaches. On another note, our findings on stigma align with Link and Phelan's<sup>31</sup> model, demonstrating the processes of labelling, stereotyping, and discrimination that leads to status loss and restricted autonomy. The results also reflect key constructs of the Health Belief Model,<sup>32,33</sup> where perceived barriers, such as social judgment and strong subjective norms, such as family expectations, overwhelmingly outweigh the perceived benefits of seeking care and limited perceived behavioural control further constrains help-seeking.

Applying the MATRix Conceptual Framework highlights how barriers and facilitators to PMH in the UAE interact across multiple, interdependent levels. Our findings confirm the framework's multi-level categories but uniquely highlight the dual-role dynamics within the UAE context, particularly the family acting simultaneously as a primary barrier and a crucial facilitator. At the individual (patient) level, the findings illustrate how low mental health literacy, stigma, and psychological obstacles hinder help-seeking, while growing awareness and readiness act as entry points for care. The interpersonal (family) level demonstrates the dual role of families as both barriers, through denial, misconceptions, and neglect, and facilitators, by providing essential emotional, practical, and financial support. At the societal/community level, cultural norms, faith-based interpretations, and systemic stigma reinforce barriers, while supportive traditions and increasing public awareness enable care. The healthcare system emerges as a mediating structure, positioned to either bridge or widen gaps across these levels.

As illustrated in [Figure 1](#), our proposed multi-level conceptual framework positions the healthcare system as a central mediator between patient, family, and societal factors. The bidirectional arrows represent the dynamic interactions



**Figure 1** Multi-Level Conceptual Framework of Social Determinants in Perinatal Mental Health Care in the UAE. The framework highlights patient-, family-, and societal-level barriers (red) and facilitators (green) to perinatal mental health care (PMHC) identified by healthcare professionals. Bidirectional interactions between levels are indicated by small two-headed vertical arrows, illustrating dynamic relationships across domains. The curved arrow on the right represents the overarching and continuous influence of the healthcare system across patient-, family-, and societal-level factors. The healthcare system functions as a cross-cutting, mediating factor that shapes and connects all levels of influence.

between these levels; for instance, societal stigma can suppress a patient’s readiness to seek help, while supportive family involvement can amplify the benefits of clinical care. The key take-home message is that determinants of PMH care are not isolated but exist in a reciprocal relationship, where a change at one level can influence outcomes across the entire system. Thus, improving PMH care requires integrated, multi-level strategies that simultaneously target knowledge, attitudes, and systemic supports of patients and the community.

From a policy and practice standpoint, the study advocates for the implementation of routine PMH screening during prenatal and postnatal care, along with rigorous confidentiality measures. Reforms in the workplace, such as paid parental leave and mental health initiatives, could alleviate stressors, while training perinatal healthcare providers in culturally sensitive and family-inclusive methods may enhance engagement. Specifically, provider training should be strengthened by integrating a module on addressing family resistance and engaging spouses, using role-playing scenarios based on common Emirati family dynamics. To combat low mental health literacy, the Ministry of Health could develop and distribute a “PMH Passport” for expectant mothers, a simple, visually oriented booklet in Arabic and English that explains common symptoms, debunks myths about medication, and lists support resources. Community initiatives should engage religious leaders, media, and peer networks to redefine PMH as a medical rather than a moral concern, challenge restrictive gender norms, and improve access for expatriates. A key initiative could be to develop and launch a public awareness campaign in collaboration with the General Authority of Islamic Affairs and Endowment (Awqaf), focusing on recognizing signs of postpartum depression and reducing associated stigma through Friday sermons and dedicated social media content. Incorporating culturally significant rituals into mental health care, providing telehealth options, and establishing moderated online support groups, as well as collaborating with traditional healers, could further increase accessibility and acceptance.

This study has limitations, including its focus on healthcare professionals from three cities in the UAE, which may limit generalizability, and the absence of patient perspectives. This may influence the interpretation of findings, as providers’ views may differ from those of perinatal women and could introduce bias, including overestimation of supportive factors such as family involvement, and under- or overestimation of barriers, including stigma and broader structural challenges. Future research should incorporate the perspectives of perinatal women to provide a more comprehensive understanding of lived experiences and to validate and extend the findings identified in this study. The 73% response rate, while reasonable, means that nearly a quarter of invited professionals declined, potentially introducing selection bias if those with the heaviest workloads or less interest in PMH were underrepresented. The use of purposive and snowball sampling may have introduced self-selection bias. Furthermore, relying on virtual platforms for data collection may have created communication barriers and excluded individuals who are less comfortable with digital

technology. Future research should expand geographically, incorporate patient perspectives, and evaluate the effectiveness of culturally adapted interventions through longitudinal and mixed-methods studies.

## Conclusion

This study sheds light on the complex sociocultural dynamics that shape perinatal mental health (PMH) care in the UAE, as perceived by healthcare professionals. Key barriers, stigma, low mental health literacy, and restrictive gender norms, intersect across patient, family, and societal levels, often preventing timely care. Conversely, facilitators like patient disclosure, family support, and culturally embedded postpartum practices highlight opportunities for intervention. The findings underscore the need for multi-level strategies: policy reforms to ensure confidentiality and accessibility, healthcare provider training in culturally sensitive care, and community initiatives to leverage existing support networks while challenging harmful norms. By addressing systemic inequities and amplifying cultural strengths, these approaches can transform PMH care into a normalized, accessible component of maternal health in the UAE and similar contexts. Future research should expand to include patient perspectives and evaluate the efficacy of culturally adapted interventions.

## Declaration of Generative AI and AI-Assisted Technologies in the Writing Process

While preparing this work, the authors used QuillBot and Grammarly AI to improve the manuscript's language and readability. After using this tool, the authors reviewed and edited the content as needed and took full responsibility for the publication's content.

## Abbreviations

PMH, Perinatal Mental Health; PMDs, Perinatal Mental Disorders; HCPs, Healthcare Professionals; UAE, United Arab Emirates; FGDs, Focus Group Discussions; IRB, Institutional Review Board; COREQ, Consolidated Criteria for Reporting Qualitative Research; MATRIx, Mental health Access, Resources, Training and implementation framework; SD, Standard Deviation.

## Data Sharing Statement

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

## Ethics Approval and Informed Consent

The Ethics Committee for Research in Social Sciences at the United Arab Emirates University (ERSC\_2023\_2749) approved the study. The research followed ethical principles concerning human dignity, confidentiality, justice, and beneficence. Adherence to the legal and ethical standards specified in the pertinent laws was ensured.<sup>34</sup> Data collection commenced after receiving ethical approval. Written informed consent was obtained from all participants prior to study commencement, including consent to participate in the study and consent to publish anonymised data. Participants were given an overview of the study's objectives, guaranteed voluntary participation, ensured privacy protection, and informed about their right to withdraw. All data was securely stored under the supervision of the lead investigator. At the conclusion of the interview, we provided interviewees who expressed a need or interest with information regarding free and paid online resources to enhance their perinatal MHL.

## Consent for Publication

All participants provided consent for publication. Where applicable, consent was obtained for the publication of anonymised data.

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## Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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