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An Exploration of Perception of

POSTNATAL DEPRESSION

in African women in Greenwich Community Health Care Services
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Dedication:

This study is dedicated to the memory of my late brother Mr Kehinde Olanrewaju Sodipo who died a few months starting the project.

Executive Summary

In the United Kingdom, 1 in 10 women experience postnatal depression following childbirth (Lewis, 2004). Postnatal depression has profound effects on quality of life, social functioning and economic productivity (Chisholm et al, 2003). The health consequences could also lead to adverse long-term emotional and physical development of the infant (Miles, 1993; Jones, 1994; Boath et al, 1998). Postnatal depression is also predictive of child cognitive and behavioural disturbances at the age of 3 years (Campbell et al, 1995; Murray et al, 1996). Moreover, failure to identify these women often leads to safeguarding concerns for both mothers and infants (Warrington et al, 2001; Department for Children Schools and Families, (DCSF) 2010).

Health visitors play a vital role in identifying and supporting women who experience postnatal depression. Their role includes supporting families from birth to five, thus giving opportunity to provide a prolonged period of contact and support to women affected by the disorder. However, evidence suggests that most vulnerable women including Black Minority Ethnic (BME) groups do not always receive this vital care. This is because the symptoms are overlooked or misdiagnosed (Edge et al, 2004; Briscoe, 1989; Lewis, 2004; MIND 1993, National Service Framework for Mental Health (NSF), 2005). In a study by Amankwaa (2003) and the current study, participants were reluctant to expose frailty, thus making it difficult for professionals to provide adequate diagnosis or treatment.

As part of the Mary Seacole leadership award project, I undertook a study to explore African women's perception of postnatal depression. The study aimed to explore the cultural determinants of postnatal depression and to help health professionals understand and recognise symptoms in these groups of women. This, in turn, will help to improve their health outcomes. Findings reveal that almost half of the participants in the study exhibited undiagnosed symptoms of postnatal depression. Equally, these women did not perceive the symptoms as abnormal or related to illness. This study highlights these symptoms were not identified by health visitors despite having prolonged contact with the women. It is imperative that health professionals who are in contact with women are educated and prepared to recognise subtleties in symptoms and manifestation of the illness and are conversant

with the diagnostic tools. This study provides an insight into complex values and belief systems in a group of African women which shape their perception of postnatal depression.

Chapter 1: Background

The postnatal period is the period following the birth of a baby (Omar & Fattah, 1998) extending up to one year after delivery. For the majority of women this marks a relatively healthy period in their lives. However, it is estimated that a significant number of families are affected by postnatal depression with 10-15% of women diagnosed with this disorder (Leverton and Elliott, 2000; Lewis, 2004). Despite the widespread nature of the problem the current process of diagnosis and treatment is not standardised, is often chaotic and may result in inappropriate care and treatment (Clifford et al, 1999).

Postnatal depression is defined as an affective mood disorder often occurring in women up to one year after child birth (Gibson et al 2009). This disorder is often characterised by feelings of loss and sadness and sometimes the loss of self-esteem (Olshansky, 2003). The depressive scale of this disorder and its presentation ranges from mild depression requiring minimal intervention to puerperal psychosis which often requires multi-therapy intervention, hospitalisation and long term support (Williamson and McCutcheon, 2004). Depression accounts for the greatest burden of disease among all mental health problems, and it is expected to become the second-highest among all general health problems by 2020 (Murray and Lopez, 1996).

Minority ethnic groups represent 29% of the population in Greenwich with an estimated increase to over 33% by 2011 (Whiteman and Guite, 2008). The Public Health Report (2008) from Greenwich Primary Care Trust predicted a 28% increase in local birth rate between 2002 and 2006 in the local data. There is also a predicted population increase from 46% up to 68% in some of the deprived areas where BME groups are more prominent. This means there is a likely increase in undiagnosed cases of postnatal depression in the area.

Similarly, there is a national recognition that over 6 million of the population in the United Kingdom experience some form of mental illness (depression), however about 2 million of these do not have access to psychological therapy (NICE, 2007b). With this in mind and the fact that the BME population is growing in Greenwich, there is a need to understand African women's perception of postnatal depression to

improve service development and outcome for these women. The African population is the second largest ethnic group in Greenwich (Census, 2001).

Perception as defined by the Oxford English dictionary is the way in which something is regarded, understood or interpreted. Applying this definition to the current study, Jones (2004) argued that the way a person perceives and understands their health is related to the subjective cultural experiences within a given society. Therefore, in order to understand how these women present, we need to explore their perception and the meaning they attached to the phenomenon of postnatal depression. Lewis (1976) posits the idea that culture is not stable and is subject to variations, innovations and change. This assertion was further illuminated by Edge (2005) whose study demonstrated that the way women understand and respond to depression is shaped by their cultural understanding of the disorder.

According to Kleinman and Good (1985), culture is described as shared beliefs, learned values and attitude which shape our influences on perception and form behaviour. In other words, culture represents a large group of people who share history, religion, language, thoughts or the lifestyle of an entire society. The term culture is also used in anthropology to refer to a complex system of values, beliefs and codes of conduct that are socially acquired. The study hopes to examine the influence of culture and ethnicity on the perception of postnatal depression in African women.

1:1 A Review of the Literature

A review of evidence was undertaken using a recognised search strategy of databases. These include subject headings MESH and text words to search Medline, Embase, CINAHL, Psycho INFO and other social care databases searched to elicit relevant studies. Table 1 presents the search databases.

Table 1: List of Data Bases

Database searched	Alternative search for evidence
Embase CINAHL BNI Psycho INFO Ahmed Health and social care websites Google scholar.	Hand search Grey literature Postnatal Depression Health Conference hosted by Royal College of Nursing Talking to colleagues Contacting voluntary sector such as MIND Use of own clinical Experiences.

This search identified 45 studies; only 9 were relevant and are included in the study. The majority of the studies were undertaken in other countries. Four were undertaken in the UK, 2 in Nigeria, 1 in Zimbabwe (Nhiwatiwa et al, 1998), Egypt (Omar & Abdel Fattah, 1998), and Ghana (Turkson, 1992). Earlier studies from East Africa (Cox, 1993; Swift, 1972) were also looked at.

The aim of this study is to explore the perception of postnatal depression in African women. The overall objective is to help health professionals understand and identify symptoms of postnatal depression in African women and to improve the quality of intervention.

1:2 The Evidence

A qualitative study by Amankwaa in 2003 looked at 12 women who have experienced postnatal depression in the past and noted that these African women believed that only white women get postnatal depression. This was considered a sign of weakness that did not represent a legitimate illness. The African women used distinctive language to describe postnatal depression. The name of the specific African country was not disclosed in the study; this is relevant as each country has variations in cultural presentation of postnatal depression even among African countries (Cox, 1999).

In 2004, in a rural area of Ethiopia, Hanlon et al (2009) conducted 25 in-depth interviews and five focus groups with purposely-selected participants. The

participants included pre-natal women, fathers, grandmother, traditional and religious leaders, birth attendants and community leaders. The aim of the study was to determine societal recognition of problematic distress states in the postnatal period. The problematic distress state was defined to include both spiritual and mental disturbance. Hanlon et al's (2009) study identified salient themes that respondents spontaneously describe as culturally problematic distress occurring in the postnatal period, but they did not consider it to be an illness. This bears similarities to the current study where women exhibited symptoms of postnatal depression but did not regard it as an illness. The implication for practice suggests that lack of identification could be a contributory factor in naming the presenting phenomenon of postnatal depression.

Edge (2005) conducted a longitudinal mixed-method cohort study between February 2000 and 2001. Women were selected from a large antenatal clinic. The Edinburgh Postnatal Depression Scale (EPDS) tool was used to screen 101 black Caribbean women and 200 white British women in Manchester – North West of England. The study compared the prevalence of depressive symptoms during and after pregnancy in black and white women from the same geographical area. Participants were assessed before, during and after pregnancy for increased prevalence of postnatal depression. The findings reported that despite a higher level of self reporting among black Caribbean women, they were less likely than white women to score above the threshold of EPDS > 12. Moreover, this group of women were equally likely to score above the threshold postnatally, yet they were less likely to receive treatment and more likely to be referred to secondary care. Other key findings from this study were; EPDS was not an effective tool for identifying predisposition to postnatal depression, their attitudes and perceptions of mental illness in black Caribbean women.

The overall findings suggest that black Caribbean women often have difficulties conceptualising postnatal depression, due to their tendency to minimise stress and their health seeking behaviour. However, current standardised tools such as the EPDS do not reflect the understanding and perception of women from BME groups as demonstrated by Clifford et al (1999). Edge's (2004) focus on ethnic groups offers greater understanding into the efficacy of the use of the EPDS. Although the findings from these studies were from Caribbean women, the overall evidence suggests that

using the EPDS alone may not be the most effective method for assessing women from different cultural background.

Oates et al (2004) looked at postnatal depression across countries and cultures and compared the emerging themes across different centres. This study found morbid unhappiness after child birth comparable to postnatal depression but not all saw this as an illness remediable by medication.

This cultural approach also helps to understand why boys, who are most valued in Asian and African societies, in western society are most at risk of insecure attachment, cognitive difficulties and behavioural problems if their mothers had postnatal depression (Sharp et al, 1995). The consequences of this delayed effect of postnatal depression for the subsequent generations could be substantial (Chisholm et al, 2003).

Abiodun (2005) used the diagnostic tool of the EPDS and the Maternity Blues Scale to identify women who were at risk. The outcome suggested that 17% of participants were identified as having postnatal depression. However, it is difficult to generalise the validity of the outcome due to lack of clarity in data collection. Moreover, the homogeneity in data collection could not be compared because participants remained in their cultural environment.

The findings therefore cannot be directly compared to the present study which looked at African women living in Greenwich, UK, whose thinking and perception might be different in the way they respond to postnatal depression (Cox, 1999).

Two anthropological studies, by Clifford et al (1999), and Oates et al (2004), in postnatal disorder, confirm the value of cultural education and training to assist with the understanding of the pathways to care and prevention of postnatal depression.

Chapter 2: Methods

This study used a focus group method to collect data from participants. Focus group is an in-depth, open ended group discussion that enables exploration of specific issues on predefined and limited topics (Krueger, 1988). The purpose of the focus group was to elicit and validate collective testimonies and group resistance narratives. These testimonies and narratives have been used by women and could be used by any subjugated group 'to unveil specific and little-researched aspects of women's daily existences, their feelings, attitudes, hopes, and dreams' (Madriz, 2000). Focus groups can facilitate the identification of cultural values and they are said to be valuable when researching ethnic minority groups (Wilkins et al 2002). For this current study, participants felt very comfortable within the groups knowing they were not alone in the way they felt during and after pregnancy. They were also able to share their experiences with their mother-in-law knowing others have the same experiences.

Despite the positive attributes of using focus groups, I was also aware of the potential influence of dominant group members. This means supporting unassertive participants to articulate their views. I was also aware that not everyone would be open about discussing deeply personal and sensitive issues in a group setting. One of the difficulties centres on recording data during the discussion whilst manipulating recording equipment and being attentive to detailed information. These difficulties were managed with a co-facilitator who assisted with field note-taking, verbatim transcribing as well as voice tape recordings.

2:1 Ethics Approval

Ethics approval was obtained from South London Research and Ethics Committee before approaching the women. An application was made through the Integrated Research Application System (IRAS) and a review of the process was made before the panel of the Ethics Committee. The Trust also gave Research and Development (R&D) approval before commencing the study.

2:2 Sampling, Eligibility and Recruitment

2.2.1 The Participants

Twenty-six women of African background aged between 16-45 years old (see Table 2, below), were purposively selected from the health visitors' list; all of whom were African women who had migrated and are settled in the UK. This age group was selected as it represents the reproductive and fertile record of a woman's life. Women under the age of 16 were excluded due to the complex and sensitive nature of the topic.

Participants were asked about their marital status and the kind of support network they have at home, as studies have shown that women's marital status and the kind of support network they have are significant risk factors that may predispose a woman to postnatal depression (Patel et al, 2002).

Similarly, their educational background or employment status may also affect their perception and the way they describe postnatal depression.

Letters were sent to all the stakeholders such as the health visiting teams, the homeless liaison team, the safeguarding team and the clinical psychologist team, after receiving ethics and R&D approval.

Table 2: The Participants

Country	Number	Education	Marital status	Employment status
Nigeria	11	2 have a degree, educated to a GCSC	9 married and single parents	1self-employed 1 on maternity 9 unemployed
Ghana	2	1 have above A/L studying for degree	married the other single parent	looking for job 1 student
Kenya	1	studying for a NVQ	s a boy friend not iving together	Student
Somalia	1	GCSC	usband abroad	Unemployed
Sierra Leone	2	GCSE	2 single	2 unemployed

2.2.2 Recruitment

Recruitment of participants was made easy by colleagues who supported the course of the study. Out of the 26 women invited, 22 confirmed attendances but only 17 participated in the study. Eight attended for Group 1 and 9 attended Group 2. The groups were seen on two separate days.

An information leaflet outlining the study (see Appendix 3), was sent to all participants followed by a 'phone call a week later. Transport was organised to take the participants to and from the focus group meeting. They were all given a gift voucher to thank them for participating in the focus group.

Each focus group lasted for two hours with 15 minutes break. Focus groups were held in the Children Centre which is a familiar environment for participants.

The benefit of having a co-facilitator meant the researcher was able to facilitate the discussion, while the co-facilitator was free to take notes and assist with the subsequent transcription of the data collected (Krueger, 1988).

2.2.3 Inclusion Criteria

It was difficult to develop a strict inclusion criterion due to limitation in numbers, but the following were essential to gather useful information for the study:

- Women in the postnatal period who have delivered a baby up to a year ago.
- Must be from African descent and between the ages of 16 and 45 years.
- Must be able to speak and understand the English language.
- Must have a live baby.

2:3 Data Collection

Women were given the consent form to sign to agree to participate in the group. A focus group schedule (Appendix 4), which focused on how women felt when they became pregnant, was used. The focus of this schedule was asking them to describe their emotional feelings and the concerns they may have had during pregnancy and after having the baby.

All participants were given codes, all conversations were tape recorded and stored in a locked cabinet on NHS premises, accessible only to the facilitator.

The two transcripts were read several times to understand the data. Initial coding of the transcripts was then performed. Codes were made to capture the descriptive language used by the participants. Once the data was sorted, the facilitator grouped the data into themes, and examined all the cases in the study to make sure that the description of each theme was captured (Pope et al, 2006).

Triangulation was used to improve the reliability and validity of the data. The key findings were presented back to the participants through follow-up phone calls. There was general agreement about the information collected. The tape recorded data was also played back to check for clarity and confirmation of their descriptions and compared with the field notes.

Chapter 3: Findings

Data were analysed highlighting key words used and grouped into themes to capture the understanding of African women's perception of postnatal depression. Table 3 provides a summary.

3:1 Responses to pregnancy

All participants were asked to reflect on when they first realised they were pregnant. This was to allow them to consider what their reaction was at the time, and to describe this vividly in relation to their emotional feelings. The women described their immediate responses. Participant 1 described her experience as a first-time mother educated up to secondary school. She reported:

'When I first became pregnant, I was scared,.. sick all the time.' Participant 1

'This was my first baby, I was afraid... and was crying all the time and very lonely.' Participant 2

Participants reported their experiences and feelings during the antenatal period which made it extremely difficult for them to see the good side of being pregnant.

'So I realise it was the pregnancy, it was a mixed feeling, I'm very happy, happy but sad'… Participant 3

The woman quoted below is a second-time mother who works full-time when not on maternity leave. She described her feelings and experiences when she had her first baby:

'…one I felt great, I was happy …second one, the pregnancy was quite hard ….but I had this apprehension in my mind because of the afterbirth of the first one' Participant 4

Facilitator: ***'Tell me about the apprehension you had.'***

'OK. …I didn't have much help for the first one, and I felt really isolated... not helping me... pregnancy is difficult… …my in-laws were around, I was frustrated… …for six months nobody helped me once... no help for me. I cried a lot, felt rejected by my husband, second time, I wasn't looking forward to having the baby, I was just thinking it's going to be horrible Participant 4

This woman's emotional turmoil may have significantly impacted on the growing foetus, her first child and even her relationship with her husband. Psychological effects such as bonding issues, have been shown to lead to adverse cognitive development in children (Chisholm et al, 2003), and resentment with the husband; a cause of many relationship breakdowns (Miles, 1993).

To some, however, it was a pleasant surprise as they had been waiting for it, as described by this woman:

'***…and being pregnant is always an exciting experience for a mum'…. so I was excited…'*** Participant 5

To some, although it was a pleasant surprise, it actually came with a price as noted by these women:

'…then I wasn't prepared for the pregnancy but I was happy' Participant 6

'When I found out I was pregnant, I was really happy because we'd been trying for some years…' Participant 7

When this woman was asked to describe her feelings at the time she had this to say:

'Mostly very frustrated, very anxious. A bit scared as well about the birth, not knowing what to expect. Very bored, but mainly just anxious...' Participant 7

The significance of this theme is that being pregnant is always a good thing, be it challenging for all women it is in most cases a pleasant moment. In particular, for an African woman who is married, if not married nobody cares about you being pregnant, once married the expectation is that the individual is ready for the responsibility and that includes having babies These women are however, not prepared for the responsibilities that come with having a baby. When compared with White British women, who have the same feelings and experience but receive help from the partners. If mother-in-law makes life difficult they can ask her to leave with the support of their partners.

3:2 Emotional feelings before the birth of the baby

There were reported emotional distress associated with being pregnant and these were reported by most participants. For example, a woman reported emotional stress she faced by getting pregnant in school and not finishing her secondary school education. She recalled:

'***I'm from Nigeria. When I had my first child……it was had… so when I finished my secondary school I got pregnant then, and there was nothing I can do then. After I had the baby I was happy but sad at the same time...***'.Participant 8

'OK. I'm Ghanaian, I will go straight to the question which is my emotional feelings. When I first realised I was pregnant, it was a mixture of excitement and sadness because of my own situation that I was going through. So I suppose I was happy to become a mum, emotionally I was sad, and I… but I just kept crying… Oh, it's OK to cry because if you don't cry you can become very depressed. And I said "Why am I crying?" I couldn't think why I was….' Participant 9

The language used by women to express emotional feelings was distinctive, and different from the psychological or psychiatric language which is more familiar to the indigenous population (Cox, 1999). African women described feelings of being sad, anger, annoyance and irritability, not at anyone but at themselves, blaming themselves for been pregnant or evaluating the tasks before them and assessing their ability to cope with the tasks. The woman speaking above is a first-time mother who is also a university student working part-time, so her life was demanding so much so that she described her emotions as that person who is running mad:

'When I saw "positive" I was like positive! I was crying and I was mad with myself. I did not believe…' Participant 9

3:3 Being alone with feelings

For some participants, having a baby meant that they were unable to escape and so they had to stay and endure the hardship. For postnatal women in general, participants indicated that a major source of distress was being unable to share their problem with their immediate family for fear of been *seen* as a failure.

'I don't think so. What I think is, before you even express it, it gets shut out already, before you even express it. Mum is here, when I say something to mum "Oh, you're complaining too much, this is how we do it, understand it." I mean for African perspective, this is how we do it. We do it this way. So then whatever you want to say has been short out of you or stays in you.' 'You want to… for me is no one can help or share the feelings. It's inside you'. Participant 9

'I don't know. Maybe it's my culture, I don't know. It could be cultural. I can't imagine myself going to my mum, or my mother-in-law… I just couldn't imagine saying to somebody "Oh do you know what? I'm really struggling, I'm really down…" It just sounds odd. It's just not… it's not something that you do, you just… Everybody expects you to get on with it and you get on with it'. Participant 10

Some of the women present suggested talking to their husband about their problem. Some agreed that was appropriate but did not hold any hope about that improving their situation as the men do not see their role as helping these women even though they live in a westernised country. Culturally it is the job of a woman to give birth, take care of the baby and also take care of the household chores.

There was no general accepted person to talk to. One participant pointed out that even when the health visitors came, the mother-in-law was present, and cannot really discuss the issues while she is there (Jones, 1994).

'Even when you're alone with the health visitor, you know that if you start you may just roll on the floor and start crying, so you just say "I'm fine, I'm fine" Before you say "I'm depressed", because it's like a taboo for an African woman to say she is depressed. So just say "I'm very fine," and when she's gone you start to deal with your life on your own and it's overwhelming and different. We're all saying the same thing'. Participant 1

3:4 Emotional feeling after the birth of the baby and not coping

The cultural principle for describing the postnatal period was strongly endorsed and contained across participants (Cox, 1999; Jones, 1994). This was accompanied by tacit acknowledgement that the actual experience of many women would fall short, leading to unfulfilled expectation and potential risk of postnatal depression (Miles, 1993).

Rest was considered a necessity following the demands of pregnancy and childbirth, but the women in the two focus groups were totally disappointed as the shock of having a crying baby hit them and demands that came with this new vulnerable child. So they described their emotional feelings as:

'so the first week was very difficult for me to cope with changing him, feeding him, it wasn't easy, it was my first time, so I would cry sometimes, and not until when my mum came, things were a little bit easier for me. But I couldn't really cope with the emotions. Sometimes like I said, it was mixed feelings. I would be happy one moment and the next I feel like crying. I didn't really know why or … that was how it happened really'… Participant 9

'Very tired/baby cried all the time'... Participant 11

'Mixed feelings –happy at times and sad sometimes'… Participant 7

'Feeling isolated/rejected by husband'… Participant 4

'Depressed' Participant 6

'Irritability/annoyance at everybody'... Participant 7

'Feeling down emotionally'… Participant 12

Women spoke of the difficulties of having to assume the role of a mother, wife and housewife. This is not peculiar to African women but the British women would readily speak out whereas these women kept this to themselves except in a forum such as the focus group where they felt comfortable discussing their emotional feelings.

These feelings were attributed to practical problems, for example having little opportunity to rest, and lack of support from home.

Participants also admitted that there were instances when they felt out of control; not coping, and even sometimes the feeling of losing it completely.

'So the urge to want to speak up and say "Hey, I actually need help… you know, I'm not coping here, superwoman, you know", I can do this, but you're not. Inside you're not'…Participant 4

'They say "Oh, you are not depressed, oh this happens, cope with it." Oh, but you wanted it so much to say I really am not coping. But I realised that we don't get the help that we're supposed to get, to help us cope with it. How do you cope with it? For instance I have such a

blockage… If it's the right thing, I don't know, because it may come back to haunt me'…
Participant 7

All participants agreed that there is a problem with the present system whereby African women's postnatal assessment is not adequately carried out due to their cultural background (McConnell et al, 2005). They also admitted that they do not speak to professionals about their true emotional feelings for fear of been labelled depressed which is a taboo in some cultures. Some said even when you attempt to say something, you are told to shut up and get on with it so you learn to live with it.

3:5 Lack of information

Participants pointed out that there is a general lack of awareness among health visitors and health care professionals in identifying when an African woman is in distress or is crying out for help. A woman remarked she was given the questionnaire (referring to the EPDS) which, to her made no sense, and reported they are not listening. This claim is supported by Hewitt et al (2009), who reported the use of the EPDS is less specific and sensitive to the needs of African woman.

'remember when I first went to see the health visitor, I mean the midwife, she just goes out… we were going through a questionnaire about what my health issues were, about health and all that, I had to cry for some reason. I don't know why, but I just kept crying and she was quite shocked and she spoke to me and said to me "Oh it's OK to cry because if you don't cry you can become very depressed." And I said "Why am I crying?" I couldn't think why I was crying, but I… something was not right with me. I don't know what it was, but that was what I'd feel. And throughout my period I had my baby at 7months, it's been kind of emotional, psychologically and mentally in every…' Participant 9.

'With my anger, I needed to tell someone that I am not coping. 'I just wish someone was there'
Participant 9

This woman pointed out threats to her mental health arising from possible inherent vulnerability during postnatal period and the consequences that these could bring if not adequately dealt with, which in her case was not resolved because of professionals' lack of awareness.

'I felt that Greenwich spend a lot of money on teaching you to breastfeed in the hospital, but the people who were trying to teach me, I don't think were very good and I felt like they were

pressuring me a bit as well, but they didn't really give me some of the other information that as a new mother I would have found really useful, without me having to look on the internet or buy a book. And speaking to some people doesn't help because they just make you feel like it's just your baby crying…' Participant 14

Again this participant felt she needed more information from the care givers that would have helped her cope better after the birth of her baby.

'There was something she said in that talk, that I can find information. I know where to get information, but not everybody does, you know, so if this research is going to help people to easily get access to information to help through whatever they… I think it's going to be really helpful.' Participant 15

There is a concession that a group of some sort will help African women in this community as there is no such thing that gives information for this client group.

'With this baby I felt really depressed because I didn't want to have another child because I raised my other daughter on my own. …some days I feel ok, some days I feel really depressed.' Participant 16

This woman is a second-time mum who got pregnant as a teenager first time around, described how she felt then and now expressed the agony of lack of sufficient funds being a single parent depending on benefits.

3.6 Lack of Social Support

Participants spoke of the difficulties they faced in their new culture which is supposed to favour equality between men and women but the reality in their own homes and cultures is totally different. Women did the entire household chores regardless of the number of days after delivery they were. They got no help from their husband and not even their mother-in-laws; in fact some women reported that the in-laws made matters worse.

'I felt really isolated, and even though I had people around, but they were not helping me, I was doing things for them, …having a baby is difficult but I did all the cooking, my in-laws were around, I was frustrated, nobody helped me once. I was cooking, I was going to the market, and there was no help for me. I cried a lot, felt rejected by my husband'. Participant 4

'…make the afterbirth very difficult, something that a bright person, very vibrant and passionate, all of a sudden you're just like demoted…' Participant 4

For this woman, having a baby was a nightmare to her and she felt she lost all the confidence in herself, including her self esteem because of the way she was treated by her husband and her mother-in-law. African women have great respect for their in-laws and husband so found it difficult asking them for help. It is a taboo among some African women (especially Nigerian women) to expect their mother-in-laws to tidy up for them or even cook for them.

'No, they didn't. They would come around just to see the baby, ask me how I'm doing, and leave when they should actually be helping me'. Participant 17

In their country of origin, things are different; families, friends will come to offer help and help them on their way to recovery from the shock of caring for a little helpless baby. Understanding the difficulties these women face by professionals will help in improving outcome of postnatal care for these women.

Table 3: Emerging themes

Emerging themes	**Key words and phrases**
Expected pregnancy	• Source of joy • Happy, long-awaited surprise.
Responses to pregnancy	• I was a little bit scared • I was afraid • Frustrated • Sick all through pregnancy • Weight loss • Anxiety about job loss due to pregnancy • Education discontinued/working while pregnant.
Emotional feelings before the birth of baby	• Crying a lot. It was quite difficult for me • Sadness, mixed feelings, happy/sad

	• Excited • Lonely • Not knowing what to expect • Baby diagnosed with sickle cell anaemia.
Being alone with feelings	• Learned to keep feelings to oneself • Nobody to share feelings with • Lack of sleep • To express feelings is a sign of weakness.
Social support or lack of it and lack of information	• Regret having a baby • In-laws' interference when pregnancy not forthcoming • No family/no family support • Not living with father/husband not supportive • No help from mother-in-law • Did all the cooking/housework • Close relative very supportive • Husband walk out • Health visitor not listening or not picking on clues • Not enough information of what to expect being a first-time mother.
Not coping and emotional feelings after the baby	• Very tired/baby cried all the time • Mixed feelings – happy at times and sad sometimes • Feeling isolated/rejected by husband • Depressed • Irritability/annoyance at everybody • Feeling down emotionally • Totally drained • Pressure of taking care of baby

	• In-laws causing rift or division between participants and partners/husband • Crying at times but only in secret as cannot be seen to be failing • Diagnosed with high blood pressure.

Chapter 4: Discussion

4:1 Recognition of postnatal depression

The majority of participants highlighted a state of unhappiness following delivery, although by no means all recognised it as an illness with a name postnatal depression. The description of the characteristics of this state among participants was comparable to the criteria for a diagnosis of postnatal depressive disorder. Participants viewed the causes of this morbid unhappiness as psychosocial with particular emphasis on marital and family relationships, and on emotional and practical support. These African women spontaneously described distress states manifested by sadness, irritability, anger and complete unhappiness which are in keeping with the western construct of postnatal depression. These distress states were recognised across all settings although, in Uganda, were not considered to constitute mental illness (Oates et al, 2004).

In keeping with the predominantly psychosocial view of the aetiology of this condition, participants also viewed the remedies as lying in the psychosocial domains. Social support from family, practical and emotional support from partners and having someone to talk to were unanimously expressed as the remedy for postnatal depression.

This adds weight to the existing concern around the use of the present tool for assessing women of all cultures. It is worth adding here that these findings warn against the bio-psychosocial model which allows distress to be expressed in somatic, psychological and socio-moral idioms. To do this one may neglect the spiritual or cultural expressions which fall outside the reified categories of science (Kirmayer, 1989).

4:2 Social support

One recurrent theme among the participants is the mention of mother-in-law as the cause of unhappiness. In Africa, once a woman gets married, it is expected that within the first year they should conceive and have a baby. The absence of this brings with it lost of expectation from both families – the woman is seen as an alien, and the longer she fails to conceive, the more the sadness is prolonged especially if

the husband remains unsupportive. This compounds the emotional stress the woman faces until there is evidence of pregnancy.

This fact is evident from two of the participants who did not conceive until over a year after marriage. When the pregnancy finally came they were elated, this was actually short-lived by the visit from their mother-in-laws who when they came did not help them at all rather causes a lot of distress for the women. The mother-in-laws or any female adult/visitor to the house during this period, were meant to help, as was the tradition if the child was born in Africa, but for women in this study it did not happen, which was a major cause of anxiety and distress. A good example of this is shown in a study by Cox (1999) when Ugandan women received help from their mothers-in-laws or immediate relatives. This study was however, done in Uganda with indigenous women, whereas the women in this study are from Africa but live in the UK.

Furthermore, women in this study understood emotional distress as something different from the physical illness, and that one may cause or influence the other. Their description fitted the psychosocial model, in that emotional distress was considered a product of social stress. This study suggests that women may positively choose not to present emotional problems to health professionals for a range of cultural reasons. This confirms the notion that far more women often go undiagnosed (Briscoe,1989) which is particularly common among African women. Similarly, Lewis (2004) suggests that women from black and ethnic minority backgrounds may be undiagnosed with postnatal depression because of women's fear of being stigmatised.

Two major stressors for mothers of newborns going through the postnatal period are:

1. Recovering from the immediate physiological changes of delivery.

2. Returning to functional status (which rarely returns to normal prior to six weeks), during the days and weeks after delivery (Fishbein & Burggraf, 1998).

Discussion of new mothers' stressors during this period must include the immediate recovery period and their postnatal functional status.

Stressors other than the immediate recovery period were reported by participants and could be divided into three categories:

1. Physical stressors such as pain, surgery, complication of pregnancy and delivery (pregnancy-induced hypertension) and mothers' current health problems.

2. Mental stress such as loneliness, unmet expectations, birth plan disappointment and abandonment.

3. External stressors such as a crying baby, sibling care, lack of support, financial concerns.

While women in the study did not experience all the stressors at once, most experienced some at the same time. Experiencing multiple stressors during postnatal period can lead to sleeplessness, fatigue and irritability which were described in the two focus groups. Studies by Beck (1996) and O'Hara & Swain (1996), have shown that these multiple stressors are risk factors for postnatal depression.

4:3 Cultural identification

Patel et al (2002), argued that culturally appropriate terminology for depression can be identified and its use may improve levels of recognition and intervention. It is also evident that culture is only one factor in the difference between, and within, human societies which has a bearing on the epidemiology of depression. From the study it was apparent that the African women's cultural background has a bearing on the reasoning and help seeking behaviour. Although, they feel sad, unhappy and depressed, they have learnt to keep their feelings to themselves because culturally to admit to having a problem coping with the after-effects of childbirth is a sign of failure or maybe weakness. So, women are often quoted by professional as OK as they themselves have hidden their internal turmoil.

Similarly, for some of the participants, sharing one's emotional feelings will lead to stigmatisation. In Ethiopia for instance, there is a socio-culturally elaborated postnatal period, and this is considered to be a good time in a woman's life (Hanlon et al, 2009). For these women, living in the UK without the opportunity to have this

sort of treatment after childbirth, there is the tendency to exhibit some distress state due to disappointment and loss of expectation.

4:4 Coping strategies

Counting on their own mothers for support seemed to help some participants cope with the distress they faced during this postnatal period. For some women who never had the opportunity of their own mothers being present; this contributed to the stress levels they experienced. These women welcomed the idea of a group such as this which allows them to verbalise their internal emotional feelings and hope for this opportunity to continue. Most of the participants have their husband but all of them reported that they did not help at all, again a common thing with most African men. These women described it as an 'African thing' and called for awareness training for African men to be educated on issues of the postnatal period. It is hoped this will raise men's awareness on the importance of giving support to their wives during this transitional period.

Some of the participants have strong religious beliefs and so turn to prayer which they reported helped them to cope with their stress levels. It should be noted that lack of social support was found in literature to be a major risk factor for postnatal depression (O'Hara & Swain, 1996). Therefore, having the right kind of social support and the support expected, seems to be more important.

Chapter 5

5:1 Limitations of this study

According to Kitzinger (1995), in group settings group norms may silence dissent, and in one of the groups a social hierarchy was observed. One of the woman tended to dominate the group silencing any mention of family problems thus intimidating the less confident women within the group. This was dealt with by inviting the less vocal among the women to contribute their experiences. Attempts were also made to call the individual up soon after the group to ensure they actually had a voice in the data collection process.

This is a small study, with a group of African women, so the results from the study cannot be generalised. It is proposed that this study be repeated using a larger multi-centre sample. Also, comparisons between African born and British born African women may highlight other variants that may reflect and influence strategies used to detect and care for these women.

5:2 Recommendations

This study highlighted a need for more effective communication between service providers and users on health service provision around the time of childbirth for African women. Cultural dissonance in expectations needs to be addressed explicitly. Information about the needs of African women during childbirth needs to be aimed at husbands/partners, mother-in-laws and healthcare professionals.

Healthcare professionals need more understanding of the language of emotional distress current in the African community. Professionals need to be made aware of the many reasons why women may not disclose emotional or psychological problems. This is needed along with a range of skills in enquiring into symptoms of emotional distress in the postnatal period. Women need to be reassured about confidentiality.

5:3 Conclusions

This study shows that African women receive little practical and emotional support on returning home after delivery of their babies. In the UK, African women suffer and cope with their emotional distress alone during the postnatal period. They see emotional distress as something different from physical illness and support outside the immediate family network is hardly promoted. Women are left with the frustration of not expressing their emotional feelings during and after the delivery of their babies which can result in serious mental health issues. The danger in this is that the mother switches in and out of depressive mood – with devastating effects on the children. There is a fear that some of these women may never bond with their children.

There are serious implications for the children and partners of these depressed women because, as described above, these children may then experience emotional neglect, lack of bonding and later on may develop behavioural problems. The evidence also indicates it may lead to relationship breakdown which will have a destructive effect on the family and society as a whole.

The study also shows that although this group of African women may exhibit or experience postnatal depression, they are less likely to disclose this to the health visitor for fear of been stigmatised.

Postnatal depression is a devastating problem for the new mother, the baby, and the family. The literature and the current study suggest that postnatal depression should not be taken lightly due to the potentially fatal nature of this mood disorder. At the time when mothers are most vulnerable, they are responsible for the care and nurturing of a new-born baby, their homes, themselves and their family. It comes as no surprise then that some mothers have difficulty managing the multiplicity of roles as well as dealing with the cultural complexities described in this study.

It seems that African women are reluctant to expose any frailty, thus making it difficult for professionals to provide adequate support and advice.

To improve postnatal outcome in these groups of women health professionals need to recognise the subtleties in language and expression used by these women and, at

the same time, feel competent enough to identify vulnerable women. This study demonstrates the need for culturally-sensitive awareness training to be provided to health visitors to enable them to identify and manage the postnatal needs of women from all cultural backgrounds.

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05 May 2010

Mrs Titilayo Babatunde
Lead Public Health Community Nurse
Greenwich Community Health Services
Wallace Health Centre
Clarence Road
Deptford
London SE8 3RX

Dear Mrs Babatunde

Study Title:	**Improving postnatal depression care in Black African women in Greenwich Community Health Care Services (GCHCS).**
REC reference number:	**10/H0805/17**
Protocol number:	**1**

Thank you for your letter of 23 April 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

CONDITIONS RELATING TO RESEARCH GOVERNANCE APPROVAL

Please provide RD number in any correspondence

1. **Amendments, extensions, discontinuation or temporary suspension of the project**
   No changes or extension can be made to the protocol without prior written approval from the relevant ethics committee. **This includes changing the person who is delegated to carry out the study**. The RDC requires a copy of the ethics committee amendment form and approval letter. The RDC should also be notified if the project is discontinued or suspended for six months or more.

2. **Research Passport, Honorary Contract and enhanced CRB check for non-NHS researchers**
   It is a requirement of the NHS Research Governance Framework that all non-NHS researchers who are working with NHS patients or their data need to apply for a **Research Passport** and honorary contract with the lead Trust **before the study can proceed**. Researchers who have individual access to patients (i.e. 1 to 1 interviews or visiting their homes) or direct access to patient identifiable data also require an enhanced CRB check. This should be undertaken by the employing organisation and a copy provided for the PCT.
   Dr Anne Grant can provide further details of the information required and can arrange for an honorary contract to be provided with the relevant Trust(s).

3. **Adverse events**
   Any unusual, unexpected or adverse clinical conditions, particularly if this directly involves patients, should be notified to the RDC and ethics committee.

4. **Misconduct and Fraud**
   The PCT policy for identifying scientific misconduct and fraud is published on our website below. It is the responsibility of the researchers to notify the RDC if they suspect professional misconduct or scientific fraud is taking place during the study. All information will be treated confidentially.

5. **Public participation in research**
   Participants or their representatives should be involved wherever possible in the design, conduct and reporting of research. Each PCT has established a Patient and Public Involvement team, which can help with identifying service users and patients who have an interest in research. Participants should be informed of the general outcome at the end of the study.

6. **Dissemination**
   Whilst it is understood that researchers strive to have their work accepted and published by a peer review journal, it is also important to inform PCTs about any general conclusions that would have an immediate effect on the PCT and ensure that the participants are informed of the general outcome of the study.

7. **RDC database**
   Approval for the research is given on the understanding that the project will be registered on the RDC website database (unless it is a commercial trial or short student project).

8. **Intellectual Property**
   In accordance with the Health and Social Care Act 2001 the Trust has a right to benefit from Intellectual Property arising during the study. The PCT policy on Intellectual property is published on our website at www.researchdevelopmentcentre.nhs.uk . If there is potential IP interest, you should notify the RDC.

9. **Funding**
   Research Governance approval by the PCT(s) does not imply that the PCT will provide funding for the project. All projects should be adequately funded and have a recognised sponsor. For 'unfunded' student projects, the funder and sponsor is considered to be the higher education institute where they are registered, unless we have received prior notification of an alternative arrangement.

10. **Duty of Care**
    In giving Research Governance approval to the study the Trust(s) accept the responsibilities of normal duty of care to patients and staff who participate in the study.

11. **Data Protection and confidentiality**
    It is a requirement of the Data Protection Act that all participant details remain confidential. When databases are created they are specific to the study and should not be used in future studies unless the anonymity of the data can be guaranteed.

12. **Monitoring**
    Approval is given on the understanding that the RDC will monitor the project and visit a random sample of studies, to ensure they are compliant with the Research Governance Framework requirements.

RDC RG conditions 11/08

research & development centre

rdc

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Mrs Titlayo Babatunde
Wallace Health Centre
Clarence Road
Deptford
London
SE8 3RX

17th June 2010

Dear Mrs Babatunde

Project Title: Improving postnatal outcomes for African women in Greenwich Community Health Care Services (GCHCS) by using focus group to determine their perception of postnatal depression and develop a draft questionnaire for use in a pilot study.
R & D Reference: RDGRE 519

Thank you for your assistance providing the documentation for the scrutiny of this project.

I am satisfied that this study meets with the requirements of the Research Governance Framework. It has been approved by the research lead for the respective NHS organisation.

Approval is given on behalf of NHS Greenwich on the understanding that you adhere to the conditions on the attached document. The end date of the project is listed as 14th March 2011.

If you require any further information, please contact Dr Anne Grant on 020 7525 0289.

Yours sincerely

Hiten Dodhia
Consultant in Public Health and R&D lead for NHS Lambeth
Chair of the Research Management Group for South East London NHS
Bexley, Bromley, Greenwich, Lambeth, Lewisham & Southwark

Developing research in: Greenwich, Lambeth, Lewisham & Southwark PCTs

APPENDIX 1

MARY SEACOLE
1805~1881

NHS Employers

A part of the NHS Confederation working on behalf of the NHS

PATIENT INFORMATION SHEET

Title of Study: An Exploration of Perception of Postnatal Depression In African Women

Invitation to take part in the study
This is an invitation for you to take part in a research project. Before deciding to be part of the project, it is necessary that you are aware of the reasons for doing the research and a brief overview of what it involves.

Please read through the following information carefully. It is in two parts:
Part 1 tells you the purpose of the study and what will happen if you take part.
Part 2 consists of more detailed information about the conduct of the study. Please do not hesitate to contact me for more detailed information or for any clarification you may require.
Thank you.

PART 1
What is the purpose of the study?
The study aims to explore the perceptions of African women of postnatal depression. How do African women express themselves when feeling low, what does postnatal depression mean, to you as an African woman, do you know when you are feeling depressed?

Why have I been chosen?
All African women who have just had a baby are being invited to participate in the study.

Do I have to take part?
Participation is voluntary and you are free to withdraw at any stage of the study without any justification. Note that your decision to withdraw will not affect the quality of service or care you receive.

What will happen to me if I take part?
You will be one of twenty women, all Africans and you will be invited to a focus group where you will be asked to discuss or express your feelings since having the baby. There will be other African women there, and you will be allowed to express your views on what postnatal depression means to you. There will also be an opportunity for you to listen to others about their own feelings.

You can also discuss the kind of support network that is available to you and how this has helped you in your new role as a mother. There will be a co-facilitator and the conversation will be audio recorded. Some field notes may also be taken. The recorded discussion will later be transcribed and the tape kept in a secure place to maintain confidentiality.

We are asking about twenty women to participate in the focus groups. Names will not be included which means that anyone taking part cannot be identified.

What do I have to do?
Take time to consider the proposed project, once you have decided, simply complete the information request form at the end of this leaflet stating your intention and return them to me in the prepaid envelop provided. If you would require more information about the study, this will be sent to you as soon as possible.

What are the possible disadvantages and the risks of taking part?
There are no disadvantages and the only possible risks may arise when very sensitive and emotional issues are disclosed. There may be a need for counselling depending on each individual circumstances; arrangement have been made for a counsellor if the need should arise. Arrangements have also been made by the researcher to support you by making the necessary referral and follow-up should this happen. Most importantly, you can withdraw from the study at any time during the interview. Transportation will be provided for you from your home to the group session and will also take you back home after the session.

What are the possible benefits of taking part?
The study provide an opportunity to unburden yourself from some issues that might have been left undisclosed for a long time and yet may have some unpleasant effect on your well being. It also provide an opportunity to explore behaviour or feelings you currently experience, an opportunity to discuss in a group session with the researcher which may not be possible during a schedule visit by your Health Visitor or at a clinic setting.

Similarly, your participation might help in the improvement of access to psychological therapy for black ethnic minority women. Also, whatever, suggestions given at this interview will be used to develop the kind of questions to ask an African woman when she has a baby. So not only will this help you, it will be nice to know that you contributed to the changing of how Health Visitors interact with African women in Greenwich.

What happens when the research study finishes?
If you wish, we will send you a summary of the findings when the research project finishes.

What if there is a problem?
It is unlikely that something may go wrong during the focus group interview. However, if anything should go wrong, it will be dealt with immediately. Detailed information is given in part 2.

At the end of this leaflet is a form inquiring whether you would like to be invited to take part. If you agree to take part you will be one of 20 women who will be interviewed for the project.

For more information on this study, please contact:
Titilayo Babatunde
Greenwich Community Health Services
Telephone: 07921492015
Email: t.festussodipo@nhs.net

PART 2
What if there is a problem?
As this is a focus group interview, it is unlikely that anything could go wrong. However if you have any concerns about any aspect of this study, speak with the researcher who will answer your questions. **Please contact Titilayo Babatunde on 07921492015**.

If you are harmed by taking part in this research project there are no special arrangements but if you are harmed due to someone's negligence, you may have grounds for legal action for compensation against the Greenwich Community Health Services but you may have to pay for it. The normal NHS complaint mechanism is available to you if you wish to complain about any aspect of the way you are approached or treated during the course of the study.

Formal complaints should be addressed to:
NHS Patient Advisory Liaison Services (PALS).
Greenwich Teaching PCT
31-37 Greenwich Park Street
Greenwich SE10 9LR.
Tel. 08001699928
e-mail enquiries to : pats@greenwichpct.nhs.uk
By Fax to: 02082936748.

Should you require independent advice about making a complaint or seeking compensation, you may wish to contact the Independent Complaint Advisory Services (ICAS):

The Independent Complaint Advisory Service (ICAS)
103 New Oxford Street
London WC1A 1DU
Tel. 0207 3798598
Fax. 0207 3798586
info@Independenthealthcare.org.uk

Will my taking part in this Study be kept confidential?
All information collected in this project will only be accessed by the relevant research staff and this information will be kept on a secure personal computer only accessible to me with a password protection. All information you will provide will be treated confidentially and you will not be identified in any report or publication arising from this project.

What will happen to the results of this study?
At the end of the study the researcher will send a report of the findings to Greenwich Community Health Services and to any organisation that has been involved in the study. If you wish a summary of the findings will also be sent to you. You will be informed if the results are to be published.

Who is organising and funding the research?
Mary Seacole Leadership Award.

Who has reviewed this study?
The study has been given a favourable ethical opinion for conduct by the South East London Research Ethics Committee 5.

Thanks for reading this information sheet. You may keep the sheet.

Interview Response Form. Please delete as appropriate.

Yes I am interested in receiving information about the focus group interview and I am interested in taking part.
No I am not interested in receiving information about the study and I would not be taking part.

Name (please print)
……
……

Address (please print)

……
……
……
……
……
……

Telephone number……

Signature……

APPENDIX 2

MARY SEACOLE
1805~1881

NHS Employers

A part of the NHS Confederation working on behalf of the NHS

CONSENT FORM

Centre Number:
Study Number:

Title Of Project: An Exploration of Perception of Postnatal Depression In African Women in Greenwich Community Health Care Services

Please initial box

1. I confirm that I have read and understood the information sheet dated for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and my medical care or legal care will not be affected. ☐

3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by the regulatory authorities and NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

4. I agree to take part in the above study. ☐

5. I understand that this focus group will be audio taped. ☐

Name of Patient _____ Date _____ Signature _____

Name of Researcher _____ Date _____ Signature _____

References

Abiodun, OA. (2005) Postnatal depression in primary care populations in Nigeria. General Hospital Psychiatry 28: 133-136.

Amankwaa, LC. (2003) Postpartum depression among African-American women: Issues in Mental Health Nursing 24: 297-316.

Beck, C. (1996) Postpartum depressed mothers' experiences interacting with their children. Nursing Research 45(2), 98-104.

Briscoe M. (1989) The detection of emotional disorders in the post-natal period by health visitors. Health Visitor 62(11), 340-342.

Boath, EH, Pryce, AJ, & Cox, JL. (1998) Postnatal depression: the impact on the family. J Reprod Infant Psychol 16: 199-203.

Bowling, A. (2002) Research methods in health. Investigating health and health services. Oxford: Open University Press.

Campbell, SB, Cohn, JF, & Meyers, T. (1995) Depression in first-time mothers: mother-infant interaction and depression chronicity. Dev Psychol 31: 349-357.

Census 2001, Office for National Statistics; Census 2001, General Register Office for Scotland; Census 2001, Northern Ireland Statistics and Research Agency.

Chisholm, D, Diehr, P, Knapp, M, Patrick, D, Treglia, M, & Simon, G. (2003) Depression status, medical co-morbidity and resource costs. Evidence from an international study of major depression in primary care (LIDO). Br J Psychiatry 183: 121-131.

Clifford, C, Day, A, Cox, J & Werrett, J. (1999) A cross-cultural analysis of the use of the Edinburgh Post-Natal Depression Scale (EPDS) in health visiting practice. Journal of Adv. Nursing 30(3), 655-664.

Cox, JL. (1983) Clinical and research aspects of postnatal depression. Journal of Psychosomatic Obstetrics and Gynaecology. Supplementary 2: 46-53.

Cox, JL. (1999) Perinatal mood disorder in a changing culture. A transcutural European and African perspective. International Review of Psychiatry 11, 103-110.

DOH (2005) Department of Health. National Service Framework for Mental Health. London: The Stationery Office.

DOH (2010) The Constitution. The NHS belongs to us all. The Stationery Office, March 2010.

DCSF (2010) Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children. DCSF publication.

Edge, D, Baker, D, & Roger, A. (2004) Peri-natal depression among black Caribbean women. Health and Social Care in the Community 12, 430-438.

Edge, D. (2005) 'We don't see Black women here': an exploration of the absence of Black Caribbean women from clinical and epidemiological data on perinatal depression in the UK. Midwifery 24, 379-389.

Fishbein, E, & Burggraf, E. (1998) Early postpartum discharge: how are mothers managing? Journal of Obstetric, Gynecologic, and Neonatal Nursing, 27, 142-148.

Gibson J, McKenzie-McHarg K, Shakespeare J, Price J, Gray R**:** A systematic review of studies validating the Edinburgh Postnatal Depression Scale in antepartum and postpartum women. Acta Psychiatr Scand 2009 , 119:350-364.

Greenwich Public Health Report (2008) The Public Health Report.

Hanlon, C, Whitley, R, Wondimagegn, D, Atalay, A, & Prince, M. (2009) Postnatal mental distress in relation to sociocultural practices of childbirth: an exploratory qualitative study from Ethiopia. Social Science & Medicine 69, 1211-1219.

Hewitt, CE, Gilbody, SM, Brealey, S, Paulden, M, Palmer, S, Mann, R, Green, J, Morrell, J, Barkham, M, Light, K, & Richards D. (2009) Methods to identify postnatal depression in primary care: an integrated evidence synthesis. Health Technology Assessment 13, 36.

Jones, LJ. (1994) The social context of health and health work. Macmillan Press. Great Britain.

Kirmayer, L. (1989) Cultural variations in the response to psychiatric disorders and emotional distress. Social Science & Medicine 29(3), 327-339.

Kitzinger, J. (1995) Introducing focus groups. British Medical Journal 311, 299-302.

Kleinman, A & Good, B. (1985) Culture and depression: studies in the anthropological and cross cultural psychiatry of affect and disorder. Berkeley: University of California Press.

Krueger, R. (1988) Focus group: a practical guide for applied research. Newbury Park: Sage.

Leverton, TJ, & Elliott, SA. (2000) Is the EPDS a magic wand? A comparison of the Edinburgh Postnatal Depression Scale and Health visitor report as predictors of diagnosis on the present state examination. Journal of Reproductive and Infant Psychology

Lewis, IM. (1976) Social anthropology in perspective. London: Penguin Books.

Lewis, G. (2004) Why mothers die The sixth report of confidential enquiries into maternal deaths in the United Kingdom. London: CEMACH.

Lovestone, S, & Kumar, R. (1993) Postnatal psychiatric illness: the impact on partners. Br J Psychiatry 163: 210-216.

MacCormack, CP. (1982). Ethnography of fertility and birth. London: Academic Press.

Madriz, E. (2000) Focus groups in feminist research. In: NK Denzin & YS. Lincoln (Eds). Handbook of qualitative research (2nd ed. pp 835-850). Thousands Oaks, CA: Sage.

Maysa, N & Pope, C. (1995) Rigour and qualitative research British Medical Journal 311: 109-112.

Miles, A. (1993) Women, health and medicine. Milton Keynes: Philadelphia Open University Press.

MIND (1993) Mind's policy on black and minority ethnic people and mental health. London: MIND.

Murray, L, Fiori-Cowley, A, Hooper, R, & Cooper, P. (1996) The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcome. Child Development 67: 2512-2526.

Murray C, & Lopez A. (1996) The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990. Boston, MA: Harvard School of Public Health on behalf of the World Bank.

Nhiwatiwa, S, Patel, V, & Acuda, W. (1998) Predicting postnatal mental disorder with screening questionnaire: a prospective cohort study from Zimbabwe. Journal of Epidemiology Community Health 52(4), 262-266.

NICE (2007a) Antenatal and postnatal mental health: clinical management and service guidance. London: National Institute for Health and Clinical Excellence.

NICE (2007b) Improving access to psychological therapies (IAPT) programme. London: National Institute for Health and Clinical Excellence, March 2007.

Oates, MR, Cox, JL, Neema, S, Asten, P, Glangaud-Freudenthal, N, & Figueiredo, B. (2004) Postnatal depression across countries and cultures: a qualitative study. British Journal of Psychiatry Supplementum, 46, s10-s16.

O'Hara, MW, Swain, AM. (1996) Rate and risk of postpartum depression – a meta-analysis. Int. Rev. Psychiatry 8, 37-54.

Olshansky, E. (2003) A theoretical explanation for previously infertile mothers vulnerability to depression. Journal of Nursing Scholarship 35:3, 263-268.

Omar, ANM, & Abdel Fattah, SA. (1998) Can postpartum depression be avoided? An Egyptian prospective study. Current Psychiatry Ain Shams University 5, 71-78.

Patel, V. Rodriques, M, & De Souza, N. (2002) Gender poverty and postnatal depression. A study of mothers in Goa; India. American Journal of Psychiatry 159, 43-47.

Richards, L, & Morse, JM. (2007) Coding. In: Readme first for a user's guide qualitative methods (2nd Edition, pp133-151). Thousand Oaks, CA: Sage Publications.

Sharp, D, Hay, DF, Pawlby, S, Schmauccker, G, Allen, H & Kumar, R. (1995) The impact of postnatal depression on boys intellectual development. Journal of Child Psychology and Psychiatry 36, 1315-1336.

Swift, CR. (1972) Psychosis during puerperium among Tanzanians. Journal of Mental Science 10, 214-230.

Turkson, SNA. (1992) Psychiatric disorders associated with childbirth among Ghanaian women-illustrative cases. Ghana Medical Journal 26, 467-470.

Warrington, S, Wright, C, Team, A. (2001) Accidents and resulting injuries in pre-mobile infants: data from the ALSPA study. Arch Dis Child 85: 104-107.

Whiteman, S & Guite, H. (2008) Building health into the future - a report on health inequalities in Greenwich. The Annual Report of the Director of Public Health.

Wilkin A Atkinson, M., Stott, A., Doherty, P. and Kinder, K. (2002). *Multi-Agency Working: a Detailed Study* (LGA Research Report 26). Slough: NFER

Williamson, V. & McCutcheon, H. (2004) Postnatal depression: a review of current literature. Australian Midwifery Journal of the Australian College of Midwives 17(4); 11-16.

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