

**REPORT FOR AMINA PROJECT**

**CONSULTATION ON MATERNITY SERVICES &  
SUPPORT FOR POST-NATAL DEPRESSION**

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Empowering women,  
Creating communities



## Key issues emerging from the report

1. The sense that midwife support was inaccessible or when accessed, inappropriate. Although beyond the scope of this report, this issue arose in many responses and should be considered.
2. Continuing reliance on medically-trained advisors as the only group to have training in the area of post-natal depression, despite dissatisfaction with contact with mainstream medical services.
3. The difficulty of women not recognising or not wanting to admit that they have PND. Any support service must consider this issue of outreach and awareness-raising as a central aspect of activity.
4. There is a need to combine the credibility of professional knowledge with the insights offered by those who have direct experience of PND and are regarded as insiders in the local community.
5. Respondents felt that maternity support services should make a wider range of information available in an accessible manner that is respectful of the patient and that gives the patient meaningful choices or direction.
6. Suitable language skills are necessary for a significant group of women, and this must include a range of languages.
7. Many responses stressed the overriding need for separate and safe space for women in the area and an opportunity for women to have personal time and attention.
8. Practical support, including free childcare and possible assistance with domestic tasks, was requested.
9. Support services need to combine access to professional knowledge with a space for peer support and advice from women who have been through PND.
10. There is a need for outreach to families, partners and the wider community in order to break down taboos around PND and including education for men to help them look out for and be able to intervene.
11. Peer support and self-help groups – this form of intervention was regarded as most appropriate by respondents. However, there is a need to balance this against the importance many respondents attributed to medical solutions offered through GPs, health visitors and midwives. There is also the obvious danger of fitting into a support group dominated by any one ethnic/age group.
12. The limits of cultural knowledge – assumptions about cultural identity and practice cannot substitute for listening to service-users and allowing them to feel control over their treatment.
13. Maintenance of professional standards – as well as suitable language skills, services must be provided in a manner that meets users' expectations of professional conduct.

## **Introduction**

146 women took part in this survey. The majority of these (63%) were between the ages of 25-35, and from the B8 (45%) and B36 (26%) postcode areas – the BEN PCT Washwood Heath and Hodge Hill locality.

Almost three quarters of Washwood Heath's population is BME (well above the city average of 32.7%) and around half are women (49.3%). Around 64% of these women are of South Asian ethnicity, and 87% of these are of Pakistani origin.

In Hodge Hill around one fifth of residents are BME (below the city average). Over half the population are women (51.2%) of which around 13% are of south Asian origin, and of which around 82% are of Pakistani origin.

Life expectancy in both Washwood Heath and Hodge Hill is below the England average (men 77.5, women 81.7 (ONS 2005-2007)). Although in Hodge Hill it is marginally higher (men 75.5, women 80) than in Washwood Heath (men 73.3, women 78).

According to the Index of Multiple Deprivations (IMD) 2007 published by ONS, Washwood Heath is the most deprived electoral ward in Birmingham with an overall IMD score of 53.371, while Hodge Hill is the 16th most deprived electoral ward in Birmingham with an overall IMD score of 35.28

The link between poverty and bad health is recognised in BENs 2008-11 Strategic Plan. The position of ethnic minorities in social structures has also been found to impact health (Ahmad 1996, Carlsen and Nazroo 2002). There are also discussions about the role of ethnicity in providing association in the form of community, and how this can be perceived as a resource in tackling health inequalities (Pickett et al (2008),

## **Key themes emerging from analysis of the survey**

### **Issues specific to maternity and pregnancy**

Most of the respondents (77%) said they knew what PND was although less (55%) said they were aware of the symptoms. 25% said they had experience of PND, while 40% said they knew someone who had suffered PND.

The top four factors identified as contributing to PND were:

1. Lack of support from family (24%)
2. Lack of support from professionals (12%)
3. Lack of support from partner (11%)
4. Family pressure (7%)

## Issues related to health services

44% of respondents said they could access ante-natal classes. 52% said they could access a health visitor. Few respondents were able to say why these services were not accessed: (8%) said because of transport and 10% said that ante-natal classes were not offered.

One respondent did identify barriers from family and partners,

"Wasn't allowed to go unless my partner said I could" in response to the question 'could you access antenatal classes, hospital clinics, health visitors?'. This respondent replied that a contributing factor to PND was "having an abusive partner" and felt that PND gave the partner "more control" and that partners did not require support "because it is their fault". This woman is in her 30s and is a Kashmiri Urdu speaker. No other response cited direct abuse.

In terms of midwives, 20% of respondents saw more than 2 different midwives during their pregnancy and 16% expressed dissatisfaction with midwife arrangements. 23% were dissatisfied with maternity services in general. Reasons given for dissatisfaction with maternity services included:

"Not enough personal care"

"Time-consuming because appointments are not seen on time"

However another respondent says "my midwife made me feel very comfortable and took me through all I needed to know" and another "I was made to feel comfortable in all of my appointments. I was taken through all the stages were needed to know". It is important to remember that the majority of women expressed satisfaction with their midwife support. For those who were dissatisfied, continuity and accessibility were significant factors.

A Pakistani woman in her 30s with four children ranging from eight to 17 in age felt a need "to be able to speak to your midwife at any time if there are any concerns". In both questionnaires and focus group discussion the sense that midwife support was inaccessible or when accessed, inappropriate, came up many times. Accessibility to general maternity services was a theme in a number of responses. Some of these linked to physical inaccessibility to other barriers,

"Organisations being too far away. Unable to communicate due to lack of being able to speak English."

84% of respondents said they would *not* be able to identify local services if suffering from PND. When asked, in an open ended question, where respondents would go to for support, the GP was the most preferred first point for help (61 responses), followed by midwives (30 responses) and health visitors (22 responses). 42 respondents said this was because they were

seen as medically trained, and 19 said it was because of a lack of awareness of other services.

Although a large proportion of respondents expressed dissatisfaction with midwife and maternity services, many also answered that if depressed after having a baby they would go to the doctor or hospital. A number of responses suggested that it was the job of medical professionals to know about this kind of thing.

"I would go there because it is a medical condition".

"They should be fully trained and educated to know about such disorders".

Another woman of mixed white and Asian heritage in her 30s with a five year old child identified an important barrier to accessing mainstream support services. In response to the question of who would you go to for help, she responded,

"Midwife/doctor. Although speaking from experience at the time I was unaware that I was suffering from PND."

This is an issue that needs to be addressed – women cannot access support if they do not understand or accept that they are suffering from PND. Any support service must consider this issue of outreach and awareness-raising as a central aspect of activity.

In another open-ended question, 123 (84%) respondents said they would *not* be able to identify local services if suffering from PND. A third of the respondents (42) suggested language/cultural barriers prevented them from accessing these services. Almost a fifth (22) said it was because of a lack of information.

### **A future service**

An overwhelming amount of respondents (84%) felt that more support should be available during pregnancy, and even more (88%) felt that more support should be available after child birth.

When asked about what kind of service should be developed, respondents described: insufficient access to midwifery support and the need for a helpline and emergency support during pregnancy. When asked about who should deliver this support, 33% of responses favoured women from a similar cultural background, 15% health professions; 14% GPs, 12% a midwife, and 8% nurses.

Some respondents were clear that they expected support services to be delivered by medically trained staff:

"A variety of educated speakers who have sound knowledge on this topic."

"Medical staff/people with a good understanding of the condition/women who have been through it"

However, at the same time, respondents recognised the value of personal experience. A Pathan woman in her 20s with a baby of five weeks thought support should be delivered by "someone who has been through it themselves".

Another woman argued that services should be delivered by "community members, not professionals. The same ethnic background. Someone who understands."

This seems to indicate that there is a need to combine the credibility of professional knowledge with the insights offered by those who have direct experience of PND and are regarded as insiders in the local community.

A significant need in maternity support services is to make a wider range of information available in an accessible manner that is respectful of the patient. Suggestions that the kind of support that is required during pregnancy and after childbirth included:

"Midwives taking more of an active role in giving more information"

"More Asian midwives the better communication"

"Financial support, emotional and moral support"

"As a patient I don't think I'll was told about all that was available to me."

"More baby groups or both classes"

"in the home/domestic for families with lots of children"

"More one-on-one support I believe would be beneficial to many women"

"Women gathering together, learning more about past childbirth and all that comes with it. I would like to see some Pathan speakers to translate that those women were not fluent in any other languages".

A significant number of respondents cited language barriers as hampering access to suitable services. However, lack of information was not always linked to language competency – thought must be given to how midwives and maternity services ensure that women are aware of the range of services and their own options.

In terms of where the support services should be delivered, the top three favoured places were: 47% in the local community, followed by 17% at GP surgeries and 6% in a hospital.

When asked what types of activity should be included, the top answers were:

1. Awareness events - 17%
2. Women's group - 15%
3. Literature on PND - 10%
4. Days out - 10%
5. crèche facilities free - 8%
6. early intervention classes - 6%

The descriptions of desired services and facilities give a sense of the overriding need for separate and safe space for women in the area and an opportunity for women to have personal time and attention. One respondent, a Pakistani woman in her 20s, indicated the need for a highly personalised service,

"In the local community centre even on a one-to-one basis at home".

Other respondents stressed the need for women to have the space to be themselves and to be together,

"Events for women, targeted solely at them to make them feel like their thoughts and views are actually considered"

"Talking space. Counsellor offer support. Ability to go out -- greenery -- without child! Learn about PND and coping strategies."

"women's group, walking group, home support"

A 19-year-old woman from Peshawar who was born in the UK this felt that support should be provided by "midwife or other mothers who have been suffering from PND previously"

Some respondents felt that PND support should be provided to antenatal classes, "advertising classes, so women are aware of support available". This respondent felt that support should be offered by midwives. Another spoke of "meetings or talks to set up for women" and in "the local area". Another said "women gathering together with a health visitor taking lead, discussing PND and how to overcome it" - this respondent, a Pathan woman in her 30s, felt services should be delivered by "by Pathan women, speakers who can speak a number of languages,"

Others stress the need for women only events in the area "letting them know about all the services available to them"

### **Peer support and self-help**

Some respondents stressed the need to enable women to make their own space and choices about activities.

"Talking space -- let women decide what they want to do when they meet!"

"A woman's group including women who've been through PND so that women can talk to each other. Promote voluntary organisations such as home start which is a befriending volunteer organisation. Have a contact number available for valuable advice and information. Promote awareness of PND at antenatal classes and postnatal classes."

This same respondent a Pakistani woman in her 30s with three children between the ages of 10 and 16 suggested the bringing together of personal experience and professional expertise,

"Mothers who have suffered from PND with professional advice from midwives or health visitors. This is because mum will be able to see there is light at the end of the tunnel".

There are two key messages in responses about what is needed from support services. One identifies a need for professional knowledge, the other stresses the value of peer support. Services need to be developed that can include elements of both of these requirements.

### **The need for practical support**

Others stressed the need for personal support, including in very practical ways. A Pakistani woman in her 20s with a seven-month-old child suggested that sufferers of PND needed "childminding, help with everyday things, helped to recover from PND quicker". Another Kashmiri respondent in her early 30s with a child of 18 months suggested that women needed "free babycare, free nurseries". Another Pakistani woman in her 40s with seven children aged between 13 and 26 suggested "childcare programmes for mothers with more than one child".

### **Outreach to families, partners and communities**

Respondents identified a need to raise awareness of PND among partners and the wider community – and also to provide active support to partners of those suffering PND.

"Detailed leaflets or maybe even events making them aware of and all that comes with it" for partners

"Husbands to attend at least one session on PND or other family members. Someone to come and talk to family had mothers house ie outreach work".

"How to look after someone suffering from PND. I think brochures and leaflets detailing PND and all its causes etc would help them understand how to deal with the woman suffering from PND."

Some respondents felt that husbands and partners needed to be educated about the symptoms of PND. "They want to help but they can't because they don't know how to does they begin to feel the pressures of PND as well as the wife." another respondent felt that the impact of PND and partners was to "make them more angry".

Another Kashmiri woman in her 30s described the impact of PND on her husband, "not understanding, not willing to understand or listen, say women make it up!" She felt that there was "a need to understand -- have programmes to raise awareness". She also identified support needs as consisting of "talking space, enjoying outside space/Park/trips"

Another Pathan woman in her 30s describe the impact of PND on partners, "can lead them to feel isolated by their wife that she is not in a position to interact with any one". This respondent felt that there is a need for meetings set up for women and for and workers to be Pathan speaking.

"I think they would benefit from organise events set up familiarising them with PND and all that comes with it such as its effects, symptoms, causes etc. Also ways on how to deal and help their wives."

This respondent also felt that there was a need to gain the support of the wider family. It would be useful for service-providers to consider this issue of outreach to the wider community when developing support services for PND in this area.

### **Further points from the focus group**

A focus group was used to gain a further understanding of local women's perceptions toward PND and related services. 10 women attended. Discussion at the focus group included: support from midwives, experience of maternity and wider health services, other available support, views about services in the area, views on the development of local support services.

The survey had revealed that most women were not happy with mid wife support they received. At least three participants of the focus group further elaborated on this saying that they had more than one midwife. This resulted in them receiving inconsistent midwifery services.

'I had three midwives and I had some that would just come in on a day to day basis without any one that I was sticking to'

'It's when you can't get hold of your midwife and you ring and you get another midwife and you have to sit there and explain your whole problem that you're going through for them to actually know what they can do for you and that's really annoying.'

'My midwife was an Asian lady and she was very fluent in the same language as I speak and everything and I went for my sister's appointment and yet she

put my sister's appointment on hold just to find out [about my case]. She really wanted to find out everything about what happened and I was like 'well, why do you want to know? You can't do anything about it. What's happened has happened. And she was like 'Oh I really know what you're going through' and I'm like 'No you don't – you have no idea'. I think she was kind of offended but I was just telling her the truth. I had just got over it, why on earth would I want to go over it again?'

A number of participants had experienced miscarriages and service-providers response to this was regarded as particularly problematic,

'You get no-one come out to see how you are doing so even if you do fall into depression, nobody's going to find out and if you deny it to yourself, if you're in self-denial, no-one's going to find out so you'll fall into this hole and it's just going to get deeper and deeper until someone actually offers a helping hand.'

'If you have to have an op – an evacuation – that's it. No follow-up appointment, no follow-up from the GP, from the midwife, health visitor, no support group. It's up to you, you've had a leaflet, now get on with your life'.

'I didn't even get that.' This woman described being left alone in a room in pain while she miscarried,

'... and once it was all done – you can go home now. No midwife checked or even rang me to see if I was actually OK. I had to ring the midwife to tell her. I had to cancel a couple of my appointments that I had, which none of them actually did. I had to cancel my first scan.'

#### The limits of cultural knowledge

Despite the identification by questionnaire respondents of cultural knowledge as a necessary aspect of support services, the professional conduct of South Asian midwives and GPs was questioned by a number of participants of the focus group. Issues raised included:

- feeling that South Asian midwives assumed a position of superiority (derived from their status as 'professionals') in relation to South Asian women as 'patients'.
- Health professionals locating south Asian womens' health needs primarily within a racial and/or religious context, including advice to pray or recite particular verses.
- GP's were not always seen as helpful, able to maintain expected standards of professionalism (such as confidentiality or time-keeping) or able to communicate effectively with younger British born Asian women.

Such attitudes were seen to act as important barriers to access to what was considered an acceptable service for the focus group participants. The focus group participants conveyed how certain characteristics of the neighbourhood and community such as low socio-economic status, and perceptions of

disempowered Asian women functioned as a stigma, and that this, then, had affects on health services for them in the area.

'I had a mid-wife who kind of thought she knew me better than I knew myself – who said, well, you're a Muslim so you don't smoke – well, I'm a Muslim but I could smoke. She made up her mind before she asked me, she made up her mind already, or she knew what I should go for without me saying 'look this is what I want to go for'.

'You just meet different midwives and they assume that they know you better than you know yourself.'

The reliance on stereotypical ideas of Asian and Muslim women had consequences for the quality of service that respondents felt they had received,

'There's a thin line. I know they have to try to be friendly to try to calm you down if you're nervous, if it's your first time with a midwife, but it's when they jump to conclusions. Sometimes whatever's happened in your past, it's very different, like they ask you questions about previous abortions and ultimately there are some Asian women that are midwives and they just assume ... and if you're Asian ask you if it's down to domestic violence in a way that they're trying to voice that 'well, you probably are going through it and we want you just to let us know now ... you know, stereotyping'.

'I think it's the traditional image – you're a Muslim woman or an Asian woman – you're a downtrodden housewife who's battered, who gets beaten and there will be more 'issues' – but it is like stereotyping.'

'Because you could be in like a managerial position and go through to see a midwife and she will assume that you are a housewife, 'so you don't work', 'yes I do'

Importantly, the impact of previous research and awareness raising about key issues such as domestic violence led to some professional practice that made respondents feel that they were not listened to or respected by health professionals.

'They just think that we haven't a sense of choice – we can't choose to do something – [it's] our family, our partners, our husband. They don't think, well, hang on, they can make choices for themselves, maybe it's her choice to do this. They just think is it your choice or is it your partner's and you think, well, I'm saying it so obviously it is my choice.'

'I think they are really surprised as well if you do say you've got a supportive husband or a supportive family. They are like 'oh you are so lucky'

'They expect the worst, they expect 'oh I don't get support from my husband'.

Other research has found that issues relating to quality of care, social class, and even discrimination are seldom considered in planning of health services for south Asian women (Bowler 1993, Templeton et al 2003)

### **Professional standards**

One woman said that she would avoid seeing an Asian midwife or health professional,

'They tend to believe that they are more educated than you or that they know better ... they got their hand over you because they are Asian. They look at you like you're nothing. They've got that mentality that they have in Pakistan that, hang on, we're a bit more educated than you are because we are their patient – but, hang on, we could be a doctor as well.'

Later the same woman expanded on this theme,

'I know once I've gone in that door and there's an Asian lady sitting there she's literally going to sit there and judge me and I'm not having that ...

'... because you're pregnant, you're already stressed and you're worried ... the first experience wasn't good, you're hoping this time you have a good experience and you're sitting there really freaking out and she's just sitting there asking you 'is everything OK at home? How are things with your partner? Is your partner happy that you're pregnant? I'm pregnant, not my partner. If I did have a problem then it would be me and him discussing it not me and you and then she will probably just assume there's something wrong because I'm not talking too much and not telling her all the details ... if I had a choice I wouldn't even go to a woman.'

The contribution of another woman gives some insight into this issue and the manner in which negative representations of Asian women continue to hamper the maintenance of expected professional standards of service,

'And sometimes I find it's not just Asian women, it's the whole field – even some other races think that because you are Asian you're put down, you're not allowed to go out – 'how are things at home? - well we don't want to tell you how things are at home, that's private, that's personal. You know, we're here to receive medical treatment, do your job.'

### **Considerations for a future service**

Research suggests that the most common predictor of PND is the overall mental health condition of the woman and that support to help establish higher self esteem and self efficacy can help reduce PND in the immediate postpartum period (Templeton et al 2003).

The questionnaires revealed mixed experiences and attitudes toward PND. While most respondents were aware of what PND was, there was less knowledge of its symptoms and causes and even less understanding of how

to access support for PND. Survey respondents and the focus group participants revealed significant incongruity between the south Asian women's medical and support needs and services available through mainstream provision. Local women challenged the professionalism of health practitioners and revealed the impact professional ideologies can have on service-users, particularly where these are derived from a pathologisation of Asian communities. If not correctly conceived, attempts to address the cultural needs of communities can result in reinforcing the same inequalities it seeks to eradicate (Ahmad 1996).

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