Bachelor's thesis

Degree program in Nursing

2020

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NURSING INTERVENTION; PREVENTING POSTPARTUM DEPRESSION IN IMMIGRANT WOMEN – A LITERATURE REVIEW

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TURKU UNIVERSITY OF APPLIED SCIENCES

BACHELOR'S THESIS | ABSTRACT

TURKU UNIVERSITY OF APPLIED SCIENCES

Bachelor's Degree in Nursing

2020 | 42 pages, 5 pages in appendices

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ABSTRACT

Postpartum depression can be life-threatening if left untreated. Postpartum depression affects 10–20% of women after delivery, regardless of maternal age, race, parity, socioeconomic status, or level of education.

Maternity clinics are required to provide health care services and promote the physical and mental health of the population while taking cultural differences into consideration. Mental health is overlooked in women, especially women of color and those with an immigrant background. The aim of this thesis is to make mental health a primary focus for immigrant mothers. By reviewing previous journals and articles, we can understand what problems immigrant mothers have faced in maternal clinics, specifically with regards to their mental well-being. We can also understand what form of help was considered beneficial in educating the patient about postpartum depression as well as preventing it, and how this form of help could continue to be promoted in maternity clinics.

The method used for this study is a literature review. Scholarly articles and academic journals between the years 2010-2020 have been collected for analysis. CINAHL, Academic Search Elite (EBSCO) and PubMed were the primary platforms used to collect the literature necessary for the literature review.

The results of the study revealed that postpartum depression was more prevalent in women of immigrant and foreign background in comparison to the native population. Women of marginalized groups often overlooked their mental health and ignored any physical ailments which were a result of their mental wellbeing. A study revealed that EPDS was not the best choice in diagnosing immigrant women with PPD, let alone helping them understand what PPD is. Communicating with patients and taking their cultural differences in to consideration when providing care was seen as much more beneficial to immigrant women. Healthcare providers and officials need to break down the barriers surrounding maternal mental health and encourage immigrant mothers to speak about their mental well-being without being ostracized.

KEYWORDS:

Foreign mothers, mental health and immigrant women, nursing interventions and mental health, postpartum depression and immigrant women.

OPINNÄYTETYÖ (AMK) | TIIVISTELMÄ

TURUN AMMATTIKORKEAKOULU

Sairaanhoitaja tutkinto

2020 | 42 sivua, 5 liitesivua

Alhaan Kasi

HOITOTYÖN INTERVENTIO; SYNNYTYKSEN JÄLKEISEN MASENNUKSEN ESTÄMINEN MAAHANMUUTTAJANAISISSA

Synnytyksen jälkeinen masennus (PPD) voi olla hengenvaarallinen, jos sitä jätetään hoitamatta. Synnytyksen jälkeinen masennus vaikuttaa 10–20%: iin naisista synnytyksen jälkeen riippumatta äidin iästä, rodusta, sosioekonomisesta asemasta tai koulutustasosta.

Äitiysklinikoiden on tarjottava terveydenhuoltopalveluita ja edistettävä väestön fyysistä ja henkistä terveyttä ottaen samalla huomioon kulttuurierot. Mielenterveyttä ei oteta huomioon naisilla, etenkään värillisillä naisilla ja maahanmuuttajataustaisilla naisilla. Opinnäytetyön tavoitteena on tehdä mielenterveydestä ensisijainen painopiste maahanmuuttajaäideille. Tarkastelemalla aikaisempia lehtiä ja artikkeleita voimme ymmärtää, mihin ongelmiin maahanmuuttajaäidit ovat kohdanneet äitiysklinikoilla, erityisesti heidän henkisen hyvinvointinsa suhteen. Voimme myös ymmärtää, minkä tyyppistä apua pidettiin hyödyllisenä potilaan kouluttamisessa synnytyksen jälkeisestä masennuksesta ja sen estämisessä, ja kuinka tämän tyyppistä apua voitaisiin edelleen edistää äitiysklinikoissa.

Tässä tutkimuksessa käytettiin kirjallisuuskatsausta. Tieteelliset artikkelit ja akateemiset lehdet vuosien 2010-2020 välillä on koottu analysoitavaksi. CINAHL, Academic Search Elite (EBSCO) ja PubMed olivat ensisijaisia alustoja, joita kerättiin kirjallisuuskatsaukseen tarvittavan kirjallisuuden keräämiseksi.

Tutkimuksen tulokset paljastivat, että synnytyksen jälkeinen masennus oli yleisempi maahanmuuttaja- ja ulkomaalaisista naisilla verrattuna alkuperäiskansoihin. Marginalisoituneiden ryhmien naiset unohtivat mielenterveytensä usein ja sivuuttivat heidän henkisen hyvinvointinsa aiheuttamat fyysiset vaivat. Tutkimus paljasti, että EPDS ei ollut paras valinta diagnosoida maahanmuuttajanaisia PPD: llä, puhumattakaan auttamalla heitä ymmärtämään, mikä PPD on. Kommunikointi potilaiden kanssa ja heidän kulttuurierot huomioon ottaminen hoidon tarjoamisessa nähtiin paljon hyödyllisemmäksi maahanmuuttajanaisille. Terveydenhuollon tarjoajien ja virkamiesten on poistettava äitien mielenterveysympäristön esteet ja rohkaistava siirtotyöläisiä puhumaan mielenterveydestään sulkematta niitä pois.

ASIASANAT:

Ulkomaiset äidit, mielenterveys ja maahanmuuttajanaiset, hoitotyöt ja mielenterveys, synnytyksen jälkeinen masennus ja maahanmuuttajanaiset.

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LIST OF ABBREVIATIONS (OR) SYMBOLS

Abbreviation	Explanation of abbreviation
CINAHL	Cumulative Index for Nursing and Allied Health Literature
EPDS	Edinburgh Postnatal Depression Scale
FIGO	The International Federation of Gynecology and Obstetrics
MIELI	Mental Health Finland
OCD	Obsessive compulsive disorder
PND	Postnatal depression
POC	People of color
PPD	Postpartum depression
TUAS	Turku University of Applied Sciences
WHO	World Health Organization
WOC	Women of color

1 INTRODUCTION

With an influx of immigrants, asylum seekers and refugees entering Western countries and starting their new lives, the government of those countries is responsible for providing a comprehensive integration program. A municipality receiving refugees needs to organize integration services, build up the competence of its personnel and make economic investments. By accepting persons entitled to international protection, municipalities support the implementation of human rights and a diverse and open society (Centre of Expertise in Immigrant Integration at the Ministry of Economic Affairs and Employment, 2017). Municipal services also include health care services. This means that immigrants have the right to use the health care services provided by the municipality and the government and local authorities are responsible for making sure these services are being offered in English as well as other languages in order to ensure the population has access to basic health care.

Mental health is often overlooked, especially when discussing the mental wellbeing of refugees, asylum-seekers, and immigrants. Research has shown time and time again that those belonging to these marginalized groups should be using mental health services, as they are prone to developing mental illnesses after escaping war, sex trafficking, religious persecution, physical abuse etc. or simply just from the process of migration. Current treatments and the dominant model of mental health care do not adequately address the complex challenges of mental illness, which accounts for roughly one-third of adult disability globally (Lake, et al. 2017). In order to improve mental health, we need to break down the stigma surrounding it. It can be hard to break the stigma surrounding mental health if we refuse to be understanding of another persons' experience. This is the case for most marginalized women, especially those that are mothers.

A mother is responsible for providing love, care, and protection. She is a disciplinarian and a friend who makes sure her child grows into a competent human being and continues to become well-adjusted individual who gives back

to the community. Because of the role that mothers are assigned to, it makes it almost impossible for her to focus on herself let alone her mental health.

Childbirth can be a traumatic experience physically and mentally especially considering environmental, social, and financial factors. It can especially be a potent trigger for women who have had any history of a mental disorder. Post-partum mental health needs to be assessed to check for signs of post-partum PTSD (post-traumatic stress disorder), post-partum psychosis, PPD (postpartum depression), anxiety, OCD (obsessive compulsive disorder), eating disorders etc. According to the WHO, worldwide about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression. In developing countries this is even higher, i.e. 15.6% during pregnancy and 19.8% after childbirth. In severe cases mothers' suffering might be so severe that they may even commit suicide. As a result, the children's growth and development may be negatively affected as well. Maternal mental disorders are treatable. Effective interventions can be delivered even by well-trained non-specialist health providers (WHO, 2020).

The EPDS (Edinburgh Postnatal Depression Scale) has been previously used to assess and diagnose postpartum depression. Responses are scored from 0-3 based on the seriousness of the symptom. The total score is found by adding together the scores for each of the 10 items. Mothers scoring above 12 or 13 are likely to be suffering from depression and should seek medical attention. A careful clinical evaluation by a health care professional is needed to confirm a diagnosis and establish a treatment plan (Cox, et al. 1987). However, it seems that the EPDS has not been successful in diagnosing PPD in women of marginalized groups like asylum seekers and refugees as they are either not able to understand the literature. Using the EPDS alone fails in allowing nurses to create trust between themselves and the patient.

It is crucial to take care of both the mother and child before, during and after pregnancy. It is important to make sure that the mother continues a life where she feels heard and supported in order to ensure a happy life for herself and her child. This should especially be the case for marginalized women.

2 MATERNAL MENTAL HEALTH

2.1 Nursing interventions

Nursing interventions is defined as any treatment, based upon clinical judgment and knowledge that a nurse performs to enhance patient/client outcomes (Fitzpatrick et al., 2012). Nursing intervention is the planning and implementation of the treatment and care that helps patients reach the goals that are set for them by healthcare professionals. A huge part of nursing intervention is independent action. This allows a nurse to be confident when planning and evaluating care for the patient.

According to a study, failure to assure the quality of nursing care leads not only to distress and dissatisfaction, but also to wider patient safety failures. Studies internationally have highlighted the prevalence and potentially catastrophic consequences of poor nursing care (Richards, et al. 2016). From this study we can understand that patient safety includes any care that can prevent and reduce risks, errors and harm that is caused directly or indirectly to the patient by the healthcare facility and healthcare workers. The catastrophic consequences of not providing and planning the appropriate nursing care include medication errors, infections, patient readmissions, and other complications which can be life threatening for the patient.

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well and in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people. A health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote, or modify health, functioning or health conditions. (WHO, 2020).

2.2 Mental health and immigrants

Mental health helps us evaluate the psychological well-being of a person. We can understand whether the individual is suffering with problems that are affecting their psychological functionality by also considering their emotional behavior. Mental disorders are common worldwide, yet the quality of care for these disorders has not increased to the same extent as that for physical health. Mental health care quality measurement and measurement-based care have a weak infrastructure in health care systems. This is due to a multitude of barriers specifically related to mental health, that involve limitations in policy and technology as well as limited scientific evidence for mental health quality measures, lack of provider training and support, and cultural barriers to integrating mental health care within general health environments (Kilbourne, et al. 2018).

Compared to the inhabitant population, immigrants and refugees have a greater risk of developing mental health disorders which also could affect the second and third-generation immigrants. Immigrants with a refugee background suffer from mental issues caused by traumatic events and need treatment in their new home country. However, despite their need, their use of mental health services is minimal. This is partly due to the insufficient availability of mental health services (MIELI Mental Health Finland, 2020).

Bearing in mind, that most immigrants, refugees and asylum-seekers are either bilingual or polyglots, it is quite understandable as to why they would not use the health services provided as these services are predominantly in the local language of the country they are moving or fleeing to. Other reasons as to why immigrants do not use mental health services as much as the native population is because of the pre-existing stigma which creates barriers for those in need of mental health services. Stigma feeds misconceptions about mental health, allowing people to make assumptions and equate mental health with negativity and thus, feel shameful when talking about mental health. Unfortunately, healthcare workers can also have stigma against marginalized groups.

2.3 Stigma

Having stigma against something can be very dangerous, especially in the world of health care as it promotes misconceptions and discrimination. Mental disorders are subject to negative judgements and stigmatization. Discrimination may be obvious and direct, such as someone making a negative remark about your mental illness or your treatment (Mayo Clinic, 2017).

Many patients not only have to cope with the devastating effects of their illness, but also suffer from social exclusion and prejudices. Stigmatization of the mentally ill has been a long tradition. Since the Middle Ages, mental illness was regarded as a punishment (Rössler, 2016). According to a study where data about cultural misconceptions, attitudes about mental illness, and public stigma of mental illness was obtained, cultural misconceptions and stigma about mental health go hand in hand. The researchers examined the mean difference in public stigma according to cultural beliefs about mental illness. The majority of participants in the study believe that mental health professionals have inadequate knowledge and expertise to treat mental disorders. Public stigma significantly differed based on these cultural misconceptions (Rayan, et al. 2018).

In the United States, studies have shown that immigrants from Asia, Latin America, and Africa use mental health services at lower rates than nonimmigrants, despite an equal or greater need. Structural barriers to service use reported included lack of insurance, high cost, and language barriers. Studies have shown that social support is particularly important for immigrants and that those who seek help for mental health concerns tend to turn first to family, friends, or religious leaders (Derr, A. S., 2016).

Both the aforementioned studies clearly state that immigrants, specifically POC (people of color), are part of a marginalized group who have a greater need for mental health services but do not use these services as compared to native-born individuals. In order to fight and overcome stigma and discrimination, we need to educate people about mental health and raise awareness.

2.4 Maternal health and immigrants

To quote Mahmoud Fathalla, the former president of FIGO (The International Federation of Gynecologists and Obstetrics) ”Women are not dying of diseases we can’t treat, they are dying because societies have yet to make the decision that their lives are worth saving”. Maternal health care should consist of care for both the mother and the baby. By providing round-the-clock care, health professionals can reduce maternal mortality (WHO, 2020).

The maternal health agenda is undergoing a paradigm shift from preventing maternal deaths to promoting women's health and wellness (Firoz, et al. 2018). This just shows how far behind we are as a society in prioritizing maternal health, let alone mental health for mothers. The number of women around the world who die every day from complications of pregnancy and childbirth. That is over 350,000 women every year – *one woman every 90 seconds*. The vast majority of these deaths are preventable (AMNESTY INTERNATIONAL, 2020).

Immigrants vary in health and disease compared with individuals born in the receiving countries. In terms of immigration reasons, individuals with a refugee background are considered a particularly vulnerable group and refugee background has been associated with several adverse outcomes in both pregnant and non-pregnant individuals. In particular, refugee women giving birth in receiving countries have been found to have higher risks of preterm birth, infant mortality and morbidity, and postpartum depression (Nilsen, 2018).

According to an observational study conducted in Australia, migrant women of refugee background from different African regions appear to be at greater risk of specific adverse pregnancy outcomes compared to migrant women without a refugee background (Gibson-Helm, 2014).

Access to healthcare, including maternity care, and the quality of services received by immigrants are influenced by low health literacy levels, stigma and mental health problems, language barriers, cultural barriers, lack of provider cultural competence, and lack of social support and isolation, despite policy

suggesting that care is to be provided equally for all members of society (Higginbottom et al., 2016). Below are the seven rights of women before, during and after pregnancy according to the Respectful Maternity Care Charter: Universal Rights of Mothers and Newborns:

1. Every woman has the right to be free from harm and ill treatment.
2. Every woman has the right to information, informed consent and refusal, and respect for her choices and preference including companionship during maternity care.
3. Every woman has the right to privacy.
4. Every woman has the right to be treated with dignity and respect.
5. Every woman has the right to equality, freedom from discrimination and equitable care.
6. Every woman has the right to healthcare and to the highest attainable level of health.
7. Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion.

2.5 Nurse's role in maternal health

The ICN (International Council of Nurses, 2020) defines nursing as an integral part of the health care system, encompasses the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages, in all health care and other community settings. According to this definition, nurses are responsible for providing care not only in health care environments such as hospitals and clinics, but also in other domains.

Primary maternity care is provided by public maternity and child health clinics to guarantee free health care services for every pregnant woman and all children under school age (Tuominen, 2012). A maternity nurse is a nurse who is qualified in providing care for new mothers and their newborn babies as well as mothers and their children that have not started school yet. Maternity nurses are

responsible for educating parents on childcare and help them with integrating a new addition into the family by providing parental assistance. A maternity nurse can also be referred to as a ’maternal and child health nurse’. A maternal and child health nurse is responsible for making sure her patient understands the medical procedures, medical terms and most importantly consent.

2.6 Postpartum depression

Postpartum depression is a common, potentially disabling and, in some cases, life-threatening condition. Postpartum depression is the most common postnatal neuropsychiatric complication. Postpartum depression affects 10–20% of women after delivery, regardless of maternal age, race, parity, socioeconomic status, or level of education. Postpartum depression can lead to impaired maternal functioning and child development. Yet, fewer than half of postpartum depression cases are diagnosed in clinical practice (Bobo, et al. 2014). From this study we can find similarities with Arroyo-Borrell’s study. A child’s psychological development is heavily affected by the environmental upbringing they experience, as well as the factors brought in by the mother’s mental well-being.

Postpartum depression often involves unfounded feelings of guilt, which, at first, may prevent the mother from seeking help. The mother may start to think that she cannot tell about her depression to anyone, because everyone expects her to be happy about the baby. However, postpartum depression is a mental disorder which has nothing to do with how much the mother loves her baby (MIELI Mental Health Finland, 2020). It is understandable why mothers feel guilt when addressed about symptoms of PPD because not only society, but even healthcare professionals, can be judgmental and biased. Immigrant mothers especially have a fear of losing their children to social services if they mention any flaw in their mental wellbeing.

According to a study, history of depression was found to be the most important predisposing factor of postpartum depression. Women without previous episodes

of depression were at an increased risk of postpartum depression if adverse events occurred during the course of pregnancy, especially if they showed physician-diagnosed fear of childbirth (Räisänen, et al. 2013). From this we can understand why PPD is prevalent in marginalized women as most asylum-seeking and refugee women are fleeing to another country with a history of physical or sexual abuse, torture, war, persecution etc.

3 AIM, PURPOSE AND RESEARCH QUESTIONS

Mental health is often overlooked in women, especially in mothers, which is why the purpose of this thesis is to increase awareness and provide information for future nurses, nursing students and those who are interested in postnatal mental health. The aim is to make mental health care a primary focus for immigrant women who are pregnant or have already given birth and to educate them on the hormone imbalance after birth which can lead to mental illnesses.

By reviewing academic journals and scholarly articles, we can understand what problems immigrant mothers have faced in the world of maternal health care, specifically with regards to their mental well-being. We can also understand what form of help was considered most beneficial and how we can continue to promote it through nursing.

RESEARCH QUESTIONS

1. What challenges do marginalized women face in being diagnosed with PPD?
2. How well-informed are healthcare professionals in recognizing PPD in immigrant women?

4 METHODOLOGY

4.1 Literature review

The methods used for this study include a literature review and qualitative research. A literature review forms the basis for high-quality medical education research and helps maximize relevance, originality, generalizability, and impact. This type of review provides context, informs methodology, maximizes innovation, avoids duplicative research, and ensures that professional standards are met (Maggio, et al. 2016).

An increasing number of health researchers are currently opting to use various qualitative research approaches in exploring and describing complex phenomena, providing textual accounts of individuals' "life worlds", and giving voice to vulnerable populations our patients so often represent (Christen, et al. 2017). A similar approach had been used in this thesis. Keywords including "postpartum depression", "nursing interventions", "foreign mothers", "postnatal", "postpartum depression" and "mental health in immigrants" were used to collect information and analyze the results.

4.2 Data search and analysis

Scholarly articles and academic journals between the years 2010 and 2020 have been acquired from CINAHL, Academic Search Elite (EBSCO host) and PubMed in order to perform a literature review. The data collection method will be current in order to provide the latest findings. The literature used for analysis and review has been published within the last 10 years in order to ensure that current information was reflected in the results. Sources are credible in order to ensure that all the information provided is valid, unbiased, and based on facts. In order to find criteria which is up to date and answers the research questions, certain

types of literature were excluded. The inclusion and exclusion criteria should be precise, which is why this limitation serves as a reminder for when searching for scholarly articles and academic journals.

According to an article, content analysis is a systematic coding and categorizing approach used for exploring large amounts of textual information unobtrusively to determine trends and patterns of words used, their frequency, their relationships, and the structures and discourses of communication (Bengtsson et al. 2013).

The purpose of content analysis is to read through multiple literatures with similar themes in order to form a generalized result based on how often the themes reoccur between each literature. By using content analysis, we are able to take texts and summarize them into smaller categories while still maintaining the core of the literature that is being analyzed.

Table 1. Criteria selection

CRITERIA INCLUDED	CRITERIA EXLCUDED
Articles from the past 10 years	Articles before the year 2010
Articles free of cost	Articles that require purchasing
Articles in English	Articles in other languages
Articles available in full text	Articles not available in full text
Literature derived from scholarly articles and academic journals	Literature other than scholarly articles and academic journals
Articles related to the topic	Articles with no relation to the topic
Articles focusing on humans	Articles focusing on animals
Articles answering the research questions	Articles not answering the research questions

4.3 Selection process

Literature was acquired from the electronic search engine FINNA, provided by the Turku University of Applied Sciences (TUAS). Initially the chosen databases included Cumulative Index for Nursing and Allied Health Literature (CINAHL), Academic Search Elite (EBSCO), Google Scholarly and PubMed. Google Scholarly provided an advanced search section which was not similar to CINAHL, Academic Search Elite or PubMed. Google Scholarly produced a very a substantial amount of results as seen in Table 2. This electronic search engine included non-peer reviewed articles and did not seem to have the type of content that was provided by articles which were found on the other databases mentioned. This is why Google Scholarly was not the preferred choice for a database.

The final chosen databases to perform the literature review include Cumulative Index for Nursing and Allied Health Literature (CINAHL), Academic Search Elite (EBSCO) and PubMed. The reason these specific databases were chosen is because of the fact that they include literature related to the topic and also contain peer-reviewed text. These databases provided articles related to nursing and mental health, mental health, and postpartum depression in immigrant women. Searches were done by inserting terms individually and using the Boolean ANDs and ORs from January 24th, 2020 onward. Specific keywords and their synonyms were also used to search the databases i.e. mental health, mental well-being.

For example, using the CINAHL database and applying the keywords mental health, mental well-being and the Boolean OR created 160,405 searches. Once we start using the criteria inclusion method (see Table 1) by only searching for articles and journals between the years 2010-2020 and searching for full text articles in English, the search results are decreased to 23,572 (see Table 2).

Upon further researching and finalizing the results, the primary focus was on articles found from search results using the keywords and the Boolean as seen in Table 2, “postpartum depression AND immigrant women” as well as “mental health AND immigrant women”. The reason for this was due to the reliability,

validity and content of the articles and journals. PPD in immigrant women is the main theme of this literature review as well as understanding the process of immigrant women using mental health services, which is why the focus was on these keywords. A total of nine scholarly articles and academic journals were chosen for analysis, five articles were chosen from PubMed, two from CINAHL and two from Academic Search Elite (EBSCO host).

Table 2. Search Results

Database	nursing interventions AND mental health	mental health OR mental well-being	mental health AND immigrant women	foreign mothers	postpartum depression AND immigrant women
Academic Search Elite (EBSCO host)	85	53,745	75	45	12
CINAHL	75	23,572	51	41	20
Google Scholar	157,000	311,000	41,600	157,000	13,500
PubMed	809	59,154	110	492	14
Total	157,969	447,471	41,836	158,578	13,546

5 RESULTS

After an extensive data collection, 9 articles were selected and evaluated for this literature review. The studies of the selected articles were performed in five different countries including Canada, Sweden, Portugal, United Kingdom and United States. Three articles were produced in the United States, two articles were based in Canada and two were based in the United Kingdom, one article was done in Portugal and one was done in Sweden. The following four major categories emerged upon analysis: communication, society and stigma, healthcare professionals and pressures of motherhood.

5.1 Communication

Structural issues, such as lack of insurance, high cost and inaccessibility of services, and language barriers, were important deterrents to service use (Derr, 2016). Language, mobility, legal status, length of stay, country of origin, health care provider's attitudes, and culture, besides occupational factors. These factors are likely to increase vulnerability during pregnancy and psychopathological complications before and after birth – postnatal depression and psychosis. Migrant women frequently report sensations of insecurity, isolation, self-perception of affective deprivation from key relationships, longing for their own culture and family, strangeness to new cultural habits, linguistic challenges, religious differences, and sometimes even hostility and indifference from the local population. Increased distress and anxiety frequently foster postpartum depression (Almeida et al., 2016).

Immigrant mothers were also confronted with nurses and healthcare providers who insisted on speaking the national language, rather than speaking in the common language they shared with the women (Wikberg et al. 2012). For mothers with higher language proficiency skills and who had lived in the receiving country for a longer period of time, the language barrier was reduced.

Nonetheless, communication barriers with healthcare providers persisted due to the limited knowledge of healthcare related terminology, and the HCPs use of medical 17 jargon. (Higginbottom et al. 2016, 5-9; Seo et al. 2014, 310.) For that reason, their questions remained basic, solely for the reason that they were unable to go in-depth the way they would have been able to if the HCP spoke their mother tongue (Lee, Landy, Wahoush, Khanlou, Liu & Li 2014).

Language is a clear factor preventing immigrant and other marginalized groups of women from connecting to healthcare professionals and others in the society they live in. Language barriers actively prohibit immigrant and refugees, including WOC, from wanting to speak about their mental health and wellbeing. There is a recurring theme which points out that majority of immigrant and refugees withhold from using mental health services simply because of the language barrier.

Another challenge for speaking about their mood was the interaction with the interpreter during the screening. The mothers were generally content with the quality of the interpreter who was provided either by phone or by on-site. If possible, they preferred a female interpreter on-site as they found it difficult to speak about sensitive things in the presence of a man (Skoog et al., 2018). Most women prefer having to be attended to and treated by female healthcare professionals. This applies to vulnerable groups of foreign women even more so, as they also prefer to have any interpreters assisting to providing health care to also be female. The reason for this is primarily due to vulnerable groups of women wanting to feel comfortable and also because of the idea that talking to a female healthcare practitioner will help them feel understood.

A study by Binder et al (2012) highlighted the importance cultural congruence when communicating with migrant women. They report that trust, engagement with care and disclosure of sensitive issues is improved when the clinician has a shared understanding of the woman's cultural background including concepts of health (such as common ideologies of mental illness) and cultural differences in expectations of healthcare providers. This understanding must come from meaningful conversation with the woman herself, being respectful and upholding her preferences around choice of interpretation method (Firth et al., 2018).

Postpartum depression is overlooked and forgotten by WOC as well as healthcare professionals providing care to WOC. Unfortunately, this is not the only mental illness which POC and healthcare workers choose to disregard. The idea of talking about mental health is something that is not as prevalent in non-Western culture as it is in Western culture.

5.2 Society and stigma

Cultural competence involves a continuous attempt to gain a better understanding of the diverse values, beliefs, traditions, and customs of different cultural groups (Ingram, 2012). Culture and society are interchangeable as culture shapes society into what it has been for centuries and what it is today. Across both Western and non-Western societies' misogyny is prevalent, which allows men to be in control and in charge of deciding a woman's needs. This includes a woman's mental and physical health.

The concept of PPD was in general unknown to immigrant mothers. Some had knowledge from their country of origin through information on the Internet, but none of them had experienced general discussions about PPD in their society, as speaking about mental ill health was not common and not accepted in their country of origin. The mothers in the interview also stated that being a woman affected them in speaking about their mood since they were not used to getting attention as a person. Being born as a girl or a boy meant different life conditions in their culture of origin in terms of having the possibility for education, working outside the household, and rights within a marriage (Skoog, 2018).

In some cultures mental illness may be associated with sorcery or curses, leading to the woman being outcast or at risk of harm (Hanlon et al. 2009; Johnson et al. 2009). The idea of wanting to discuss mental health for these participants in their current place of residence was clearly different when compared to their native country. Qualitative studies describe how social stigma related to depression may

inhibit help seeking for PND, particularly if the expression of emotion is unusual or inappropriate in a given culture (Parvin et al. 2004; Posmontier and Horowitz2004; Teng et al. 2007; Collins et al., 2010). Many refugees and asylum-seekers in particular found it easier to speak about mental wellbeing in their host countries due to the lack of stigma surrounding it.

Migrant women describe additional risk factors including hostile attitudes from the local community (Mulvey 2010). Racism and discrimination is prolific in qualitative studies exploring the experiences of vulnerable migrant women (Berggren et al. 2006; Briscoe and Lavender 2009; Balaam et al. 2013). This can especially cause additional stress and anxiety for refugees and asylum-seeking women as they do not feel welcome in their host country and therefore, they do not feel as if they are part of society.

The intersection of culture and PPD was also evident in familial response to PPD. Some cultures do not acknowledge PPD in the same way as Western cultures, therefore causing some of the participants in these studies to keep symptoms to themselves. A participant mentioned that family “don't realize when a woman is depressed, or they don't understand or want to understand about the importance of giving birth. Most men or people, family members take it like it's something normal” (Connelly, Baker-Ericzen, Hazen, & McCue Horwitz, 2013, p. 182) indicating that sometimes other cultures do not have the same perspectives on the postpartum period as the Western culture might (Maxwell et al., 2018).

It is important for nurses and other healthcare professionals to know that family education is crucial when providing care to mothers during pregnancy as well as after giving birth. Society likes to promote the idea that women are born to give birth and giving birth is easy, natural, and meant for everyone.

In addition, these women face dispersal, being moved with little notice, often during the night and relocated to new accommodation elsewhere in the country. Women have reported feeling de-humanized by the process, removed from their support networks, facing hostility from dispersal staff and feeling abandoned in unfamiliar locations with delays in accessing medical and maternity care due to

language barriers and unfamiliarity with UK health system processes (Feldman, 2014). Knowing that these women felt de-humanized helps us understand that language is a core component of helping vulnerable groups integrate into their host country.

Poverty due to restricted benefit entitlement also impacts on the ability to make social networks and access consistent maternity care appointments (Merry et al., 2011). Consideration of these factors demonstrates some of the ways in which a vulnerable migrant woman can easily become an invisible member of society and consequently miss valuable maternity care. It also provides key indicators for the high maternal mortality rate in migrant women in the MBRRACE report (Knight et al., 2016). Lack of self-worth can make anyone feel less important which is why including vulnerable women when discussing mental health is crucial. The moment women from vulnerable groups feel as though they are seen and heard is the moment there will be a change in the social and healthcare system.

Knowledge of social stigma might also affect the nurses when presenting the screening and make her hesitate for fear of jeopardizing the relationship with the mother. As a first step to overcome difficulties in working effectively with immigrant mothers, health-care professionals must recognize and understand their own barriers and challenges (Donnelly et al., 2011).

5.3 Healthcare professionals

A Canadian study by Vanthuyne (2013) used an online survey completed by clinicians, administrators and support staff; one third of respondents felt that access to care is a privilege for pregnant women and described immigrants as an additional strain on a struggling healthcare system.

Having healthcare professionals describe access to health care as a privilege rather than a basic human right just showcases the stigma that is existing within the world of healthcare as well as healthcare workers. Additionally, describing providing care to vulnerable groups as a burden is discriminatory.

By participating in the screening, the mothers felt reassured that the nurse would identify signs of PPD in case they did not recognize suffering from it by themselves. This raises the question of health literacy and the importance of providing educational services to immigrant mothers since they are at high risk of contracting PPD (Skoog, 2018). Likewise, it has been shown that when immigrant mothers were made aware of services and had more knowledge about PPD, their access to help was facilitated (O'Mahony et al., 2012; Skoog, 2018).

Healthcare professionals should refrain from using medical terminology when explaining physical ailments or mental illnesses. Being able to explain medical terminology in layman's terms will allow a bridge to be built between patients and healthcare workers, creating trust, and understanding. Healthcare providers should take the time to thoroughly explain practices in the healthcare system.

In earlier research, immigrant mothers articulated the need for written resources in their own languages and making them available on the Internet and in public places (Riggs et al., 2012). Governmental bodies and local authorities in charge of healthcare in the country are responsible for providing equal health care for everyone regardless age, sex, race, political or socioeconomic background. This means that the system is required to provide health care and any information regarding health care to the immigrant and refugee population in their native language.

Despite the fact that all mothers should be invited to participate in screening for PPD (Swedish National Board of Health and Welfare, 2010), research shows that immigrant mothers are not invited to participate to the same extent as native-born mothers (Massoudi et al., 2007). Health-care professionals experience screening of immigrant mothers as a challenging task (Teng et al., 2007; Skoog et al., 2018)

Knowledge of differing ways of articulating symptoms of depression may aid midwives recognizing signs of PND in vulnerable migrant women (Firth et al., 2018). Health-care providers also need to be aware of how differently symptoms of PPD can be expressed in the EPDS. Recently, published research found that the level of education and the continent where they live influenced the expression

of PPD in the EPDS much more than ethnicity and race. Women with lower levels of education were less likely to report crying and thoughts of self-harm and more likely to report anhedonia. This highlights the need to be careful and not stereotype mothers on the basis of their ethnic/racial background but rather explore the mothers' cultural milieu (including education) beyond ethnicity and race (Di Florio et al., 2017).

To prevent and support migrant women suffering postpartum depressive symptoms, barriers in the world of healthcare need to be addressed and interventions should include assessments and support/programs for abuse/violence, lack of social support, food insecurity, and stress/poor mental health. Treatment of pain during the postpartum period is also critical (Dennis et al., 2017). These are factors which healthcare workers need to seriously take into consideration when providing care to vulnerable groups of women of immigrant and refugee background. Maternity care providers should regard all recent immigrants as at high risk of PND and give closer observation and support as necessary (Collins et al., 2010).

5.4 Pressures of motherhood

Vulnerable migrant women engage less with maternity care than the average woman for reasons including a lack of knowledge of the UK healthcare system, fear of being charged for care or fear of contact with clinician's negatively impacting their migration application (Firth et al., 2018). Migrant women fear that if they present any signs and symptoms of PPD or other mental illnesses to their healthcare providers, they might be deported or worse they might lose their children to Child Protective Services in the process. This is a common feeling among migrant women across most countries. They fear that discussing their mental wellbeing will result in receiving a punishment as severe as losing their children.

Maternal education above 10 years of schooling was found to play a major role regarding potentially protective effects to preserve an adjusted mental functioning after delivery (Almeida et al., 2016). Migrants and refugees fleeing from countries where education for women is not considered important can be a huge factor when preserving mental health after childbirth.

Research has shown that the level of education a mother has affects her mental wellbeing as well as the baby's. Educated mothers can provide a better life for their children. Women from marginalized backgrounds are almost set up to fail by society due to the lack of social support and governmental funding towards educating women. Regarding maternal mental health, explicitly the ability to maintain an adjusted mental functioning after delivery, we observed that several conditions and procedures contribute to deprive mothers' emotional, psychological, and behavioral well-being, increasing anxiety, perceptions of losing control, and discouragement. The major contributions found explaining possible further deterioration of maternal mental function are associated with episiotomies and multiparous mothers (Almeida et al., 2016).

Both society and the healthcare system can be unfair in the treatment of multiparous mothers. Multiparous mothers are expected to know and remember everything because they have previously had a pregnancy. Multiparous mothers also feel pressure from themselves and judge themselves, expecting nothing less than perfection. In migrant and marginalized women especially, healthcare workers need to consider that the previous birth was performed in another country where the mother may not have received all of the information on pregnancy, nutrition, breastfeeding etc.

The number one cause of maternal death within the first year after birth of a child in the United States is PPD resulting in maternal suicide (Doe et al., 2017). Experiencing PPD puts mothers at an increased risk of having decreased self-efficacy, feelings of sadness, worthlessness, perceptions of incompetence, and decreased sense of self-worth (Edhborg, Nasreen, & Kabir, 2011; Letourneau et al., 2012). Early intervention can help reduce these numbers and by encouraging

marginalized groups of women to talk about their maternal mental health, we can allow them to be a part of society and no longer feel invisible.

Another hindrance for bringing up negative emotions was feelings of guilt and shame and not being grateful enough for the comfortable life they now were living in Sweden (Skoog, 2018). Feeling pressures of motherhood is something that all mothers feel and unfortunately this feeling can lead to parental burnout. With immigrant women, these pressures are higher as they hold themselves to a different standard. Feelings of guilt are worse, as they not only feel guilt for not having a mother-baby bond and addressing their own mental health, but they also feel guilt for coming across as ungrateful for their new lives in their host country.

6 ETHICAL CONSIDERATIONS, VALIDITY AND RELIABILITY

According to the Finnish National Board on Research Integrity (TENK), in order for research to be ethically acceptable and reliable and for its results to be credible, the research must be conducted according to the responsible conduct of research. The researcher takes due account of the work and achievements of other researchers by respecting their work, citing their publications appropriately, and by giving their achievements the credit and weight they deserve in carrying out the researcher's own research and publishing its results (Guidelines of the Finnish Advisory Board on Research Integrity, 2012). The Finnish Advisory Board on Research Integrity (2009) divides ethical principles of research in the humanities and social and behavioral sciences into three areas:

1. Respecting the autonomy of research subjects

2. Avoiding harm

3. Privacy and data protection

The work of previous researchers was respected, and credit was given where it was due. All scholarly and academic literature as well as other findings have been referenced according to the guidelines provided by TUAS. It has been understood that any manipulation of research material, equipment, research process, research data is seen as fabrication and falsification, and this has been taken into consideration. Studies including participants being interviewed were conducted ethically and with the consent of the participant. Names were not mentioned and the country where the participant originated from was also not mentioned in order to avoid creating bias and discrimination.

It is important to use literature where the findings of the study are valid, reliable, and ethically responsible. All sources used for the research and results are credible. In order to avoid bias, the study is not limited to one particular country, rather research from multiple countries has been include. This will allow an unbiased understanding of vulnerable women's' experience in maternal mental health care to be created.

7 CONCLUSION

The results obtained from the articles between the years 2010-2020 help us understand the mindset of female immigrants, refugees and asylum-seekers entering Canada, Portugal, Sweden, the United States, and the United Kingdom with regards to maternal mental health. Research shows that immigrant women face multiple challenges and barriers in maternal care. These marginalized groups of women are at a higher risk of developing postpartum depression although their lack of using mental health services would say otherwise.

Women of color in particular tend to brush aside any discussions regarding mental health and insist on the “I keep it to myself” ideology. This is partially due to the lack of medical literature being available in languages other than that of the host country. Other reasons include marginalized women feeling de-humanized based on how they have been treated in health clinics in their home country as well as their host country.

Studies show that healthcare providers in Canada view immigrants as a burden on the social system and view health care as a privilege for pregnant women. These are personal, albeit discriminatory beliefs that in no way should affect the care that should be provided by healthcare workers. Access to health care is a basic human right regardless of race, age, status, or citizenship. Healthcare professionals need to be given the tools to help provide the best possible care to vulnerable groups of women whether it may be through spending more time by explaining each and every medical term related to their care or by understanding how to appoint female interpreters.

In Sweden, the participants of the survey had mostly positive experiences, but still felt guilty and shameful when talking about their mental wellbeing. Their overall experience with nurses and healthcare providers was positive. In the UK, migrants felt ostracized and dehumanized while in the US marginalized groups of women had many more obstacles in addition to being an immigrant. Neither of the participants in the UK or US had positive experiences with nurses or other healthcare providers.

Nurses and other healthcare practitioners can benefit from cultural awareness. By understanding different cultures and also considering that people from different cultures come from different backgrounds. Healthcare professionals need to understand that childbirth and postpartum life is even more stressful for marginalized women in

comparison to the non-immigrant local population. Communication is key when providing care and the faster governmental and local authorities include people of color when addressing mental health or health care in general is when women of color will begin to share more.

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Appendix 1: Content analysis of academic literature

Author(s), Year, Country	Title	Aim	Method	Results
Almeida et al., 2016, **United States**	**The impact of migration on women's mental health in the postpartum period**	Assessing and understanding the influence of immigration on the psychological health of women after childbirth.	89 immigrants and 188 Portuguese women were included in the study. The questionnaire included the application of four validated scales: Mental Health Inventory-5, EPDS, Perceived Stress Scale, and Scale of Satisfaction with Social Support. Statistical analysis included t-test and Chi-square or Fisher's test, and logistic regression models	Immigrant women had an increased risk of developing PPD. A previous diagnosis of depression, adverse obstetric outcomes in previous pregnancies and obstetric complications during the last pregnancy are scientifically recognized to induce accountable levels of anxiety and discomfort and to be associated with increasing odds of postpartum depression.

Christensen et al., 2011, **United States**	**Unintended pregnancy and perinatal depression trajectories in low-income, high-risk Hispanic immigrants**	Identifying depressive symptoms during pregnancy and through the first year postpartum and examining the association between unintended pregnancy and depressive symptoms	217 low-income pregnant Hispanic women were enrolled in the trial. Women were eligible if they were between 18-35 years old, no more than 24 weeks gestation and at high risk for major depressive episode in the perinatal period but not currently depressed.	Prenatal care providers should inform women who report unintended pregnancy of their increased risk of PPD, provide them with information on the symptoms and treatment options, even if they demonstrate no or low symptoms. Health care providers should be prepared to offer the proper mental health referrals and if possible, screen new mothers for depression in the months following birth.
Collins et al., 2010, **United Kingdom**	**Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors**	To identify the rate of PND among refugees, asylum seekers and immigrant women and highlight the risk factors among them.	Qualitative study, a systematic review.	Immigrant women are at higher risk of PND in comparison to the general population with rates of PND in migrant women ranging from 24% to 42%. Lack of social support is strongly associated with PND as asylum-seekers and refugees are often separated from family and friends.

Daoud et al., 2019, **Canada**	**Postpartum depression prevalence and risk factors among Indigenous, non-Indigenous and immigrant women in Canada**	To compare prevalence and risk factors across immigrant, Indigenous and Canadian-born non-Indigenous population groups to guide better programming to prevent PPD among mothers in different minority groups in Canada.	Quantitative study, data was first obtained from a 2006 survey on maternity experience after which 74,231 participants were collected: N = 3152 Indigenous, N = 53,803 Canadian born non-Indigenous and N = 17,276 immigrant mothers.	The study revealed that Indigenous and immigrant mothers in Canada are at higher risk for PPD compared to non-Indigenous Canadian-born mothers, with immigrant women experiencing slightly higher risk for PPD than Indigenous mothers.
Dennis et al., 2017, **Canada**	**Postpartum depression risk factors among recent refugee, asylum-seeking, non-refugee immigrant, and Canadian-born women: results from a prospective cohort study**	To examine and compare the risk factors for PPD among recent migrants and Canadian-born women and asylum-seeking and non-refugee immigrant women.	1536 women were recruited from 12 hospitals to complete questionnaires 16 weeks postpartum in order to examine risk factors for PPD symptoms.	Recent migrant women had significantly higher rates (6%) of depressive symptoms at 16 weeks postpartum than Canadian-born women (2.9%). Asylum-seekers had the highest rate (14.3%), followed by refugee (11.5%) and non-refugee immigrant women (5.1%).

Derr, 2017, **United States**	**Mental Health Service Use Among Immigrants in the United States: A Systematic Review**	To gather data and findings on mental health service utilization among immigrants and to inform future research efforts addressing access to care.	Qualitative study, literature review.	Results indicated that immigrants from Asia, Latin America, and Africa use mental health services at lower rates than nonimmigrants, despite an equal or greater need.
Firth et al., 2018, **United Kingdom**	**Vulnerable migrant women and postnatal depression: A case of invisibility in maternity services?**	To explore the issues surrounding immigrant women developing postnatal depression and presenting reasons why it goes unnoticed by healthcare professionals.	Qualitative study.	Vulnerable migrant women have an increased risk of developing postnatal depression. Risk factors such as dispersal, fear of immigration and lack of familiarity with healthcare systems affect postpartum depression being identified.
Maxwell et al., 2018, **United States**	**"I keep it to myself": A qualitative meta-interpretive synthesis of experiences of postpartum depression among marginalized women**	To understand the PPD experience of women belonging to marginalized groups.	Qualitative study including a QIMS methodology (qualitative meta-interpretive synthesis).	Belonging to a marginalized population creates consequences which can intensify the PPD experience. Engaging in cultural humility and culturally responsive care for those experiencing PPD may allow for more effective interventions.

Skoog et al., 2018, **Sweden**	'Happy that someone cared' - Non-native-speaking immigrant mothers' experiences of participating in screening for postpartum depression in the Swedish child health services	The aim was to explain a non-native immigrant mothers' experience of participating in screening for PPD.	In total, 13 non-Swedish-speaking immigrant mothers were interviewed approximately 1-2 months after being screened for PPD.	The perspectives of immigrant mothers, specifically those who are non-native speaking, receive little attention. Interviewing these vulnerable mothers was important and gave valuable information for future clinical practice.