Migrant mothers' mental health communication in the perinatal period

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SEPTEMBER, 2019

FUNDERS
The Wellcome Trust
The British Academy

PRODUCED AT
The University of Surrey, Guildford, UK
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This report owes its existence to generous funding from the Wellcome Trust who I am very grateful to for recognising the importance of migrant mothers’ perinatal mental health and funding this study. Likewise, my gratitude to the British Academy, for funding for a prior study on early motherhood which made it possible to find tailored data on digital communication.

A number of excellent people have contributed to this project. I thank in particular Louise Davies, Nadine Page and Victoria Redclift. I thank Jasmine Kapoor for her outstanding contributions to fieldwork, Dagmara Kowalska for preliminary coding and Daniel Beszlag for throwing himself fully into the final lap of analysis and evidence searching. Particular thanks to Nadine Page for connecting me to an exemplary team of healthcare professionals who took an interest in this project, some of whom took part in it as well, and many of whom will be present at the launch event for this report. My thanks to Paul Hodkinson for the motivation he often provided and for his interest in the progress of this work. And much gratitude to the healthcare professionals who took time out of their busy schedules to speak to us about the project.

My greatest thanks go to the mothers who spoke to us, let us into their worlds and homes and without whom this project would not exist.

Ranjana Das

Guildford, September 2019.
About this Report

This report brings together findings from a project on perinatal mental health difficulties amongst migrant mothers, funded by the Wellcome Trust (208437/Z/17/Z), and on early motherhood and digital media, funded by the British Academy (SG151884). Both projects involved interviews with mothers in their homes, with a very small number of them interviewed online. Healthcare professionals were sometimes interviewed on phone. Interviews were qualitative and semi-structured and took the form of free-flowing conversations broadly based on a topic guide. Recruitment through informal channels such as social media and word-of-mouth had limited success and participants recruited through this route accounted for around a quarter of the final set of participants. A recruitment agency was commissioned to administer a door-to-door questionnaire to recruit remaining participants who lived across England, covering mainly the Midlands the South of England and Greater London. Mothers came from a wide range of countries of origin largely in South Asia and Africa and a few from continental Europe. There was a mix of first and second generation immigrants in the final sample. A total of 68 mothers participated across the projects. All participants have been assigned pseudonyms. This report uses selective instances of quotes from interviews to illustrate overall findings and themes.
This snapshot of evidence is far from exhaustive and is intended to work as an indicative list of recent evidence on perinatal mental health difficulties in the context of migrant motherhood. It is intended as a starting point for further explorations into the subject matter.


This study aimed to find the differences in proportions of mothers suffering from Postpartum depression in varying Canadian social groups and to detect whether each group posed distinctive risk factors for the illness. Data from the Canadian Mothers Experiences Survey (2006/2007) was analysed in this paper by dividing the participants (proportionately to the population) into three groups: Indigenous, Non-Indigenous Canadian and Immigrant. This work found that there are significant differences in risk factors and disproportions in how many mothers experience Postpartum depression between the analysed groups. Recognition of the factors and tailoring treatment and prevention programmes to the varying social groups is pointed out as the key for progress in combating Postpartum Depression.


This study aimed to explore ethnic minority women’s experiences of perinatal mental health problems, how they seek help and what perinatal health services are offered in Europe. This study reviewed 15 projects on women of ethnic minority backgrounds in the UK. The paper found that women of ethnic minority backgrounds do not receive appropriate mental health support in the UK because of the following factors: lack of awareness about mental health illnesses; cultural expectations/stigma; culturally unsavvy, insensitive or dismissive health services. Further research is pointed as a necessity across Europe to explore the problem with greater depth.

This study examined associations between migrant status and region of origin in relation to mental health during pregnancy and 2 months after giving birth. The research used data from a French survey on 17,988 women, which divided them into 5 migrant categories. The analysis found that first generation and especially non-citizen migrant women were more likely to develop depression during the post-partum period.


This paper is a summary of what is known about perinatal mental health of migrant women. The findings and recommendations were based on the analysis of previous research and statistics. The paper concludes the following: many migrant women from Low and Medium Income Countries continue to live in difficult socioeconomic conditions and possibly experienced hardship during the transit period significantly increasing the risk of developing mental illness due to trauma or high stress levels; their poor material situation often makes seeking help regarding mental illness impossible; Community-based initiatives, interpreters and culturally-sensitive healthcare professionals present during routine checks and further data collection during interventions are emphasised as a necessity in combating the mental health problems among migrant mothers.


This study focused on analysing the prevalence of perinatal depression and its risk factors among migrant women on the Thai-Myanmar border. 568 women in their first trimester of pregnancy were interviewed and were put under observation for up to one year postpartum. The study discovered that most participants were poorly educated, often worked in the agricultural sector or had unpaid employment and over 25% of the group suffered from depression. Further findings are to be discovered.


This article focused on exploration of issues unrecognised by health services which increase the risk of developing postnatal depression and which often accompany migrant women. The research finds that: forced-migrant women (e.g. refugees) have the highest risk of developing postnatal depression; depression screening tools might not be accurate in identifying symptoms in this population; lack of awareness of how the UK healthcare functions is an obstacle in seeking appropriate care; migrant women in particular, have difficulties building relationships with midwives.
Logsdon, M. C., Morrison, D., Myers, A. J., Capps, J., Masterson, M. K. (2018). Intention to Seek Depression Treatment in Latina Immigrant Mothers. Mental Health Nursing, 39(11), 962-966. The article sought to find what determines Latina immigrant mothers’ will to search for treatment for depression and whether the severity of depression influences that will. 50 interviews were conducted with Latina immigrant mothers and analysed to answer these questions. The study found that the analysed group of mothers was more willing to seek depression treatment whilst having a generally good attitude towards mental health therapy, although better social support (e.g. large families) was a predictor of lower probability for seeking professional help.

O’Mahony, J., Clark, N. K., (2018). Immigrant women and Perinatal Mental Health Care: Findings from an Environmental Scan (Forthcoming) Issues In Mental Health Nursing. Issues in Mental Health Nursing, 39(11), 924-934. This study aimed to increase the understanding of immigrant women’s perinatal mental health services in Western Canada. Survey, interviews, document and relevant literature analysis were conducted. Four recommendations emerged as a result of the study: cultural safety and competency training for healthcare professionals would increase the probability of detecting potential risks of developing depression by migrant mothers; creation of community support groups is a necessity; new culturally and gender sensitive policy making has to take place to minimize the discussed problems; adjustment of depression screening must occur to also spread awareness about the illness to the close family.

Maxwell, D., Robinson, R. S., Rogers, K. (2018). “I keep it to myself”: A qualitative meta-interpretive synthesis of experiences of postpartum depression among marginalised women. Health and Social Care in the Community, 27(3), 23-36. This work’s goal was to find the answer to the question “What are the Postpartum Depression (PPD) experiences of women belonging to marginalised populations?”. Authors analysed data from 12 pieces of scientific literature. The study found that mothers from marginalised groups are at risk of more intense PPD experiences due to their racial, cultural or financial circumstances. Increased cultural awareness of the mothers’ circumstances allows for a more effective intervention. The paper also mentions existence of PPD triggers related to abuse experienced by mothers in the past, although more research is needed.

Anderson, F. M., Hatch, S. L., Comacchio, C., Howard, L. M. (2017). Prevalence and risk of mental disorders in the perinatal period among migrant women: a systematic review and meta-analysis. Archives of women’s mental health, 20(3), 449-462 This work was produced to evaluate the proportion of migrant women suffering from mental health disorders in the perinatal period and what risks contributed to the development of mental illnesses in this group. 53 studies from 6 databases were analysed giving a perspective on the topic in Australia, Canada and the USA. Minority ethnicity, low social support, lack of proficiency in the language of the host country, poor socioeconomic conditions and refugee or asylum-seeking status were detected as putting migrant women at increased risk of perinatal mental health problems.

This paper combined studies on migrant women’s experiences with postnatal depression to understand how services’ ability to help them could be improved. The research analysed 12 studies in 15 scientific literature pieces. This work found that: healthcare tends to not respond to the emotional needs of migrant women, keeping focus on the pregnancy itself, which might discourage them from seeking further help in case postnatal depression occurs; emotional and practical support during early stages of pregnancy are a good tool for preventing the development of Post Natal Depression (PND); it is recommended for the health services to develop working relationships with the migrant communities to build trust and develop better understanding of socio-cultural needs of migrant women through the presence of culturally appropriate interpreters and an ongoing training in support and cultural competence.


This study reviewed the factors, interventions and proportions of occurrence of perinatal mental disorders among migrant mothers from Lower and Middle-Income Countries. The authors analysed data from 40 studies resulting in the collection of 19349 responses to various projects strictly relevant to the topic. The paper pointed out several findings: one in three migrant women suffer from perinatal depression; risk factors for developing mental illness are complex and context specific for each mother; previous depression and poor social support are predictors in developing perinatal depression amongst migrant and non-migrant women; the cultural barrier can pose a significant hardship for migrant mothers. The study also emphasised the importance of development of health services to address the analysed problem given the increasing global migration trends.


This paper has three main objectives: to explore female migration to the UK (to develop understanding on levels of diversity); to investigate why migrant women seek help from maternal mental health services relatively rarely; to consider how maternal mental health care providers can improve their services to meet the needs of migrant women. The analysis of statistics, and topic-related data resulted in the following findings: pregnant and early postnatal migrant women are a far more diverse group than previously suspected; the group experiences material and cultural barriers preventing them from seeking help with mental illness; maternal mental health practitioners will need to obtain a new set of skills related to cultural awareness to be able to help the analysed group.
This review sought to examine risks and rates of postnatal depression among refugee, asylum seeker and immigrant women in developed countries. A thorough literature and databases search was conducted in order to achieve the goal. The work concludes that up to 42% of migrant women in comparison to 15% of native-born women may be affected by postnatal depression. The common risk factors for postnatal depression amongst the studied cohort include: stressful life events, lack of social support and cultural factors. The authors identify all recent immigrant mothers as a group at high risk of developing postnatal depression.

This report was conducted to develop a better understanding of the extent to which maternal mental health care is capable of providing effective services to black and minority ethnic women. A literature review and, national and mother and baby units’ surveys in England, Scotland and Wales were conducted to provide information for this paper. The study concluded that initiatives to improve perinatal mental healthcare for Black and Minority Ethnic (BME) women are needed, Regional Managed Clinical Network should be developed as a body responsible for providing strategies addressing the provision of mental health services and that community-based models of support are favoured by BME women. Further research is pointed at as a necessity for improving the understanding of factors affecting poor diagnosis of mental health in the researched group.
Following on from Beszlag’s snapshot in this report, of evidence on perinatal mental health issues amongst migrant communities, it is clear also from race studies and healthcare that ethnic minority migrant mothers face increased postnatal mental health risks (Almeida et al, 2016; Latif, 2014) and migrant mothers struggle particularly with cultural taboos around mental ill-health (MIND, 2010; NELSHA, 2003)[1]. A few studies have investigated in particular the maternal mental health issues faced by migrant mothers (c.f. Onozawa et al., 2003; Edge, 2007a and 2007b; Almond and Lathlean, 2011; Babatunde and Moreno-Leguizamon, 2012). But, as the Race Inequality Commission identifies (2014), there is currently a “knowledge gap regarding the impact of cultural factors on maternal mental disorders” (p 6) and that existing structures are geared very closely towards Western women and a range of linguistic and cultural barriers stand in the way of migrant mothers finding adequate amounts of post-natal mental health support.

But, ‘migrant mothers’ as a term might risk constructing a monolith. The perinatal period was experienced vastly differently by the women interviewed, as their experiences of mothering were highly situated and contextual. When one speaks of any particular group of mothers – for instance when speaking of migrant mothers – one might risk failing to recognise and account for the various intersectional attributes which cut across each other to produce the experiences being spoken of. Class and privilege cut across migrant mothers’ experiences significantly. Privileged migrant mothers such as Kavya and Raagini, demonstrated significantly higher levels of engaging with the online and with myriad digital spaces, and both had family support, but for Kavya, this support made her feel significantly surveiled. Raagini, a migrant mother, but with many lines of privilege on a variety of different counts, and benefitting also from a supportive family, displayed high levels of confidence, resilience and familiarity with finding the kind of support she needed, online.

Women’s coping strategies and resilience to such a wide array of cross-cutting rhetoric in conditions of the perinatal ideal are and will continue to be divergent. Some like Nasreen, or Raagini, reported very high levels of offline social support, high amounts of confidence in their own professional roles and positioned everything perinatal as a question of ‘choice’ and control.
Nasreen confidently spoke of hypnobirthing communities online and her determination to avoid “a messy birth”, and Raagini reported very detailed, and organised research online to prepare for birth. Raagini’s significant confidence, and high levels of resilience and literacy contrast starkly to, for instance, Ollee’s, whose circumstances of isolation, severity of experiences and emotional struggles, makes it impossible for her to even consider engaging with others, when online or offline. As she says - I looked on-line to see if I could see any groups, I didn’t join any though, I didn’t join any. Because I thought have I got perinatal mental health difficulties, I thought that to start with, when I didn’t pick her up. And I thought, no, I’ll be alright tomorrow, I’ll be alright in a few days, but I wasn’t. Just feeling ... I just felt really down, didn’t want to burden anybody with it, just kept it to myself”.

Women’s offline support networks are highly complex, and their existence alone should not be taken to indicate the availability of support. Large offline support networks, often female support networks, paint a less straightforward picture than is expected. In many cases, mothers reported that they felt monitored and subjugated by the very networks which surrounded them and indeed might even have been providing them practical everyday support. Bearing in mind such a wide diversity of contexts, communicative practices, nature and severity of perinatal difficulties and resilience, it is critical that work done to support maternal well-being does not bypass these issues and can work with critical questions about difference and diversity amidst wider National Heath Service (NHS) ambitions of delivering culturally competent care.
Mothers perceptions of perinatal mental health difficulties

1. The perception of motherhood as ‘a blessing’ (especially amongst wider relatives and family) creates a pressure on mothers often leading to escalation of perinatal mental health difficulties.

“I think one of the worst things about it was that you’re not really meant to talk about it, because you’re meant to be so happy that you’ve given birth and you love your child, and you’ve got this blessing, and obviously you know …” Kaavya

2. Many participants report lack of awareness about perinatal mental health difficulties within the community. Often close relatives attach stigma to perinatal mental health problems, making recognition and reporting the symptoms to a HCP very difficult.

“They outcast you totally, they don’t do anything about … You’re treated more differently then.” Shona

3. In particular, older generations very often are reported to contribute to the development of perinatal mental health difficulties by imposing traditional perceptions and sometimes superstitions on mothers’ lives.

“Their idea of mental health is completely different, they think any form of you know mental health means you’re a psycho basically” Shona

4. The nature of perinatal mental health difficulties hinders mothers’ ability to take action, often making it impossible to actively seek help.

5. Mothers within the analysed community often do not have time to rest after giving birth due to social pressures, which is reported to initiate perinatal mental health difficulties. Analysis has shown that in many cases in the researched group, the perception of motherhood as ‘blessing’ and necessity of maternal ‘sacrifice’ for the child, disregards the possibility of the mother feeling exhaustion after labour and birth.

“You’re responsible for the baby, it grows in you and you know they say the mother’s at the heart of everything and the mother’s responsible and things like that, so I think it really fell upon her shoulders to make herself better somehow.” Ria
6. One of the most commonly reported immediate causes of developing perinatal mental health difficulties is the lack of stimulating activities and an extensive amount of time spent at home, making social isolation despite an extensive at-home familial network a significant struggle.

7. Loneliness and the extensive amount of time spent at home are reported to be significant causes of perinatal mental health difficulties development. The sense of lack of purpose and self-development accompanying the process of early motherhood prove to be unbearable for many. Paucity of dedicated self-development workshops for mothers, during which their children might be provided with care, or mothers' groups focusing on maternal development and progress instead of solely baby development and progress might be useful.

“I want to get out of the house, I feel like I’m stuck, I need to get out of the house, I need to shove her into a school, into a nursery, I need to, you know, get my life back, get my career back on track and everything.” Tara

8. Mothers cited a range of factors contributing to perinatal mental health difficulties –
  - Proximity of in-laws
  - Religious taboos and restrictions
  - Superstition
  - A high emphasis on tradition in the family
  - Early, arranged or abusive marriages
  - Lack of a supportive partner
  - Giving birth to a baby of a sex viewed as less desired within the community
  - Strong perceptions of themselves as active/independent/hard working/sociable
  - A recent change of residence
  - A history of miscarriage or giving birth in any other way than what is considered 'natural'.

Opportunities spoken about by mothers

1. An opportunity to communicate the problems experienced by mothers is almost unanimously pointed at as the most helpful tool in fighting perinatal mental health difficulties. The need to be able to speak up and speak out is significant.

“they do send you a list of places you can go for like playgroups, for example, like to take your child, but it’s very, it’s ... it’s hard to go out when you’re in certain states of depression.” Edna

2. Gaining an understanding about perinatal mental health difficulties – the knowledge that perinatal mental health issues are often common and that one is not alone in facing these – is often reported by participants as a therapeutic experience.

3. Support groups were commonly reported as the most effective way to fight perinatal mental health difficulties. However, many participants were not aware of their existence, or were not able to find an appropriate one until the late stages of perinatal mental health difficulties.

“I think seeing other mums and ... and interacting with other mums and seeing him happy playing, and being able to talk to other mums, it helped a lot.” Tanaya
5. Social media, blogs and fora (see Das's detailed section on this issue later in the report) contribute to achieving a greater understanding about perinatal mental health difficulties, but many remain offline or very lightly connected online. The most therapeutic features reported seemed to be the ability to provide understanding of how common perinatal mental health difficulties really is; enabling mothers to communicate the problems and share their thoughts in a safe environment; socialisation and providing a sense of purpose (many mothers reiterate that they do not want help but are keen on helping others through e.g. giving advice, which is also experienced as therapeutic); accessibility of these without the need to organise childcare at specific times.

6. However, it has been found that many Internet fora are not judgment-free, especially in the researched community. It might be useful to create small private social network groups, specific to the mothers’ area and circumstances, with access granted by HCPs, who would also have the role of a gatekeeper. Further, assigning HCPs to these groups as advisors, who might oversee the conversations once a week, could enhance the therapeutic qualities of these networks. Such a step, of course, also has its potential downsides in terms of stilting and halting free-flowing conversation.

7. Partners and close family are reported to be most likely to first witness the change in a mother's behaviour hence they have the greatest potential in initiating searches for help. Yet, often, these networks are where mothers experience taboos, stigma and surveillance. It might be worthwhile for HCP to aim to meet the mother's family at least once, during which the topic of perinatal mental health might be briefly discussed.

**Perceptions of support institutions and professionals**

1. Medication seems to be very often perceived as more harmful than beneficial. Prescription of anti-depressants early on in the interaction with a mother from the analysed group seems to result in loss of trust in healthcare professionals (HCP).

> “doctors offered me you know medicine, but I said no, you know at the time I was breastfeeding, and at the same time one of my friends has depression, and she take the tablets, it doesn’t help her, you know” Nia

2. Social Services are commonly reported as an institution causing anxiety in the analysed community of mothers. This often results in participants' lack of will to interact with a HCP or admit existence of mental health (MH) issues.

> " I think I was afraid that if I declared it to her that how I was actually, truly feeling, that doctors and other, other organisations would get involved and then next thing you know social care’s involved. Sara

3. Nurses and midwives seem to represent the most trusted groups of HCPs, and they hence have a high potential of discovering the symptoms of perinatal mental health difficulties early on. Their work however was often acknowledged as too heavy on record-keeping, significantly restricting the much-needed time spent talking to mothers.

4. The NHS is often experienced and spoken about as an understaffed institution.
5. Mothers often expressed an expectation for Health Visitors to put more emphasis on assessing mothers’ mental health with greater depth during the visit and felt as though there was limited time and limited empathetic understanding during interactions with health visitors. Perinatal mental health difficulties often made its sufferers unable to take action, hence underlining the importance of early recognition by an HCP. Although in some cases leaflets with information might be helpful, it might often work best for HCP to take the first step on behalf of a mother showing symptoms of perinatal mental health difficulties, discussing support groups/classes/workshops and even organising the first meeting for her.

“I know the nurses have got a lot of things to do, in terms of record keeping, the record keeping and stuff, but I think what needs to be changed is they need to actually spend time with the woman that's had the baby. Records are not important as much as sitting with the mother” Arshi

6. The length of waiting lists for receiving help from the NHS often discourages mothers from attempting to ask for help from the health institution.

7. Mothers’ felt that their own wellbeing was often neglected during routine baby growth and development assessments.

“I know midwives and General Practitioners (GPs) and health visitors, when they check baby they also ask about her health, about ... they also check the mother. But not everyone does that in-depth really.” Anushka

8. Familiarity and continuity of contacts with designated HCP is a strong factor contributing to mothers’ openness about experienced problems.

“So if you’re seeing the same person, at least they know who you are, they’ve seen your face before, and at least, I mean they might not remember exactly everything you said to them the last time you spoke, but at least when you’re speaking to them, you feel more comfortable because you’ve already seen that person, it’s not a new face to you. And especially if you’re going through that, you know, you’re already worried that people are going to be judging you, so having to see someone new to tell your story again...” Nritya
Digital communication is not accessed by all, and even when it is, it has complex, nuanced outcomes. Many mothers are not online, many who are online appear to seek information only and not support, and telephony continues to be significant.

**Unevenness in Access and Use**

- Interviews with migrant mothers, especially those from lower socio-economic backgrounds, showed many accounts of isolation throughout the perinatal period, despite them being surrounded by a larger extended family (and often, precisely, due to being surrounded by a larger, extended family by whom many felt surveilled and monitored). Some were entirely offline, and often, dependent on their husbands to top-up phone calling cards to call sympathetic relatives on a different continent.

- Shamima, who arrived in the UK to stay with her new husband, found herself having two children, both born with significant special needs and born through complex and traumatic labours. She found it difficult to speak during interviews, in a house full of relatives offering her help with material aspects of the day to day, but from whom she says she had to hide her perinatal emotional difficulties. She relied on her husband’s income to buy phone scratch cards to call distant relatives instead, while she managed a household and looked after a tube-fed baby at home.

- For many like Moumita, Jaya, Heeya or Hema, not surrounded by a family of relatives, small mobile apps and internet telephony were the extent of connection, both on and offline.

- Runia is a second-generation migrant mother from Leicester. She experienced the perinatal period as what she described as a “cataclysmic incident, like some kind of an earthshattering thing”. She expressed a lack of choice as “you just listen to whatever they say, don’t you. But maybe I didn’t really research into it enough myself, but if I’d known more or said help me more...”.
As she located the responsibility for things going wrong on her own shoulders, for not researching more or asking for help more, rather than a broader system of pressures which did not support her, she turned to the world of peer to peer forums online to be able to make decisions for herself. But as she did so, all information she found sat within moralised, divided camps, and contrasting, and highly emotional networks of debate.

- Runia speaks about how she commuted from one source of information online on Netmums and Mumsnet, to another, until she, in her own words, found the ‘right’ information. In the context of real and perceived cultural pressures both to exclusively breastfeed (which she was struggling to establish) on the one hand and to move to formula to increase baby’s weight on the other (which she struggled to commit to), she spoke of finding the right information finally, which turned out to be a version of combination feeding. Information gathered till that point had felt restrictive, and ‘wrong’ to her, something she described as ‘not scientific’. Runia undertook extensive online searches for, encountered, and interpreted a wide range and sources of information ranging from official leaflets as online PDFs to lay, yet professional looking infographics produced within online groups, within the cultural paradigms and the associated moral weight attached to infant feeding methods.

- Anisa was a second-generation migrant mother from an African background, and whilst she did not have family locally, she had a very supportive and strongly connected network of sisters and a mother she adored, living a short train ride away, and she had a fulfilling career she was eager to return to when we spoke. She had not experienced significant perinatal difficulties and was happy and feeling positive she said, throughout. But she noticed on her WhatsApp new mothers’ group, subtle but definitely present degrees of self-censoring from those women who felt their experiences did not quite fit real, or perceived, dominant narratives of the perinatal period - "For my antenatal group from the hospital, we made a little WhatsApp group, just… So there were a few people just before me. Like two or three weeks before. Most of them had... Actually I think before me most of them were natural births. But one…..But it was almost after... But I think people who had a caesarean seemed to hold off their announcements a little bit... I’m not sure."

- So, as Anisa makes evident, even using small-scale, private online groups, and doing the emotional labour involved with making decisions on when disclosing something might be safe, even small-scale inter-group conversations might be difficult and sometimes stilted. It seemed, even in small-scale online groups such as Whats-App groups which had a history of offline connection, self-disclosure might be halted or contained owing to pressures and expectations of ‘good mothering’.

- For Leticia, a newly arrived migrant mother, with severe experiences of trauma, including child-loss in her country of origin, the disconnection, both on and offline was stark, in the face of a sense of feeling overwhelmed with everything that was going on as she arrived in the United Kingdom. Leticia’s sense of not needing online connections or information links to a stark sense of isolation and feeling overwhelmed in a new country with a significant set of cultural differences to overcome.
Many, like Nritya or Jemima spoke of using the online world very little, for information, rather than connection, and some, like Rumia emphasised the nature of information found online as necessarily “not very scientific”, emphasizing the pursuit of information far more over connection. Indeed, we cannot extrapolate from this group to conclude that they somehow did not ‘need’ online ties or sources of support, or that their offline networks were always enough or fully satisfactory, because that is not the case in reality. Amongst this group of mothers, who had an information-only, rather than connection-based approach to, and expectations of online spaces, apps emerge to be significant. Neeta spoke of how apps helped both her and her partner. Vanini, who did not venture online at all, spoke of the importance to her, almost as a daily ritual, of pregnancy progression apps to keep worries in check. Hema articulates this in her use of an app to cope with low-level worrying about her pregnancy and its progress.

Following this example, we often found lower levels of internet use, and hence far lower levels of being able to benefit from the many instances of positive and supportive uses of the internet, keeping in mind of course the many darker, and less-than–supportive aspects of practices unfolding in these spaces. Harini, spoke of significant isolation, and of venturing online to find information, but what became significant for her in the end was audio-calls and mobile telephony, which served on the one hand to connect her to one or two key relatives, but arguably, disconnecting her from a potentially wider network of support, albeit uneven in nature. “I used to see online, you know, that apps and everything they send you message every week about what’s going on with the baby, how growing and I used to do a lot of online search. What to eat, what not to eat, things like that, so. I’ve got few friends, but all went to work and a bit busy, so we used to talk but not that much. You know how life here is…. We talk through our phones and Skype and things like that”

A heavy use of internet telephony to connect with families, a larger reliance on in–person services at children’s centers, and low use of online fora for information or support seeking came up frequently in conversations with mothers from migrant backgrounds who were also socio–economically disadvantaged. In general, amongst this group of mothers, there seemed to be a greater focus on information seeking from the internet as opposed to support-seeking or venturing into the more social dimensions of online spaces. However, some then went on to use this information for broader social purposes within offline networks.

The use of networked media in familial relationships

Moumita, a first–generation migrant Bengali mother in the UK, explains how her in–laws did not, owing to ‘family and cultural norms’, permit her to invite her own family to visit or stay with her, to provide crucial perinatal support. She was living in a village in India, when she entered into an arranged marriage with a food factory worker living in a UK city, who was originally from India. She arrived in the UK with no family of her own, and unexpectedly for her, found herself pregnant within two months of her arrival.
She had strong, warm relationships with people back in India, but was unable to invite any of them over owing to her husband’s family in the UK refusing to let her do so. In theory, Moumita was surrounded by a network of relatives (her husband’s family), but in practice she was significantly isolated, her broken English in the way of her being able to access any meaningful amount of resources both on and offline. "I go on the Pampers website and just read what happened... I read and I tell my aunty and others in india. I WhatsApp or Skype as well."

- Moumita spoke about how she used limited information she could find on nappy websites to piece together the basics of what labour might look like, or what terms such as waters breaking actually mean. She would then use information she had read online in her WhatsApp and Skype calls back to India, filling gaps in information, establishing her own expertise and agency in her own eyes, in these conversations as she transmitted information back to female relatives back home, whilst being surrounded by a large, but unsupportive offline network of in-laws in a country very foreign to her.

- A similar story, in some ways, is reported by Vanini. Like Moumita, she is of Indian heritage and living in the UK, but unlike Moumita, she is surrounded by warm, supportive and helpful offline ties and a largely functioning on-ground network and thus had a low need for emotional support. What she missed and needed though, was up to date information for her to feel in control and empowered through her own perinatal journey with hyperemesis which needed hospitalisation and a traumatic birth. She needed information on all of this, to circulate through her own offline networks from where she suspected a range of pressures and wrong information were making their way to her. Whilst what she needed, on the surface was information the information was not simply information alone. It was needed, also, to play a role for her in her existing strong, offline ties, to establish her authority and expertise and help her on-the-ground networks work better for her. And hence, information-seeking through apps was regularly used by her to fill gaps in on ground networks to help them work even better peri-natally.

- While for native British mothers, and equally for migrant mothers from professional and affluent backgrounds, the benefits and risks of digitally mediated social ties emerged to be comparable. Migrant mothers from less affluent socioeconomic groups showed few online ties, owing to not accessing these spaces, although they reported feelings of isolation and being alone while in a crowd, and even feeling watched by large extended families. This is echoed by findings on Polish migrants from Ryan (2011), who notes that the greatest gendered networking seemed to emerge around childcare, and despite migrant mothers engaging in childcare-centred ethnic, local networks, these did not necessarily amount to sustaining, emotionally supportive, strongly bonded rapports.

- Nasreen, originally from Bangladesh, had three children, aged eleven, six and two, at the time of the interview, and described herself as a busy housewife. When Nasreen got pregnant with her third child, she wanted to figure out a way to be more in control of how birth and perinatality went for her, from labour to breastfeeding and she started looking up resources online.
Whilst she established very quickly from a range of videos and online groups that she wanted to have a natural birth, and that she wanted to exclusively breastfeed, she encountered, within her relationship, some resistance to some of her ideas – for instance to have a natural birth at home. "Yes, I looked up the hypnotherapy online what that was all about. ..And that helped me. .. it reassured me to think it is possible. I think having hope makes such a difference." The use of these online materials to open up dialogue and negotiate positions in her relationship within the context of what she described as a ‘traditionally’ gendered family is significant here.

- Marie, a Zimbabwean mother living in the UK, also demonstrates, albeit in a different sense cross-cutting pressures around 'good mothering' lie embedded within support and supportive structures, meaning few relationships are experienced as fully supportive or fully unsupportive. Whilst Skype became a lifeline for Marie, with family back in Africa, it was through Skype that a series of misunderstandings and pressures were transmitted as to why Marie was not coping well on her own in the UK with two high risk pregnancies. Marie was a first generation migrant mother, both of whose pregnancies had been classed as high risk meaning that she had to be in hospital every two weeks with both pregnancies. She used a range of online resources for her second pregnancy, anxious not to repeat her son’s suffering with colic. She was plagued by cross-cutting pressures between Africa and the UK. Back in Zimbabwe, she felt nobody quite understood how hard it was to cope alone with high risk situations. She also encountered borders and immigration restrictions so much so that her “GP had offered to write a letter to the Home Office for me to be able to bring somebody over to help”.
As already noted, one in five women will be affected by mental illness during the perinatal period (RCOG, 2017). Furthermore, Fellmeth et al. (2016) highlighted in their systematic review of 40 studies that one in three migrant women from low and middle income countries suffer from perinatal depression and that social support is an important protective factor. As noted in this report, cultural barriers are suggested as a significant hardship for migrant mothers and the importance of developing health services to address the barriers is emphasised, given the increasing global migration trends.

A small group of Registered Health Visitors (HVs) working within a University in the South of England were invited to participate in 1:1 semi-structured interviews with a member of the research team. All four members of the group volunteered to give their experiences of communication practices with mothers of South Asian descent in the postnatal period regarding their mental health. The aims and objectives of the interviews were to understand:

1. The way in which mothers communicate with their family/friends/other interpersonal relationships;
2. What feelings/thoughts migrant mothers with post-natal mental health issues present with;
3. HV’s sensitivity of women’s cultural needs/personal circumstances;
4. What support migrant mothers seek from HVs; and
5. What gets in the way of giving support.

Interviews took an informal, semi-structured format in order to achieve an appropriate balance between ensuring that the key topics as above were covered with each of the HVs and allowing flexibility for them to recount their experiences and understandings freely. A topic guide was used but the precise content and order of the interviews did vary from one interview to the next according to the issues that emerged.

A thematic analytical approach was used to identify patterns in communication practices between HV’s and women from the following countries: Brunei, China, Indonesia, Malaysia, Philippines, Thailand and Vietnam.
Findings revealed that -

· Although the HVs practiced in different areas in the South East of England there was general consensus that migrant women are isolated and in need of connectedness.
· On reflection the women that they had worked with did not express feelings of depression and did not seek help for mental health problems either. It was felt that it was difficult for women to acknowledge post-natal depression let alone accept it.
· Aspects of depression were not recognised as depression. For example, isolation and low mood would be explained as missing home, friends and family.
· Whilst women would smile and say everything was alright, their body language may say something different. However, this was not explored further because of the perceived language barrier.

The HVs all said they felt disappointed with their practice and if they could go back would change how they assessed and supported women.

· “If I could go back I would change my practice. It was very mechanical then”
· “I would have tried to develop a relationship by visiting women at home for longer”
· “I would have facilitated more open communication”
· “I would communicate without fear that their first language was not English”

All HVs agreed that language was a barrier to engaging women as was their lack of training in working with migrant women and understanding the cultural differences. They also agreed that they should have had training in developing therapeutic relationships and skills to facilitate listening visits.

Thus, going forward, four main themes need addressing:

· Education for all health care professionals at both pre and post registration levels;
· A multidisciplinary approach to understanding cultural differences and awareness;
· Developing therapeutic relationships and building rapport with migrant women; and
· Engaging migrant women more in mental health services.

Embedding training in pre and post registration nursing, midwifery, paramedic and health visiting professional practice courses and working closely also with clinical practice partners will be beneficial. A greater focus on educating women about mental health as part of their ante-natal care would also bring significant advantages.


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