

Better
Health
Briefing

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**The maternal
mental health
of migrant
women**

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A Race Equality Foundation
Briefing Paper

March 2014

www.better-health.org.uk

Key messages

- 1 Pregnant and early postnatal migrant women are a heterogeneous and far more diverse population group than has previously been experienced.
- 2 Migrant women experiencing maternal mental health related illnesses face practical barriers and cultural factors which may prevent them from seeking help.
- 3 Maternal mental health related services tend to be focused on helping migrant women to overcome practical barriers, in particular, language difficulties, and risk obscuring cultural factors and attitudes to mental health.
- 4 Further research is urgently needed to acquire accurate data on the needs of the newer migrant population which can then inform the development of appropriate services as well as culturally competent care.
- 5 Maternal mental health practitioners will need to acquire new knowledge and skills in order to deliver effective services to a super-diverse cohort of pregnant and early postnatal migrant women.

Introduction

The maternal mental health and wellbeing of migrant women is an area which requires a much stronger public focus. In the UK, over the past thirty years, female migrants have originated from a far more diverse range of countries. Higher fertility rates among migrant women (see ONS, 2012) indicate that they will become one of the main users of maternity services.

Black and minority ethnic people are over-represented in mental health care services (CQC, 2011) and it is plausible to hypothesize that this trend would be reflected in maternal mental health care too. However, this does not appear to be the case.

This paper has three main objectives. Firstly, it explores female migration to the UK, in order to develop an understanding of the level and types of diversity. Secondly, it uses existing evidence to investigate why there is low take-up of maternal mental related services by migrant women. Thirdly, it considers how maternal mental health care providers can develop services which meet the needs of migrant women.

Migrant women, new migration and super-diversity

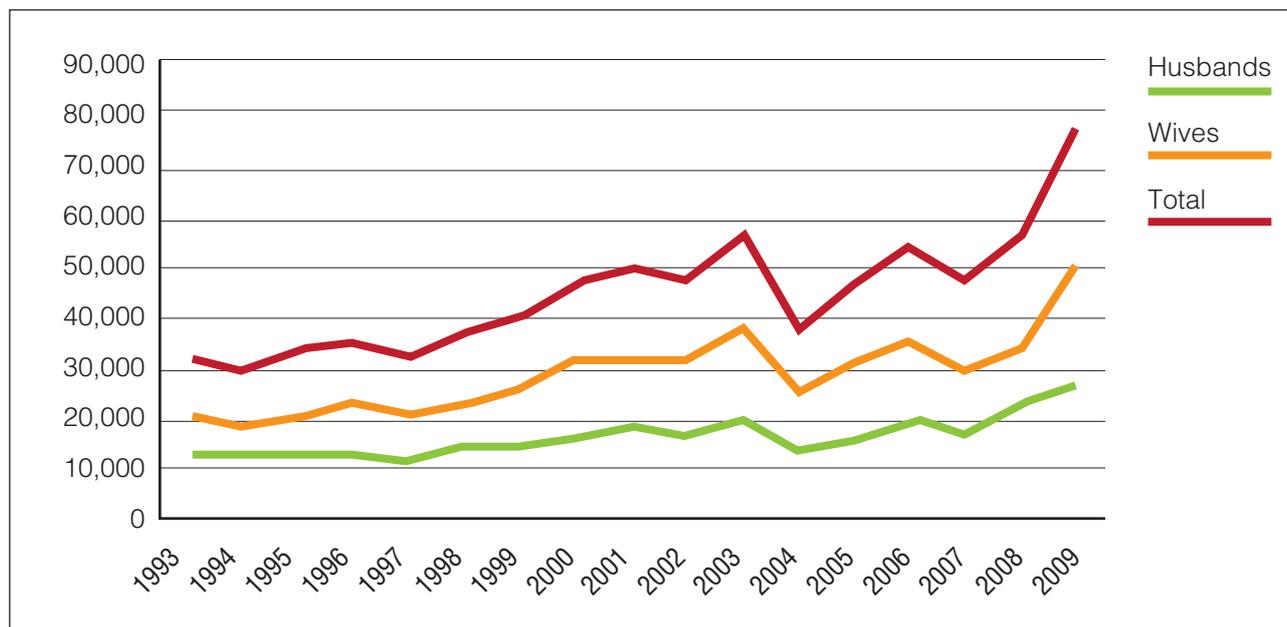
The UN (1998, p18) definition of “long-term international migrant” is “a person who moves to a country other than that of his or her usual residence for a period of at least a year, so that the country of destination effectively becomes his or her new country of usual residence”. British migrant communities have conventionally been associated with the Asian sub-continent, Africa and the Caribbean including Commonwealth countries like Pakistan, India, Bangladesh, the Caribbean, Kenya and Uganda. During the 1950s and 1960s, Commonwealth migration was characterised by the arrival of single men from the sub-continent who were later joined by wives and children (see Ballard, 1994; Gardner and Shukar, 1994; Shaw, 1998; 2000) and both men and women from Africa and the Caribbean (see Byron, 1998; Foner, 2009). Since the 1990s, there has been a significant increase in migration to the UK from diverse countries of origin by both men and women. Migrants are not a homogenous group: there are several different “migration channels and immigration legal statutes” combined with both men and women seeking asylum in the UK (Phillimore *et al.*, 2010, p.14). They include economic migrants, asylum seekers, refugees, refused asylum seekers, undocumented migrants, and individuals who entered the UK with visa clearance. Visas may be granted to migrants for the purposes of study, tourism, visiting family, employment or marriage (Home Office, 2011).

1 Feminisation of new migration

Today, across the world, more than 33 million people are persecuted and forcibly displaced because of wars. Women and girls represent half of this population (UNHCR, 2013). There is some evidence to suggest that new gendered migration patterns are emerging in the UK. For example, in London the majority of migrants from Eastern Europe (Slovakia, (80%), Czech Republic (72%), Slovenia (68%)), the Philippines (71%), Thailand, (68%), and Madagascar (67%) were women coming normally to seek employment (GLA, 2005, p89). In contrast, migrant men largely applied for asylum and originated from Algeria (71%), Nepal (63%), Kosova (61%), Afghanistan (61%), Yemen (60%) and Albanian (60%) (GLA, 2005, p90). Since 1993, settlement statistics have supported an existing trend which indicates significant migration from the Indian Sub-continent related to marriage (see Charsley *et al.*, 2012, p867).

New patterns of marriage-related migration are also emerging which show spousal migrants can originate from over 70 countries (see Charsley *et al.*, 2012, p867). In 2008, Charsley *et al.*, (2012, p867) noted that 14 countries of origin accounted for the largest numbers of marriage migration, these included India (8,865), Pakistan (7,050), Philippines (3,220), Bangladesh (2,880), South Africa (2,515), China (2,455), USA (1,880), Nigeria (1,840), Turkey (1,735), Ghana (1,520), Thailand (1,190), Zimbabwe (1,175). Historically, female spousal migration has always out-numbered equivalent male migration, a trend that continues (see figure 1.1).

Figure 1.1: Spousal grants of settlement by category, all nationalities 1993-2009



Source: Charsley et al. (2012, p 867)

This figure shows the number of visas which were granted for spouses to settle in the UK.

In 2008, wives accounted for 60% of overall applications for settlement in the UK (Charsley, 2012, p866).

2 Migrant women and super-diversity

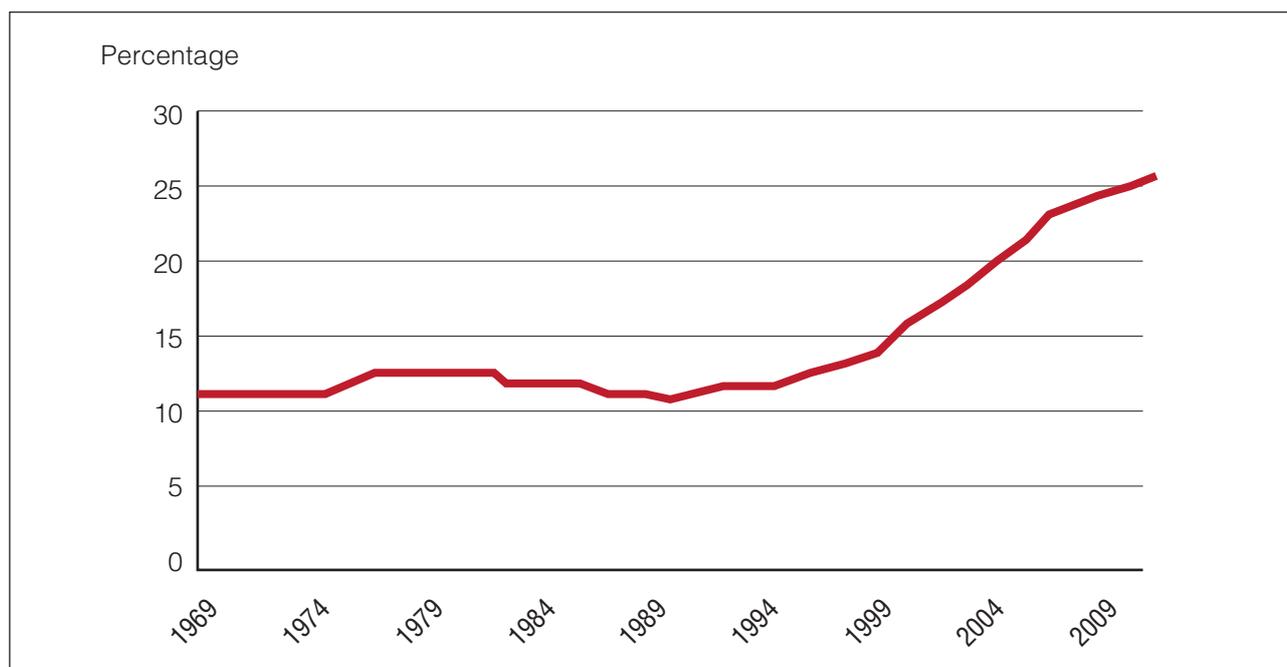
Upon arrival in a host country, migrant women often face multiple spheres of diversity, as women, as workers, and as foreigners (Agnew, 1996; Oxman-Martinez *et al.*, 2000). Women who have left their countries by force are most vulnerable because they usually are separated from their families, have limited knowledge of the English language, are visible minorities, and are in uncertain immigration categories, such as asylum-seekers. Those who claim asylum must deal not only with an, at times, baffling and bureaucratic system, but also with the practical and psychological challenges of restarting a new life in a new country, living in a new culture, adapting to new systems, and, sometimes, having to learn a new language.

Vertovec (2007 p. 1025) explains these multiple spheres of diversity in new migration as “transformative diversification of diversity” which he terms as super-diversity. Super-diversity is “distinguished by a dynamic interplay of variables” (Vertovec, 2007, p1024) which include: “ethnicity, immigration status, different rights and entitlements based on immigration status, differing labour market experiences, gender and age and patterns of spatial distribution” (Phillimore *et al.*, 2010, p15). Super diversity creates a new set of challenges for policy-makers, commissioners and service providers who have traditionally conceptualised diversity through the lens of ethnicity (Vertovec, 2007).

Office for National Statistics (2013) data shows that while there are fewer children born to non-UK born

women (189,079) compared with their UK born counterparts (540,572), rates of live births for non-UK born women have steadily increased (see figure 1.2.) Non-UK born is used as a proxy indicator for migrant women. Not all women born outside the UK will be recent migrants; similarly UK born mothers will include the children of earlier migrants i.e. the second and third generations.

Figure 1.2 Percentage of live births to mothers born outside the UK, England and Wales, 1969-2012



Source: Office for National Statistics (2013)

Fertility rates for non-UK born women are higher than those of UK born women (see Table 1.1)

Table 1.1 The total fertility rate (TFR) for the United Kingdom, for UK born and non-UK born women, 2007 to 2011

	2007	2008	2009	2010	2011
UK born	1.80	1.85	1.85	1.87	1.89
Non-UK born	2.51	2.50	2.44	2.43	2.28
All women	1.91	1.97	1.96	1.98	1.97

Source: Office for National Statistics (2012)

Data from the Office of National Statistics shows the top 10 countries of origin for live births to non-UK born women (See Table: 1.2). Live births to migrant women from Poland, Pakistan and India are higher compared with other migrant women. Migrant women from these countries of origin are likely to be a mix of spousal and economic migrants.

Table 1.2 *Top ten countries of birth for non-UK born mothers of live births in the UK, 2011*

Position	Country of maternal birth	Thousands
1	Poland	23.0
2	Pakistan	19.2
3	India	15.5
4	Bangladesh	8.5
5	Nigeria	7.9
6	Somalia	5.7
7	Germany	5.6
8	South Africa	4.8
9	Lithuania	4.2
10	China	4.1

Source: Office for National Statistics (2012)

This data, combined with our understanding of super-diversity, suggests that maternity services will have to rise to the challenge if they are going to meet the care needs of a diverse socio-economic group of migrant women.

3

Migrant women and maternal mental health inequalities

In this paper, 'maternal mental health related illnesses' is a term used to describe mental disorders associated with pregnancy and the early postnatal period. These disorders are aligned with and include terms like: perinatal mental illness, postnatal depression (PND), baby blues, puerperal psychosis, antenatal depression, perinatal depression and post-partum depression (see National Perinatal Mental Health Project, 2010). There are currently no national statistics which show rates of maternal mental health related illnesses among women in the United Kingdom, so accurately predicting the numbers of migrant women suffering with maternal related mental illness is not possible. There are relatively few studies which investigate Commonwealth migrant women's experiences of maternal mental health related illnesses (see Yoshida *et al.*, 1997; Onozawa *et al.*, 2003; Edge *et al.*, 2004; Edge and Rogers, 2005; Edge, 2007a and 2007b; Almond and Lathlean, 2011; Babatunde and Moreno-Leguizamon, 2012; Husain *et al.*, 2012), recently arrived migrant women (see Babatunde and Moreno-Leguizamon, 2012) and those who are seeking asylum or refuge (see Katz and Gagnon, 2002; Small *et al.*, 2003; Dennis *et al.*, 2004; Zelkowitz *et al.*, 2004; Stewart *et al.*, 2008; Collins *et al.*, 2011).

According to the research evidence there are two main factors which impede and/or prevent diagnosis and treatment: cultural factors and practical barriers.

4 Cultural factors

Current literature reviews reveal a knowledge gap regarding the impact of cultural factors on maternal mental disorders (Bina, 2008; Clare and Yeh, 2012; Higginbottom *et al.*, 2013). Many studies have focused on the influence that health care practices based on Western cultural concepts have on the ways in which migrant women use mental health care services. Others have examined immigrant women's perspectives on their social support preferences, the barriers they experience and their preferred support interventions (Kurtz *et al.*, 2008; Ganann *et al.*, 2012). Difficulties may arise in relation to access to services and patterns of help-seeking (O'Mahony and Donnelly, 2010), including language barriers, stigma-related concerns and discriminatory practices (Hyman, 2001).

Existing mental health services may not provide appropriate support to migrant women (Sword 1997; Sword *et al.*, 2006; Kurtz *et al.*, 2008). Tools which help to diagnose maternal mental health illnesses are often tailored to meet the needs of Western populations and are dependent on women self-reporting their symptoms to practitioners. For example, the Edinburgh Postnatal Depression Scale (EPDS) is widely used to screen for PND, despite the fact that it may not have cultural congruence for all ethnocultural groups (Zubaran *et al.*, 2010). In cultures where there is little understanding and awareness of maternal mental health related illnesses, women may not be able to easily identify symptoms or, in other cases, women may understand symptoms, but be unable to recognise them or express them (Yoshida *et al.*, 1997; Zubaran *et al.*, 2010). Additional research is required to evaluate women's health service needs and barriers to services.

International cross-cultural comparative research exploring post-partum depression shows that women from non-Western cultures are more likely to present somatic symptoms of depression i.e. physical symptoms (Bashiri and Spielvogel, 1999). Women may 'somatise' symptoms of depression because of a lack of awareness of symptoms of psychological distress and cultural stigma attached to mental health symptoms. Bashiri and Spielvogel (1999) argue that depression diagnosis tools exclude somatisation related questions and therefore are ineffective at detecting depressive symptoms in non-Western women. However, some small scale research studies in the UK have used Western diagnosis tools to identify maternal mental health related illnesses among some migrant women (see Onozawa *et al.*, 2003; Edge *et al.*, 2004; Edge, 2007; Husain *et al.*, 2012). It is not clear why, in some migrant communities, Western diagnosis tools are sensitive to detecting depression in pregnant and postnatal women, while in others they are not. In both Edge (2004, 2007) and Hussain *et al.*, (2007) studies, research samples consisted of established black minority ethnic migrant women rather than those who had arrived recently. It is plausible that acculturation factors affect diagnosis rates (Husain *et al.*, 2012), although the implications of these factors upon migrant women from different communities is unclear from the limited evidence base.

Research with recently arrived African migrant women in London found that postnatal depression was stigmatised in their country of origin and to a lesser degree in the UK (Babatunde and Moreno-Leguizamon, 2012). The risk of being stigmatised prevented these women from disclosing their real feelings to practitioners. Attitudes towards women's mental health in some Commonwealth migrant communities were derogatory; women often believed if their mental health problems became public knowledge they would be exposed and stigmatised by families and communities (see Gilbert *et al.*, 2004; Wheeler, 1998).

5 Practical barriers

Studies have highlighted some practical barriers which prevent migrant mothers from accessing mental health service provision. These have included language difficulties and lack of understanding of how and where to seek help (see Edge *et al.*, 2004; Edge and Rogers, 2005; Edge, 2007a and 2007b; Almond and Lathlean, 2011; Babatunde, and Moreno-Leguizamon, 2012). Lack of social support and living in poverty/economic hardship were found to be problems encountered by migrant women, but they appeared to be exacerbated during and postnatal period (see Onozawa *et al.*, 2003; Edge *et al.*, 2004; Edge and Rogers, 2005; Edge, 2007a and 2007b; Almond and Lathlean, 2011; Babatunde, and Moreno-Leguizamon, 2012; Husain *et al.*, 2012).

Research exploring health practitioners approaches to migrant women suggests that they are not always assessed for mental health related illnesses and therefore do not receive the same level of support as white indigenous women (see Edge *et al.*, 2004; Edge and Rogers, 2005; Edge, 2007a and 2007b; Almond and Lathlean, 2011). Findings from the National Perinatal Mental Health Project, (2010) show that half of the service providers who responded to the research had no specific service provision for migrant women. In the cases where such services were available, there was a tendency to focus on providing help to overcome language barriers. Whilst good communication is a vital element of interaction with patients, focusing primarily on language barriers may detract from a full understanding of the impact of cultural differences on migrant women's decisions to seek professional help.

6 Maternal mental health of asylum seeking and refugee women

The needs of asylum seeking and refugee women were found to be particularly complex. These women are more likely to have fled from gender-specific forms of persecution: sexual violence, marital rape, domestic violence, female genital mutilation, forced abortion or sterilisation (ICAR, 2007). According to the limited evidence, there are several risk factors associated with maternal mental health disorders among migrant women (see Katz and Gagnon, 2002; Small *et al.*, 2003; Dennis *et al.*, 2004; Zerkowitz *et al.*, 2004; Pumariega, *et al.* 2005; McColl and Johnson, 2006; McColl *et al.*, 2006; Royal College of Psychiatrists, 2007; Stewart *et al.*, 2008; Collins *et al.*, 2011). These include: being unfamiliar with the host country's health care and other allied services, lack of understanding of the cultural needs of migrant women on the part of the host country, lack of social support, language barriers, uncertainty about their future in the host country and financial hardship. For those women seeking refuge and asylum, they come from backgrounds which are particularly stressful and are at greater risk of feeling socially isolated as a result of being separated from their support systems in their home countries. Migrant women are at particular risk of postpartum depression compared with women in the general population (see Ghaffari, undated; Zerkowitz *et al.*, 2004; Gavin *et al.*, 2005; Sword *et al.*, 2006; Mechakra-Tahiri *et al.*, 2007; Huang and Mathers 2008; Stewart *et al.*, 2008; Zerkowitz *et al.*, 2008). Untreated cases of PND may lead to severe clinical depression and evidence indicates that in a few cases has led to suicide (Lindahl *et al.*, 2005; Lewis 2007).

7 Delivering mental health services in an age of super-diversity: Facing the challenges

The National Perinatal Mental Health Project (2010) study commissioned by the National Mental Health Equalities Programme, National Mental Health Development Unit, conducted a review of current mental health provision for pregnant and postnatal migrant women. This research noted that service providers believed that they were ill-equipped to manage the range of diversity and complexity of migrant women's needs which they encountered. The report suggests that there should be greater emphasis on training healthcare professionals to help them work with diverse population groups. Delivering services to a super-diverse population requires new understandings and skills (Phillimore *et al.*, 2010).

A better understanding of cultural differences and attitudes towards maternal mental health illnesses in diverse migrant communities is a vital component of delivering services which address both the practical and cultural needs of pregnant and postnatal migrant women (see National Perinatal Mental Health Project, 2010).

There is an emerging but limited evidence base which has investigated maternal mental related illnesses in migrant women from Commonwealth countries (see Edge *et al.*, 2004; Edge and Rogers, 2005; Edge, 2007a and 2007b; Husain *et al.*, 2012). In contrast, there is little understanding of the issues faced by women from different countries of origin, for example, those from Eastern Europe. Considering that live birth rates are highest among Polish women (see table 1.2), there is some urgency in acquiring insights into maternal mental wellbeing among these women. Indeed, in order to develop culturally competent and sensitive services, research is needed to illuminate attitudes towards maternal mental health and the needs of women from super-diverse migrant communities. It then becomes imperative for policy-makers and service providers to embrace the evidence to develop policies and service that address these needs effectively.

In this respect Edge's work (see Edge *et al.*, 2004; Edge and Rogers, 2005; Edge, 2007a and 2007b) has been instrumental in bringing perinatal depression in Black Caribbean women to the fore. This research found that Black Caribbean women experienced poorly defined care pathways which impeded and in some cases prevented diagnosis and treatment. Edge's research studies have been influential in developing Department of Health (2012) guidance on integrated working between health practitioners and clearly defined pathways for the mental health and wellbeing of pregnant and early postnatal women. Recent examples of best practice include providing specialist mental health midwives as an important point of contact and specialist support for pregnant and postnatal women (see Specialist Mental Health Midwives, undated).

Conclusion

There are disparities between rates of diagnosis and treatment of maternal mental health related illness among migrant women compared with their white counterparts. Much of the limited evidence indicates that practical barriers and cultural factors may prevent access to maternal mental health service provision for some newly arrived and common wealth migrant women. Practical barriers included language difficulties and not knowing where to seek help. Cultural factors involved derogatory attitudes towards mental health in migrant communities and medical tools which were insensitive to detecting maternal mental health illnesses in some migrant women. In the case of asylum seeking and refugee women, their needs are complex, which may prevent them from accessing appropriate services.

Current interventions are largely focused on eradicating practical barriers, which remain relevant for non-English speaking migrant women. However, a better understanding of how cultural factors impede access to service provision maybe a vital component of not only what prevents some migrant women from seeking help, but also how practitioners may orient their services towards meeting the needs of diverse groups of migrant women. The limitations of research in this area has serious implications for delivering maternal mental health services to a super-diverse female migrant population in the UK. Until further research is available, the increased risk for disorders such as PND suggests that service providers should regard all migrant women as at high risk of mental health disorders and give closer observation and support as necessary.

Resources

Tamil Health Advocacy Project, South London

A local service, commissioned by the London Borough of Merton which helps to support Tamil women towards equal access to maternity services.

YAD L'YAD (Hand in Hand), Manchester

A voluntary and community-based organisation which helps to support Jewish women suffering from postnatal depression.

MRANG: Merseyside Refugee and Asylum seekers pre- and post-Natal support Goup, Liverpool

A voluntary and community-based project which supports refugee and asylum seeking women who are pregnant or have children missing in their country of origin.

References

- Agnew, V (1996) *Resisting discrimination: Women from Asia, Africa and the Caribbean and the women's movement in Canada*, Toronto: University of Toronto Press.
- Almond, P, and Lathlean, J (2011) 'Inequity in Provision of and Access to Health Visiting Postnatal Depression Services', *Journal of Advanced Nursing*, 67, 11, pp. 2350-2362.
- Babatunde, T and Moreno-Leguizamon, C J (2012) 'Daily and Cultural Issues of Postnatal Depression in African women immigrants in South East London: Tips for health professionals', *Nursing Research and Practice* <http://www.hindawi.com/journals/nrp/2012/181640/>
- Ballard, R (1994) (ed.) *Desh Pardesh: The South Asian presence in Britain*, London: Hurst and Co.
- Bashiri, N, and Spielvogel, A M, (1999) 'Postpartum depression: A cross-cultural perspective', *Psychiatry Update*, 6, 3, pp.82-87.
- Bhugra D *et al.*, (2010) (eds.) *Mental health of refugees and asylum seekers*, Oxford: Oxford University Press.
- Bina, R (2008) 'The impact of cultural factors upon postpartum depression: A literature review', *Health Care Women International*, 29, 6, pp.568-592.
- Byron, M (1998) 'Migration, work and gender: The case of post-war Labour migration from the Caribbean to Britain' in Chamberlain, M (ed.), *Caribbean Migration: Globalised identities*, Routledge: London, pp217-231.
- Charsley, K, Storer-Church, B, Benson, M and Van Hear, N (2012) *Marriage-related migration to the UK* <https://www.gov.uk/government/publications/marriage-related-migration-to-the-uk>
- Clare, C A and Yeh, J (2012) 'Postpartum depression in special populations: A review', *Obstetrical & Gynecological Survey*, 67, 5, pp.313-323.
- Collins, C H, Zimmerman, C, and Howard, L M (2011). 'Refugee, asylum seeker, immigrant women and postnatal depression: Rates and risk factors', *Archives of Women's Mental Health*, 14, 1, pp.3-11.
- Care Quality Commission (CQC) (2011) *Count me in census 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales* www.cqc.org.uk/sites/default/files/media/documents/count_me_in_2010_final_tagged.pdf
- Dennis, C L, Janssen, P A, and Singer, J (2004) 'Identifying women at-risk for postpartum depression in the immediate postpartum period', *Acta Psychiatrica Scandinavica*, 110, 5, pp.338-346.
- Department of Health (2012) *Maternal mental health pathway* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212906/Maternal-mental-health-pathway-090812.pdf
- Edge, D, Baker, D, and Rogers, A (2004) 'Perinatal depression among Black Caribbean women', *Journal of Health and Social Care in the Community*, 12, pp.430-438.
- Edge, D, and Rogers, A (2005) 'Dealing with it: Black Caribbean women's response to adversity and psychological distress associated with pregnancy, childbirth and early motherhood', *Social Science and Medicine*, 61, pp.15-25.
- Edge, D (2007a) 'Ethnicity, psychosocial risk, and perinatal depression— a comparative study among inner-city women in the United Kingdom', *Journal of Psychosomatic Research*, 63, pp.291-295.
- Edge, D (2007b) 'Perinatal depression and Black Caribbean women: Lessons for primary care', *Primary Health Care*, Vol.17, p 32-5.
- Foner, N (2009) 'Gender and migration: West Indians in comparative perspective', *International Migration*, 47, 1, pp.3-30 <http://onlinelibrary.wiley.com/enhanced/doi/10.1111/j.1468-2435.2008.00480.x/>
- Ganann, R, Sword, W, Black, M, and Carpio, B (2012) 'Influence of maternal birthplace on postpartum health and health services use', *Journal of Immigration and Minority Health*, 14, 2, pp.223-229.
- Gardner, K and Shukar, A (1994) 'I'm Bengali, I'm Asian, and I'm living here: The changing identity of British Bengalis' in R. Ballard, (ed.) *Desh Pardesh: The South Asian Presence in Britain*, London: Hurst and Company.
- Gavin, N I, Gaynes, B N, Lohr, K N, Meltzer-Brody, S, Gartlehner, G and Swinson, T (2005) 'Perinatal depression: a systematic review of prevalence and incidence.', *Obstetrics & Gynecology*, 106, 5.1, pp.1071-1083.
- Ghaffari, Z (undated) "Immigration and Postnatal Depression", Faculty of Health and Human Sciences, University of West London, PhD Poster. https://www.academia.edu/5798922/Immigration_and_Postnatal_Depressio
- Gilbert, P, Gilbert, J, & Sanghera, J (2004) 'a focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian Women living in Derby', *Mental Health, Religion and Culture*, 7(2), 109-130.
- Greater London Authority (GLA) (2005) London – *The world in a city: An analysis of the 2001 Census results*, London <http://legacy.london.gov.uk/gla/publications/factsandfigures/dmag-briefing-2005-6.pdf>
- Higginbottom, G M A, Morgan, M, O'Mahony, J, Chiu, Y, Kocay, D, Alexandre, M, Forgeron, J and Young, M (2013) 'Immigrant women's experiences of postpartum depression in Canada: a protocol for systematic review using a narrative synthesis', *Systematic Reviews*, 2, 65, <http://www.systematicreviewsjournal.com/content/2/1/65>
- Home Office (2011) *Visa Application Guide*
- Huang, Y C and Mathers, N J (2008) 'Postnatal depression and the experience of South Asian marriage migrant women in Taiwan: Survey and semi-structured interview study' *International Journal of Nursing Studies*, 45, 6, pp.924-931.
- Hyman, I (2001) Immigration and health, Working Paper 01-05, *ON: Health Canada* <http://www.better-health.org.uk/resources/research/immigration-and-health>
- ICAR (2007) *Women refugees and asylum seekers in the UK* http://www.icar.org.uk/ICAR_briefing_on_WomenRefugees.pdf
- Katz, D and Gagnon, A J (2002) 'Evidence of adequacy of postpartum care for immigrant women', *Canadian Journal of Nursing Research*, 34, 4, pp.71-81.
- Kurtz, L C, Sword, W and Ciliiska, D (2008) 'Urban women's socioeconomic status, health service needs and utilization in the four weeks after postpartum hospital discharge: Findings of a Canadian cross-sectional survey', *BMC Health Services Research*, 8, 203 <http://pmcc.web-t.cisti.nrc.ca/articlerender.cgi?accid=PMC2570364>
- Lewis, G, Ed. (2007) *The Confidential Enquiry into Maternal and Child Health (CEMACH): Saving mothers' lives: reviewing maternal deaths to make childhood safer-2003-2005*. London: CEMACH.
- Lindahl, V, Pearson, J L and Colpe, L (2005) 'Prevalence of suicidality during pregnancy and the postpartum', *Archives of Women's Mental Health*, 8, 2, pp.77-87.
- McColl, H and Johnson, S (2006) 'Characteristics and needs of asylum-seekers and refugees in contact with London community mental health teams: a descriptive investigation', *Social Psychiatry and Psychiatric Epidemiology*, 41, 10, pp.789-795.
- McColl, K, Pickworth, S and Raymond, I (2006) 'Project: London - supporting vulnerable populations', *British Medical Journal* 332, 7533, pp.115-117. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1326945/>
- Mechakra-Tahiri, S, Zunzunegui, M V and Sequin, L (2007) 'Self-rated health and postnatal depressive symptoms among immigrant mothers in Quebec', *Women Health*, 45, 4, pp.1-7.

References

- National Perinatal Mental Health Project, (2010) *Perinatal mental health of black and minority ethnic women: A review of current provision in England, Scotland and Wales* <http://www.better-health.org.uk/resources/research/national-perinatal-mental-health-project-report-perinatal-mental-health-black-and>
- Office for National Statistics (2012) *Childbearing among UK born and non-UK born women living in the UK* http://www.ons.gov.uk/ons/dcp171766_283876.pdf
- Office for National Statistics (2013) *Births in England and Wales by Parents' Country of Birth, 2012* <http://www.ons.gov.uk/ons/rel/vsob1/parents--country-of-birth--england-and-wales/2012/sb-parents--country-of-birth--2012.html>
- O'Mahony, J and Donnelly, T (2010) 'Immigrant and refugee women's post-partum depression help-seeking experiences and access to care: a review and analysis of the literature', *Journal of Psychiatric and Mental Health Nursing*, 17, 10, pp.917–928.
- Onozawa, K, Kumar, R C, Adams, D, Dore, C and Glover, V (2003) 'High EPDS scores in women from ethnic minorities living in London', *Archives of Women's Mental Health*, 6, 2, pp.51–55.
- Oxman-Martinez, J, Abdool, S N and Loiselle-Leonard, M (2000) 'Immigration, women and health in Canada', *Revue Canadienne de santé publique*, 91, 5, pp. 394–395.
- Phillimore, J and Thornhill, J with Latif, Z Uwimana, M and Goodson, L (2010) *Delivering in an age of super-diversity: West Midlands review of maternity services for migrant women* <http://www.better-health.org.uk/resources/research/delivering-age-super-diversity>
- Pumariega, A J, Rothe, E and Pumariega, J B (2005). 'Mental health of immigrants and refugees', *Community Mental Health Journal*, 4, 5, pp.581–597.
- Royal College of Psychiatrists (2007) Improving services for refugees and asylum seekers: Position Statement. London, *Royal College of Psychiatrists; Health for Asylum seekers and Refugee Portal (HARP); MEDACT*.
- Small, R, Lumley, J and Yelland, J (2003) 'Cross cultural experiences of maternal depression: associations and contributing factors for Vietnamese, Turkish and Filipino immigrant women in Victoria, Australia', *Ethnicity and Health*, 8, 3, pp. 189–206.
- Specialist Mental Health Midwives, (undated) *Specialist Mental Health Midwives: What do they do and why they matter*, National Society for the Prevention of Cruelty to Children http://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/mental-health-midwives-pdf_wdf99836.pdf
- Stewart, D E, Gagnon, A, Saucier J F, Wahoush O and Dougherty G (2008) 'Postpartum depression symptoms in newcomers', *The Canadian Journal of Psychiatry*, 53, 2, pp.121–124.
- Sword, W (1997) 'Enabling health promotion for low-income single mothers: an integrated perspective', *Clinical Excellence for Nurse Practitioners*, 1, 5, pp.324–332.
- Sword, W, Watt, S and Krueger, P (2006) 'Postpartum health, service needs and access to care experiences of immigrant and Canadian-born women', *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35, 6, pp.717–727.
- Shaw, A (1988) *A Pakistani Community in Britain*, Blackwell: Oxford
- Shaw, A (2000) *Kinship and Continuity*, Amsterdam: Harwood.
- UNHCR (2013) *Refugee Women and the Istanbul Convention, Preventing and combating sexual and gender-based violence*, Proceedings based on the hearing organised by the Parliamentary Network "Women Free from Violence". Strasbourg, The Committee on Migration, Refugees and Displaced Persons of the Parliamentary Assembly of the Council of Europe and the United Nations High Commissioner for Refugees (UNHCR): 14.
- United Nations (1998) *Recommendation on Statistics of International Migration, Revision 1*, New York: United Nations
- Wheeler, E (1998) 'Mental illness and social stigma: Experiences in a Pakistani community in the UK', *Journal of Gender and Development*, 6, 1, pp.37–43.
- Yoshida, K, Marks, M N, Kibe, N, Kumar, R, Nakano H, and Tashiro, N (1997) 'Postnatal depression in Japanese women who have given birth in England', *Journal of Affective Disorders*, Vol. 43, p 69–77
- Vertovec, S (2007) 'Super-diversity and its implications', *Ethnic and racial studies*, 30, 6, pp.1024–1054.
- Zolkowitz, P, Saucier, J F, Wang, T, Katofsky, L, Valenzuela, M, and Westreich R (2008) 'Stability and change in depressive symptoms from pregnancy to two months postpartum in childbearing immigrant women', *Archives of Women's Mental Health*, 11, 1, pp.1–11.
- Zolkowitz, P, Schinazi, J, Katofsky, L, Saucier, J F, Valenzuela, M, Westreich, R, Dayan, J (2004) 'Factors associated with depression in pregnant immigrant women', *Transcultural Psychiatry*, 41, 4, pp.445–464.
- Zubaran, C, Schumacher, M, Roxo, M R, Foresti, K (2010) 'Screening tools for postpartum depression: validity and cultural dimensions', *African Journal of Psychiatry*, 13, 5, pp.357–365 www.ajol.info/index.php/ajpsy/article/viewFile/63101/50970.pdf

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