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Pinar, S., Johnson, J., Sulandari, S. et al. (2026) Exploring help-seeking behaviours among minority ethnic women regarding perinatal mental health challenges in England: a qualitative study. Midwifery, 161. 104916. ISSN: 0266-6138

https://doi.org/10.1016/j.midw.2026.104916

Exploring help-seeking behaviours among minority ethnic women regarding perinatal mental health challenges in England: a qualitative study

Semra Pinar[1,2,a], Judith Johnson[2,3,b], Santi Sulandari[2,4,c], Keven Joyal-Desmarais[2,d]

[1] Department of Midwifery, Kahramanmaraş Sütçü Imam University, Kahramanmaraş, Türkiye

[2] School of Psychology, University of Leeds, Leeds, United Kingdom

[3] School of Health Sciences, University of Manchester, Manchester, United Kingdom

[4] Faculty of Psychology, Universitas Muhammadiyah Surakarta, Surakarta, Indonesia

[a] semrapinar@ksu.edu.tr, s.pinar@leeds.ac.uk, ORCID: 0000-0002-5270-5905

[b] judith.johnson@manchester.ac.uk, ORCID: 0000-0003-0431-013X

[c] ss280@ums.ac.id, ORCID: 0000-0002-0091-3382

[d] k.joyal-desmarais@leeds.ac.uk, ORCID: 0000-0003-0657-8367

Corresponding author: Semra Pinar

Address: Kahramanmaraş Sütçü İmam Üniversitesi, Sağlık Bilimleri Fakültesi, Avşar Mahallesi, Batı Çevre Yolu Bulvarı, 46100, Onikişubat/ Kahramanmaraş, Türkiye

Email: semrapinar@ksu.edu.tr

Abstract

Background

Minority ethnic women (MEW) face a high risk of perinatal mental health issues but are among the least likely to disclose emotional concerns to healthcare professionals. However, what leads to low help-seeking behaviours among MEW is poorly understood, and it is unclear how to best promote help-seeking in this population.

Objectives

To explore the help-seeking behaviours of MEW related to perinatal mental health and identify approaches to promote greater help-seeking.

Methods

In this preregistered qualitative study, we used purposeful sampling via social media to recruit MEW who had experienced perinatal mental health problems. Semi-structured interviews exploring these women's experiences of perinatal mental health and help-seeking behaviours were conducted via Microsoft Teams. Data were analysed using reflexive thematic analysis.

Findings

Seventeen interviews were conducted between January and April 2025. Participants' mean age was 34 years and the mean age of their youngest child was two years. Participants identified as African, Indian, Turkish, Filipino, Chinese, Indonesian, Latino, Sri Lankan, White and Black Caribbean, and any other Asian background. The findings indicated that cultural silence around mental health and low confidence in healthcare professionals/maternity services were major barriers to help-seeking. Suggestions to facilitate help-seeking included clearer, more reassuring information about services, and attending to MEW's sense of belonging and representation within the services.

Conclusions

Intervention efforts should prioritise using culturally sensitive language that is clear, informative and reassuring to MEW. Cultural sensitivity training for healthcare professionals and developing strategies to reduce loneliness and isolation may also be helpful for MEW mental health.

Keywords

Help-Seeking Behavior; Mental Health; Health Disparities, Minority and Vulnerable Populations; Ethnic and Racial Minorities; Pregnant People; Healthcare Disparities

Statement of Significance

Issue: This paper explores why minority ethnic women (MEW) are less likely to seek help for perinatal mental health (PMH) issues, despite facing higher risk.

What is Already Known: MEW in England face disparities in PMH outcomes and often do not disclose emotional concerns. However, specific cultural or individual barriers to help-seeking remain underexplored.

What this Paper Adds: This study provides first-hand insight from MEW into the emotional and cultural factors influencing help-seeking behaviours, offering practical recommendations for healthcare professionals and service design to reduce disparities in PMH care.

Introduction

Mental health conditions are common during the perinatal period, affecting 10-27% of women worldwide (Al-abri et al., 2023; Howard and Khalifeh, 2020). These conditions increase risk of maternal morbidity and impact the cognitive, behavioural, emotional, and physical health of children (Brown et al., 2021; Pierce et al., 2020; Stein et al., 2014; Uy et al., 2023) while also resulting in significant resource burdens for healthcare services (Bauer et al., 2016; Brown et al., 2021; Margiotta et al., 2022). These impacts can be particularly felt among minority ethnic groups (Watson et al., 2019).

Minority ethnic group membership is defined as when individuals identify as part of an ethnic collective that is numerically smaller or socially subordinated relative to a dominant or majority population in a given country (Erens, 2018). Refugees, immigrants, and asylum seekers are commonly part of minority ethnic groups when they are considered minorities in their host country. Minority ethnic groups demonstrate a higher prevalence of common mental health conditions compared to the majority population across many countries. For example, such discrepancies have been documented in the UK, the US, Australia, Japan, and Brazil, where minority ethnic populations, particularly perinatal women, experience higher rates of depression and distress, alongside racial disparities in prenatal care and access to mental health services (Adane et al., 2020; Anderson et al., 2017; Bamford et al., 2021; do Carmo Leal et al., 2017; Kita et al., 2015; Rees et al., 2016; Watson et al., 2019). Refugees, asylum-seekers and economic migrant women from low- and middle-income countries are often particularly vulnerable, with one in three experiencing symptoms of perinatal depression (Fellmeth et al., 2016).

In the UK, between 2021 and 2023, the leading causes of maternal death during pregnancy and up to six weeks after the end of pregnancy were thrombosis and thromboembolism, heart disease, COVID-19, mental health conditions, and epilepsy and stroke (Hinton et al., 2025). Among late maternal deaths - those occurring between six weeks and one year after the end of pregnancy - mental health-related causes, including suicide and substance-use-related deaths, were the leading cause (Hinton et al., 2025). Black women are twice as likely to die from pregnancy-related complications as White women, and people living in the most socioeconomically disadvantaged areas also face double the risk of maternal death compared with those in the least socioeconomically disadvantaged areas (Hinton et al., 2025).

Early assessment, detection, and treatment of perinatal mental health (PMH) issues is crucial (Harrison et al., 2023; Prady et al., 2021); however, minority ethnic women (MEW) are less likely to receive treatment (Jankovic et al., 2020; Miller et al., 2024). For example, Jankovic et al. (2020) reports that the use of mental health services during the perinatal period among Indian and Pakistani women is less than half the rate among White British women living in England. This gap reflects broad systemic and cultural issues. MEW may face multiple barriers to accessing mental health services, including low

mental health literacy, cultural stigma, lack of awareness, fear of discrimination, language barriers, and limited trust in health services (Bansal et al., 2022; Darwin et al., 2022; Naz et al., 2019; Smith et al., 2019; Soltani et al., 2020; Watson et al., 2019; Watson and Soltani, 2019). In some instances, MEW turn to family members or religious leaders rather than professionals (Conneely et al., 2023). In many other cases, MEW normalise psychological distress during pregnancy and postpartum, shaped by feelings of shame and guilt, and are influenced by family or community beliefs that prioritise endurance over disclosure (Pilav et al., 2022; Viveiros and Darling, 2019).

Barriers related to healthcare professionals and organisations further limit minority groups' service access. Insufficient training, uncertainty regarding professional roles, and lack of time and confidence among HCPs reduce the likelihood of PMH issues being identified and managed appropriately (Bains et al., 2023; Bayrampour et al., 2018; Viveiros and Darling, 2019). In some instances, unclear referral systems, long waiting lists, and limited specialised services compound these challenges and further deter engagement (Bayrampour et al., 2018; Smith et al., 2019). Differences in screening practices between HCPs and the absence of clear guidelines also hinder continuity of care (Bayrampour et al., 2018; Smith et al., 2019).

The existence of these barriers to care have led governments, organisations, and researchers to examine ways to redress them. Several governments including Australia, the US and the UK are now focused on reducing these disparities (Highet and the Expert Working Group and Expert Subcommittees, 2023; Office for Health Improvement and Disparities, 2025; U.S. Congress, 2021). In the UK, "the Better Births: Four Years on" report and "Equity and Equality Guidance for Local Maternity Systems" by NHS England called for improved equity in maternity and perinatal mental health services, particularly for minority ethnic women (National Health Services, 2021; The Maternity Transformation Programme, 2020). The Five-Year Forward View for Mental Health also prioritised perinatal mental health for underserved groups (Mental Health Taskforce, 2016). Despite UK Government aims to reduce racial disparities in maternal care, however, ethnic inequalities persist in mental health care delivery (Hinton et al., 2025; Naz et al., 2019).

One factor that may help counter these persistent inequalities is achieving a better understanding of the lived experiences of MEW themselves. The aforementioned barriers are predominantly focused on healthcare systems and delivery. Though these are important, individual and cultural-level factors can also be crucial to developing culturally responsive interventions. For example, research suggests women's decisions to seek help are often shaped by prior experiences, and their personal fears around social services (Conneely et al., 2023). MEW can also hold perceptions of mental health services and healthcare professionals (HCPs) as culturally insensitive and/or dismissive of their experiences (Pilav et al., 2022; Watson and Soltani, 2019), hindering their service use. Recent publications thus highlight the need to actively engage with minority ethnic groups to learn their traditions, beliefs and values to

develop more responsive health interventions (Bains et al., 2023; Demir, 2022; Naz et al., 2019; Pilav et al., 2022; Prady et al., 2021). Initiatives such as co-designed psychoeducation tools, culturally sensitive training for professionals, and peer-led community support have shown promise in increasing the engagement of minority ethnic individuals generally (Buist et al., 2007; Naz et al., 2019; Saherwala et al., 2021; Vahdaninia et al., 2020), but much remains to be understood when it comes to MEW's personal experiences and beliefs around seeking help in the perinatal period. For example, a mixed methods review of MEW's experiences of perinatal mental health conditions and services found there were no studies which focused on the help-seeking behaviour of MEW in particular (Watson et al., 2019).

To address this gap, this study set out to (1) explore the behaviours and experiences of MEW around seeking help from HCPs regarding PMH issues and (2) identify approaches that would encourage increased help-seeking among MEW. It was conducted in England, where maternal morbidity and mental health disparities are well evidenced between minority ethnic and majority white individuals.

Methods

The study was preregistered on the Open Science Framework (OSF; DOI: 10.17605/OSF.IO/V7E8Y) and follows the Standards for Reporting Qualitative Research framework (O'Brien et al., 2014). Ethical approval was granted by the University of Leeds School of Psychology Research Ethics Committee.

Design

To address the research aims, a qualitative design using a critical realist approach was employed (Bhaskar and Hartwig, 2016). Critical realism suggests that exploring the social world should focus on identifying the systems and processes that generate events and discourses, with the goal of better understanding underlying mechanisms and offering solutions to social issues (Fletcher, 2017). Semi-structured, one-to-one online interviews were carried out with MEW.

Participant selection

A criterion sampling method was used to select participants, which is a purposeful sampling strategy (Palinkas et al., 2015). Participants who met the following criteria were included: Aged 18 years or older; identified as belonging to a minority ethnic group; experienced emotional wellbeing challenges (e.g., low mood, anxiety, stress) for more than two weeks during pregnancy and/or in the first two years after childbirth, within the last five years; have a youngest child between 3 months and 5 years old; had a live birth following their most recent pregnancy; living in England; and have gone through pregnancy, birth, and raising their youngest child in England. Participants who had received inpatient mental health care were eligible only if they had been discharged at least 6 months before taking part. These criteria were developed to ensure that participants had relevant lived experience and could

provide information-rich accounts relevant to the study aim, while also reflecting ethical considerations for recruitment in mental health research.

The study was advertised through virtual flyers circulated via social media platforms (e.g., Facebook, X, Instagram, LinkedIn), universities' minority ethnic staff and postgraduate student networks, and the researchers' networks. Participants expressed their interest by emailing SP. To screen out high-risk individuals and minimise the risk of distress during the interviews, participants were asked a series of questions when they initially expressed interest via email (see supplementary materials_eligibility criteria). Participants signed up for the study via an online form, where they read a participant information sheet and provided consent. If they consented, they completed a demographics form and were invited to participate in an interview.

Stigma-sensitive, non-clinical language was used in participant-facing materials. Specifically, the term "emotional wellbeing challenges" was used in the advertisement, participant information sheets, and topic guide, and was illustrated with examples such as low mood, anxiety, and stress. Participants were not required to identify with a formal mental health diagnosis to take part, both to avoid evoking stigma and to recognise that mental health struggles often go undiagnosed. The term "birthing individuals" was also used in the study materials to be inclusive of people accessing perinatal care who may not identify as women, for example, trans-men and non-binary individuals.

A total of 69 participants expressed interest in the study. After screening (see Supplementary Materials: Excluded Responses), 51 were identified as not meeting the inclusion criteria and were excluded. In total, 18 participants were interviewed; however, one interview was excluded from the final analysis after both coders agreed that the participant did not meet the inclusion criteria for the study.

Data collection

Prior to formal recruitment, pilot interviews with two MEW were conducted to finalise the topic guide; these were not included in the analysis (see supplementary materials_topic guide). Interviews were conducted online via MS Teams by SP between January and April 2025. Sampling, transcription, and analyses were conducted iteratively, guided by information power (Malterud et al., 2016), until the dataset was sufficiently rich to address the research question. £30 shopping vouchers were provided as compensation to each participant. The mean interview duration was 49 minutes. For participant descriptive information, see Table 1. Random codes were used to anonymise participants' original recruitment numbers. A draft of the analyses section of the manuscript was shared with all participants and feedback requested. Two participants responded providing affirmative, positive feedback; the remainder did not respond. In addition, a sample of anonymised transcripts was shared publicly to enhance the transparency and auditability of the analytic process.

Data analysis

The data was managed using NVivo 14 and analysed through reflexive thematic analysis (RTA) (Braun et al., 2022). RTA includes six phases; (1) familiarisation; (2) coding; (3) initial theme generation; (4) reviewing and developing themes; (5) refining, defining and naming themes; (6) producing the report (Braun et al., 2022). Themes were generated inductively, primarily through semantic coding, with latent coding used to support interpretation of underlying meanings, rather than through prespecified codes or themes. An iterative approach was used to conduct thematic analysis throughout the research process, rather than only at the end of data collection, enabling researchers to remain closely connected to the data, participants' experiences, and the research context (Udayanga, 2025). SP led the analysis, going over all transcripts (n=17). To minimise bias, enrich reflections and enhance robustness, a proportion of the transcripts (n=4; 25%) were independently double coded by a second reviewer (SS) and codes compared between both raters. Candidate themes were then discussed by all four authors and refined through iterative discussion and feedback.

Reflexivity

To enrich our interpretation of the data, a diverse authorship team contributed to the project. SP is a Turkish-registered midwife with experience supporting women during the perinatal period. JJ is a UK-based clinical psychologist with expertise in treating mental health conditions. SS is an Indonesian psychology lecturer specialising in mental wellbeing across the lifespan, and KJD is a French-Canadian psychology lecturer whose research focuses on understanding and promoting positive behaviour change. All four authors resided in England for most of the project; three of them were ethnic minorities in England, and one has had experience of being a MEW in the UK, bringing 'insider' understanding to the topic. The inclusion of both 'insider' and 'outsider' perspectives within the research team further strengthened the study, as insider perspectives enriched interpretation, while the outsider position of the lead interviewer may have enabled more in-depth questioning and richer participant accounts.

Findings

Seventeen MEW participated, with a mean age of 34 years, and a youngest child with a mean age of two years. Participants had between one and three children (mean = 1.6 children). All were married except two; one of whom was divorced and the other never married. All participants identified as women. The sample comprised a diverse range of ethnic backgrounds (Table 1).

Six participants reported emotional problems that began during pregnancy. Of these, five reported that their symptoms continued postpartum. Five women indicated the onset of emotional problems prior to pregnancy and five indicated an onset after giving birth. One participant reported emotional problems

that began during a previous childbirth and persisted throughout her most recent pregnancy and postpartum period.

All participants described experiencing a variety of emotional difficulties. Before pregnancy, the most frequently reported feelings included anxiety and feeling down. During pregnancy, participants reported anxiety, worry, crying, and feeling down. Labour and birth were described as traumatic by some participants. After childbirth, women commonly reported feeling alone, tearful, or emotionally low, along with continued experiences of anxiety. Although almost all of the MEW were asked about their emotional wellbeing during the perinatal period, only a small number said they disclosed their true feelings to HCPs, due to various barriers outlined below. Only five participants accessed professional support in the UK, receiving either therapy alone (n=3) or therapy and medication (n=2). A further two received therapy from providers based in their country of origin.

Participants offered rich recollections of their experiences during these times. We developed four major themes in our analysis of these recollections: (1) cultural silence surrounding mental health; (2) low confidence in HCPs and health care services; (3) need for clear and reassuring information; and (4) shared belonging and representation. A thematic map with relevant codes is provided in Table 2.

1. Cultural silence surrounding mental health

Many of the women raised cultural differences around mental health and maternal care as major barriers to disclosing emotional struggles, shaping a "cultural silence" around the topic.

Participants repeatedly pointed out that mental health was not something talked about openly; that they felt they were expected to conceal their troubles: *"We have that belief... people don't talk about emotional wellbeing..."* (P86). Such beliefs discouraged disclosures, even when MEW were asked directly about their mental health. For example, one MEW who worked in healthcare noted that while most white British women she asked admitted to struggling, *"with other ethnicities… they always say 'fine',"* (P27) even when it was unlikely to be true. Outside such services, MEW may also be less likely to be asked about their mental health by others due to these norms of silence. For instance, another participant reflected that after giving birth, her mother-in-law would ask practical questions about the baby but *"never actually how I felt"* (P24).

Cultural silence was intertwined with both stigma and pressures for MEW to present themselves as strong and successful. As one participant reported: *"I think it's just a stigma… you need to be seen as really strong and coping and surviving after you've had a baby"* (P56). Several participants also worried that admitting to difficulties would mark them as a "bad mother" or a "weak person", undermining their identity as strong and capable.

Several participants also normalised their emotional difficulties as intrinsic to motherhood: "*I thought nothing wrong with me. I thought it was normal to feel like down and anxious and stressed out. I just*

put it out to lack of sleep" (P56). Similarly, difficulties were described as something to "get used to" or "deal with" alone: "*I like keeping things to myself. So, I think that was what actually made it … bad for me on that day because I couldn't really communicate that… I just bottled it up…*" (P23).

Family structures and expectations further created challenges for disclosing struggles. Several participants expressed that *"there is a hierarchy"* (P27) in some families, where older relatives were seen as authoritative when it comes to child rearing and maternity care. These family members would sometimes attend MEW's appointments, where their presence could limit MEW's ability to speak openly about their emotional wellbeing.

Difficulties getting adequate practical support from family members also created tensions. One woman explained, *"…people like, oh, you've got your mother-in-law here, she can help. But the help you need which is cooking for you, doing your washing. That help you don't get. Their idea of help is very much let me hold the baby and look after the baby whilst you run around and carry on doing everything else"* (P85).

Another woman expressed that even when support was given, this could inadvertently undermine help-seeking: *"because like the family around you… They'll help, like, bath the baby, look after the baby, tell you to go to sleep, have a break and stuff like that. You can't seem to be, like, not coping. They think that because they're supporting you, why would you be struggling basically?"* (P56). Here, practical help with childcare was seen as incompatible with MEW's continued emotional distress, leaving little space for these needs to be recognised, and representing another way in which cultural norms reinforced silence.

2. Low confidence in healthcare professionals and health care services

For many MEW, decisions around whether to seek help for emotional wellbeing were shaped by a lack of confidence in HCPs. Several participants brought up ways in which HCPs failed to adequately engage with their wellbeing needs. Some women reported that HCPs "*did not ask about… mood*" (P46). Others described interactions as lacking warmth, or as exercises in *"[ticking] boxes instead of really trying to get to know the person as a human"* (P39), which discouraged them from opening up.

MEW emphasised the importance of being asked directly and regularly about their mood. Regular engagement by HCPs normalised conversations about emotional wellbeing and reduced the burden of initiating disclosure themselves. Some women described positive experiences of being asked at every visit, while others reported that questions about mood were rare or superficial. One participant explained: "*If they asked me how I was feeling, I would have told them*" (P86). Importantly, several women suggested that the standard phrase "how are you?" was too easily dismissed as a social nicety and encouraged HCPs to use more explicit language about mood and wellbeing.

Some participants reported having tried to initiate help-seeking themselves. As one individual recounted: "*…it was me that made that first step to seeking help*" (P22). However, such initiatives could be met by dismissiveness, discouraging further help-seeking efforts. *"I didn't really feel comfortable telling the health visitor how I feel because I just felt like they just kept fobbing me off. I felt like they weren't really listening to me. They were just dismissing me as this like anxious mum"* (P24). These reports highlight that check-ins must be more than routine questions; they require empathetic responses that validate women's feelings and avoid minimising their struggles.

A specific lack of confidence in HCPs' ability to understand cultural differences also prevented them from seeking help. One MEW noted, *"[HCPs] can't understand me… it's not related with language… When I say my mum returned home and I am feeling alone, they probably won't understand this because all the mums almost alone here, and not all the grandmothers always be there for them… huge cultural differences"* (P64). Other participants highlighted how cultural differences created barriers to seeking and receiving support. As illustrated by one participant: *"I sometimes feel as though I'm not well understood… it makes me feel embarrassed… and I just want to withdraw"* (P23). This withdrawal also affected participants' interactions with their broader social networks beyond HCPs, leaving them reluctant to share their feelings more generally.

Adding to the above, participants reported that a lack of sufficient follow-ups, as well as seeing different HCPs at different appointments, created further doubt about whether seeking help was worthwhile. Participants emphasised that continuity of care and particularly being able to interact with the same midwife or HCP throughout pregnancy and postpartum were critical to building rapport and trust. This could also ease communication of their emotional struggles with HCPs, as they would not have to repeat their medical or emotional history at every appointment. As one participant explained: "*I think, especially in maternity care, it's very, very important to have the same midwife throughout, because that's where you build a rapport… I feel like every day I'm going to a new person and I'm telling everything from the beginning… That doesn't help at all to talk about this type of things*" (P39). Another MEW reflected that a sustained relationship would have made disclosure easier.

Many MEW noted practical ways to strengthen emotional wellbeing check-ins. Some suggested that regular follow-up phone calls, outside of rushed appointments, would provide reassurance and create opportunities for disclosure. Others suggested a "*24/7 helpline*" (P56) to ensure support was available when it was most needed, rather than waiting until the next appointment. Even when MEW were aware of feasible services to obtain help, and might have wanted to receive help, they were reluctant to take action due to uncertainty around the capacity of the system to offer timely aid.

Adding to the lack of continuity in care, several participants also expressed concerns around safety. For example, one participant described the root of their reluctance as: "*It was mainly… fear that my*

child will be taken away from me" (P95). As one MEW reported, reassurance was needed that "*there's no intention of taking your baby away… togetherness of my baby and me*" (P38) will be maintained.

3. Need for clear and reassuring information

Compounding the effects of lack of confidence in HCPs, participants also highlighted a lack of awareness around services as a barrier to seeking help, particularly in the absence of language-appropriate information: "*We don't know what are the services out there. Sometimes they are not well communicated to everyone. Again, in the different languages or in different websites or different groups... So it's difficult… to reach out to some services if you don't know that they exist…"* (P90).

Similarly, participants reported being unaware of the implications of accessing certain services, such as their cost or coverage, which also led them to avoid services. Importantly, participants were uncertain about the stability of policies and noted access could vary significantly based on factors like immigration status. Other women reported that charities are not government-funded, so seeking help from them might not affect their immigration status. "*I prefer the charity aspect because I know that whatever charity does is not government funded. There's no issue with you having to think twice, like, oh, I don't want to do… something that will affect my immigration status subsequently and say, OK, you have been taking government stuffs, and you did not pay…"* (P97).

In addition, breastfeeding was seen as a hindrance to starting medication, due to misconceptions about potential harm to the baby, which resulted in delayed access to treatment: *"I had to wait until I stopped breastfeeding my son to go and, you know, ask for GP to give me some medication. So, I think breastfeeding was also a barrier for me"* (P47). In this case, inadequate information about the safety of pharmacological interventions led women to focus on coping privately rather than seeking external support.

Participants highlighted that the way information is delivered is as important as the content. A few described difficulties understanding medical terminology. Terms such as "miscarriage" were not always explained clearly, leaving women confused. "*I did not know a lot of medical term with the pregnancy*" (P50). They emphasised that HCPs needed to check understanding, rather than assuming comprehension. Women suggested that interpreters should be used more proactively when English proficiency was limited, with face-to-face interpretation preferred over guessing at "broken English." "*…having good interpreters is really challenging for lots of women*" (P90). For those referred to therapy, having a professional who spoke their language was described as particularly important. With this regard, two MEW received online therapy from their own country, as they felt more comfortable discussing their perinatal emotional wellbeing challenges in their own language and within a familiar cultural context.

Beyond the provision of information per se, participants also indicated that timing of information delivery is an important factor. Notably, several participants expressed missing opportunities for early preparation, noting, for instance, that antenatal classes and midwife appointments were too late to meaningfully address emotional wellbeing. Women suggested that awareness-raising activities before pregnancy or at its earliest stages could help MEW recognise symptoms and seek support sooner.

4. Shared belonging and representation

As a final theme, MEW discussed the importance of having a sense of belonging and representation. MEW reported that being able to receive support from peers who were familiar culturally or linguistically to them was particularly important. Being able to connect with "*someone like me*" (P23) encouraged trust and openness, reducing the fear of judgement. Another participant echoed this view, noting that for many, cultural representation within healthcare services could help them open up and seek help.

Women also called for information to be presented in ways that reflected their identities and experiences. They suggested "*information leaflet about you know mental health wellbeing*" (P47) in multiple languages and formats, posters in waiting rooms featuring people who "look like them" to raise awareness of PMH and encourage help-seeking. For many participants, visibility and representation were central to feeling the information is relevant to their communities and not only for majority populations.

Speaking to the isolation mothers often felt after childbirth, participants indicated that community groups and charities, whether in person or online, helped to reduce this loneliness, provide reassurance and normalise their experiences. However, the cultural makeup of such groups mattered. One mother recalled feeling different and hesitant to attend groups dominated by white attendees: *"you can see blonde eye, blue eye babies and mine is like dark haired, but it's just all physical. But at the same time, you think that am I doing it right? Am I OK to be here? Cause, it feels like I'm the only one different, and sometimes I just stay on the corner."* (P95). This highlighted the need for ethnically diverse groups that allowed MEW to connect without fear of alienation.

Participants wanted community groups to be regular, accessible, and informal. Mothers valued the idea of small gatherings led by community members or peers, which could provide both emotional reassurance and reliable information about available services. For those unable to access in-person community groups (e.g., due to living further away or childcare responsibilities), online platforms provided vital alternatives. WhatsApp groups, Instagram accounts, and Facebook pages provided accessible, immediate, and less intimidating ways to share experiences, ask questions, and seek support. Women emphasised that such digital groups, especially when culturally or linguistically tailored, allowed them to exchange advice and reassurance in real time.

Discussion

MEW are less likely to seek help from HCPs, and it remains unclear how best to promote help-seeking behaviour in this population. Therefore, this study aimed to explore the help-seeking behaviours of MEW related to perinatal mental health and to identify approaches to promote increased help-seeking. The findings indicate that while cultural traditions (e.g., silent resilience and family dynamics) and lack of confidence in HCPs play key roles in hindering help-seeking among MEW, providing clear and reassuring information and establishing culturally matched peer community groups may help to reinforce help-seeking behaviours in this population.

The current study indicates that MEW experience individual barriers to seeking help from HCPs due to cultural issues, fear of social services, lack of knowledge about available services and their costs, the normalisation of emotional difficulties, and childcare demands. Some of these findings are consistent with a previous study exploring Black and South Asian women's experiences of accessing PMH services in the UK, where barriers related to help-seeking included feelings of stigma, mistrust in services, and discrimination related to their emotional feelings (Conneely et al., 2023). Uniquely, in this study, none of the participants reported discrimination, but felt they were not understood by HCPs. This subtle but consistent pattern of feeling misunderstood, unheard, or dismissed suggests that the barriers they experienced were not individual or internal but rather embedded in the structure and systems around them, both at the social level and in the delivery of care. This aligns with wider arguments that health inequalities are rooted in structural inequalities rather than biological or individual deficits (Demir, 2022). In this context, improving outcomes requires more than individual-level interventions; it calls for racial literacy to be embedded in health education and for global health training and research to be actively decolonised, so that systems are equipped to recognise and challenge inequities in practice (Demir, 2022). Importantly, by focusing on lived experiences, this study doesn't dismiss structural explanations—in fact, it helps reveal them. It sheds light on how systemic inequalities are experienced and managed in everyday life. This perspective also supports the development of future interventions that move away from paternalistic models and instead embrace culturally sensitive, decolonised approaches to care.

Furthermore, MEW stressed that HCPs should spend time explaining what emotional changes to expect, what support is available, and what disclosure would mean. This aligns with a systematic review of women's experiences of mental health problems, which reported that women from diverse backgrounds may not be familiar with the atypicality of elevated symptoms of mental health problems (Smith et al., 2019). Taking this further, another study showed that educating women about expected physical and emotional changes during pregnancy helps reduce stigma and promotes open conversations about mental health throughout the perinatal period (Gennaro et al., 2020). The current study showcased the particular importance such strategies may have for MEW, as well as how this

information could be delivered. Participants highlighted that providing clear and reassuring information should be supported by higher quality and culturally sensitive communication, for example, using interpreters and offering translated materials that reflect diverse communities. Support was seen not only as a requirement but as active engagement tailored to women's cultural needs, creating a sense of safety and belonging. This included strategies such as visual communication tools, follow-up contact with HCPs, empathetic conversations in community-based or non-clinical settings and addressing their immigration concerns. Previous studies have similarly reported that barriers such as stigma, mistrust, and limited visibility of services are exacerbated by the absence of culturally sensitive care (Darwin et al., 2022; Watson and Soltani, 2019). This highlights the urgent need for perinatal mental health services to move beyond generic approaches and adopt communication strategies that are both culturally attuned and relationally responsive, in order to build trust and promote meaningful engagement with MEW.

Implications for policy and practice

Improving help-seeking among MEW requires culturally responsive and structurally informed changes in both policy and practice. Providing clear, transparent, and linguistically appropriate information—particularly for women new to the UK or unfamiliar with local services—is essential. Translated materials, interpreter use, and visual resources representing diverse communities can help bridge knowledge gaps and build trust. Additionally, common concerns around confidentiality, medication, and breastfeeding highlight the need for direct, accessible education that corrects misinformation and clarifies service pathways, including how these might affect immigration or visa status.

Beyond information provision, interventions should address deeper cultural and systemic barriers. Support should not be limited to individual screening but should also promote open conversations within routine perinatal care and community-based settings. Frequent follow-ups and empathy emerged as crucial facilitators of disclosure, especially among women with limited social networks, and should be embedded into standard care. Finally, increasing representation in healthcare staff and recognising the unique needs of MEW aligns with efforts to decolonise health systems, ensuring that services are inclusive, safe, and empowering for all.

Strengths and Limitations

Seventeen women participated in the study; the sample size was guided by information power (Malterud et al., 2016), with recruitment ceasing once the dataset was judged sufficiently rich to address the research question. The sample also had a rich composition, representing 10 unique ethnic backgrounds. As such, the codes we generated represented common themes across a wide berth of experiences. This study aimed to explore help-seeking across MEW as a group rather than to compare specific ethnic subgroups; the small number of participants within each group therefore means our findings should not be read as representing any particular subgroup. Although this study identified

important barriers to help-seeking, including financial barriers, the sample was relatively highly educated and largely employed. Therefore, the help-seeking experiences captured here may not fully reflect those of more socioeconomically disadvantaged MEW. Although the study aimed to use inclusive language and be open to the participation of individuals who experience pregnancy and birth but may not identify as women, all participants in the final sample identified as women.

In this study, immigration status, years living in the UK, and highest level of education were not systematically collected and therefore could not be reported reliably. In presenting Table 1 and the participant characteristics collected, we aimed to strike a balance between adequately describing the sample and avoiding the inclusion of excessive detail that might increase the risk of participant identification. From the interview data, we were able to determine the UK birth status of only six participants, of whom one was UK-born and five were non-UK-born; we therefore considered this information too limited to be meaningful to report. Future research may benefit from collecting these characteristics systematically while carefully considering participant confidentiality and the potential risk of re-identification.

Multiple authors engaged with the data and discussed the developing analysis, and participants were invited to reflect on the findings, enriching the interpretive process. A sample of anonymised transcripts was also shared publicly to enhance transparency and auditability. These strategies support the trustworthiness of the analysis via transparency and ensured consistency in interpretation. Dependability was supported by preregistering the study protocol on the OSF prior to data collection. In addition, a reflective account was maintained to document the researchers' influence on data analysis and interpretation, and to outline efforts made to minimise bias. Given that the study was conducted in England, where disparities in maternal morbidity and mental health between minority ethnic and majority white individuals are well documented, the context is similar to other Western nations and findings may have broader relevance.

Conclusion

By exploring the help-seeking experiences of MEW around PMH and identifying approaches that could facilitate help-seeking, this study highlights the importance of cultural sensitivity training for HCPs to meet the needs of MEW and to implement culturally inclusive strategies when designing interventions. In addition to addressing cultural reluctance, interventions should also target the broader cultural silence and stigma surrounding mental health, which discourage open dialogue and help-seeking. Building sustained and trusting relationships with healthcare providers, ensuring continuity of care, and providing linguistically appropriate and reassuring information are essential to fostering disclosure. Representation and visibility of diverse cultural groups within healthcare spaces and resources may further promote belonging and trust. Together, these strategies align with a decolonized

and racially literate approach to perinatal mental health care—one that recognises structural inequities rather than individual or cultural deficits.

Authors declaration

The authors declare:

• that the article is the author(s) original work

• the article has not received prior publication and is not under consideration for publication elsewhere

• that all authors have seen and approved the manuscript being submitted

• the author(s) abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives

The study abstract was accepted on 08.10.2025 as a poster presentation at the 34th International Confederation of Midwives Triennial Congress, which will be held in Lisbon, Portugal on 14-18 June 2026.

Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgement

This postdoctoral research was conducted with the support of Kahramanmaras Sutcu Imam University, including a one-year research visit by Semra Pinar to the University of Leeds (01.07.2024-30.06.2025) and a second year of remote collaboration following an extended research affiliation (01.07.2025-30.06.2026).

Funding declaration

This research did not receive any specific grant funding from agencies in the public, commercial, or not-for-profit sectors.

Ethical approval

This study was conducted in accordance with the Declaration of Helsinki. Written consent was obtained before participation began, and verbal consent was obtained again prior to interviews. The participant information sheet and consent form stated that anonymised transcripts might be shared publicly. A sample of anonymised transcripts is provided in supplementary materials. Ethical approval was granted by the University of Leeds School of Psychology Research Ethics Committee on

13.12.2024 (PSCETHS-1230). The distress protocol from another study was adapted for use in this study to minimise potential risks to participants (Wright et al., 2020).

Author contributions

SP: Conceptualization, Methodology, Project administration, Investigation, Data Curation, Validation, Formal analysis, Writing - Original Draft, Writing - Review & Editing; **JJ:** Conceptualization, Methodology, Writing - Review & Editing, Supervision; **SS:** Formal analysis, Validation, Writing - Review & Editing; **KJD:** Conceptualization, Methodology, Writing - Review & Editing, Supervision.

Declaration of generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this work SP used ChatGPT to improve the language. After using this tool, SP reviewed and edited the content as needed and takes full responsibility for the content of the published article.

Appendix. Supplementary materials

Research data_Anonymised Transcriptions

Excluded Responses

Topic Guide

Eligibility Criteria

Table 1: Demographic characteristics of MEW

Participant number	Age	Age of youngest child	Number of children	Location	Occupation	Current living situation	Ethnicity
P50	36-41	≤12 months	2	Yorkshire and the Humber	Post graduate student	Living with spouse/partner	Indonesian
P22	36-41	3<years≤5	1	Yorkshire and the Humber	---	A single parent household	Indian
P64	30-35	≤12 months	1	Southeast England	Post graduate student	Living with spouse/partner	Turkish
P38	30-35	1<years≤3	1	Northwest England	Post graduate student	Living with spouse/partner	Any other Asian background
P97	30-35	≤12 months	3	West Midlands	Unemployed	Living with spouse/partner	African
P27	36-41	1<years≤3	1	Southwest England	Healthcare professional	A single parent household	White and black Caribbean
P90	36-41	≤12 months	2	Greater London	Case worker	Living with spouse/partner	Latino
P56	36-41	1<years≤3	2	Yorkshire and the Humber	Self-employed	Living with spouse/partner	Indian
P47	36-41	1<years≤3	2	East Midlands	Freelance interpreter	Living with spouse/partner	Turkish
P48	30-35	1<years≤3	1	England	Post graduate student	Living with spouse/partner	Turkish
P23	<30	≤12 months	1	East Midlands	Cleaner	Living with spouse/partner	African
P39	36-41	3<years≤5	1	England	Academic staff	Living with spouse/partner	Sri Lankan
P46	36-41	1<years≤3	2	Greater London	Healthcare professional	Living with spouse/partner	Filipino
P85	>41	3<years≤5	3	East Midlands	Academic staff	Living with spouse/partner	Indian
P95	36-41	3<years≤5	1	West Midlands	Unemployed	Living with spouse/partner	Filipino
P86	30-35	≤12 months	2	Yorkshire and the Humber	University employee	Living with spouse/partner	African
P24	30-35	≤12 months	1	Northeast England	Academic staff	Living with spouse/partner	Chinese

Table 2: Thematic map

Theme	Supporting Quotations
1. Cultural silence surrounding mental health	*"A lot of the time is expected that you have… someone elder. They will help care for your child. And then when the health visitor comes, he can impact what you can discuss because you be self-conscious that somebody else is there listening… You have every right to tell them to leave the room, however… you will be frowned upon…after the health visitor leaves… the elder people will not be very happy about it because ethnic minorities have a lot of, you know, respecting your elders and all that… if you're white British, you might not have that issue because that's not the way things are done here. You know, you have your right as you know, you have your individuality and then you don't have those challenges. So I think that would also impact on the care that people can receive as minority too"* (P86).
2. Low confidence in healthcare professionals and health care services	"[Asking about mood] *was like for the first a couple of visits, yeah. And then yeah, when I noticed that change during my moods, no one asking me about that*" (P48). *"…I had like, maybe four midwives during the pregnancy, which I just found very, very concerning... But they were not giving any attention to it, I think… I told her that I'm feeling little bit anxious about giving birth… Then I remember that midwife was saying… you are not high risk. So, you can just give birth normally so don't be anxious about it. So, I think these sort of things, I thought like more like kind of brushing off what's happened, what are the anxieties and things rather than just trying to really understand what this is about or anything…"* (P39). "*I think also like waiting times do not help because if you think about it, you know, obviously with women in the postnatal period, like their referrals tend to be prioritised. But that still doesn't mean you're going to get seen that quickly… I think it's really easy to think, well, I'm not going to be seen for ages and probably by then I'll feel better. And so like you put off things*" (P27).
3.Need for clear and reassuring information	"*From the experience I had… I understood the fact that not all services you receive from any chances actually covered by the IHS will be, so that's where the lack of knowledge comes from… if you stated freely and we are able to know, OK, this is free, you know it's*

	also covered by your IHS. So we'll know what we're getting into. But if I'm not sure, I would rather keep myself right and get myself into that…" (P97).
4. Shared Belonging and Representation	"*If the person kind of looks like you, it does somehow make things easier. Yeah, I don't know if that makes sense*" (P27). *"I spoke to so many parents and moms, you know what the thing they say? I wish I knew English fluently… I think they feel also very relaxed in their own ethnic group, and they might disclose more information. To be honest… because of the language barrier*" (P47). "*…maybe a way for mothers to be able to communicate whenever they need to, so they don't have to waste till maybe next week when we have a group or next month. OK, something like a WhatsApp group… So, whenever a mother is feeling down, yeah, like, OK, I can send a voice note. So, this is how I'm feeling right now. I need some help and then they'll tell you. Don't worry, you'll be fine… Do this. You can do that. Something like that"* (P23). *"So, for example, they run like social media platforms like Facebook, Instagram. So, I wonder whether targeting like those types of groups will be more fruitful than targeting, like more generic like baby classes because… we might all be from ethnic minority groups, we are very diverse as well. We also have individual beliefs. I wonder whether targeting those more specific groups will probably be a bit more fruitful and bit more targeted and tailored"* (P24).

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