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Sociocultural Factors Affecting Mental Health Service Utilization by African Newcomer Women Following Childbirth in Canada

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Graduate Program in Nursing

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ABSTRACT

Immigration to Canada and thereupon giving birth are life-changing events for newcomer women. The stress of resettlement and being a new mother, may place newcomer women at risk of mental health challenges. However, there is a paucity of literature focused specifically on Black African newcomer women's perspectives of mental health care after experiencing childbirth in Canada. This qualitative study explored sociocultural factors that impact on Black African immigrant women's perception of mental health and mental health service utilization within a year after childbirth in Canada. A purposive sample of 10 newcomer women from Africa were interviewed individually. A thematic analysis of data revealed three main themes: 1) Postpartum sanity, 2) Help-seeking and treatment preferences, and 3) Barriers and facilitators. Findings from this study have the potential to inform culturally safe and racially sensitive nursing practice to meet the postpartum mental health needs of newcomer African women in Canada.

Keywords: newcomer African women; postpartum mental health; mental health service utilization; sociocultural context

CO-AUTHORSHIP STATEMENT

Deborah Baiden completed this Master's thesis under the supervision of Dr. Marilyn Evans and Dr. Erica Lawson who will be co-authors on the publication resulting from the chapter two of this work.

DEDICATION

Birds sing not because they have answers but because they have songs. — African proverb.

This work is dedicated to all ten African newcomer women who participated in this study: Ada, Adoma, Akoto, Akua, Fatima, Mayy, Naana, Olivia, Sadia, and Sandy.

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CHAPTER 1

INTRODUCTION AND BACKGROUND

Approximately 3.3% of people worldwide live outside their home countries (United Nations Population Fund (UNFPA, 2015). Canada is recognized as one of the developed countries that takes in many immigrants (Hiebert, 2016). In 2014, more than 260,000 immigrants settled in Canada, with a total of over 11 million newcomers forecasted to become residents of Canada by the year 2031 if current immigration trends and public policies continue (Hudon, 2015). According to Statistics Canada (2015), women make up about half the number of immigrants moving and resettling into the country. Furthermore, there is an increasing diversity in the population moving to Canada (Statistics Canada, 2017). Since the 1970s, there has been a shift in migration patterns, with more immigrants moving to Canada from non-European countries than previously, particularly from African countries (Hudon, 2015). About 3.9 million people living in Ontario identify as visible minorities with 16.2% of African and Caribbean descent (Statistics Canada, 2016). Also, almost 80% of female newcomers to Canada identify as visible minorities (Statistics Canada, 2010 as cited in Hudon, 2015).

Migrating to a new country may present several challenges that could affect a person's mental health (Guruge, Collins, & Bender, 2010). According to the World Health Organization (2018), almost 13% of new mothers worldwide experience mental stress. This means that, newly arrived immigrant women who have delivered a baby away from their home country and a familiar culture may encounter additional challenges that may affect their mental status. For example, risk factors for maternal mental illness among newcomer women include low income levels, unemployment, language barriers, lack of social support, uncertain immigration status, and vast cultural differences

(Ahmed, Stewart, Teng, Wahoush, & Gagnon, 2008; Ganann, Sword, Thabane, Newbold, & Black, 2016; O'Mahony, Donnelly, Bouchal, & Este, 2013; Sethi, 2013).

Immigrant women who identify as visible minorities reportedly experience high depressive symptoms following childbirth (Mechakra-Tahiri, Zunzunegui, & Seguin, 2007). Therefore, Black newcomer women who have recently given birth may be at risk of mental stress. Results of a study conducted in Manchester, UK by Edge, Baker, and Rogers (2004), with a primary focus on Black women from the Caribbean, indicate that race can have a significant impact on women's use of postpartum mental health services. Prejudice in the mental health care system against the Black population may contribute to their limited use of mental health services (Alang, 2019; Fenta, Hyman, & Noh, 2006; Edge, Baker, & Rogers, 2004). Likewise, a US study by Alang (2019) reveal that racial discrimination experienced by Black people while accessing mental health services result in their underutilization of these services. Similarly, a cross-sectional secondary analysis by Grace et al. (2016) with a focus on ethnocultural minorities in Ontario, reveals that visible minorities of African descent, are more likely to have poor mental health outcomes and less likely to use mental health services.

Research indicates that culture also plays a significant role in determining the mental well-being of newcomer women moving to Canada (Crooks, Hynie, Killian, Giesbrecht, & Castleden, 2011). Culture is an integral component in the provision of holistic and quality health care for clients. Gray and Thomas (2006) define culture as a "set of complex interactions to be examined and engaged" (p.77). Thus, in exploring culture as a determinant of health, nurses must also "examin[e] the processes whereby groups are defined as different, marginalized or vulnerable; analyz[e] the ways in which such groups are defined, and the limitations imposed by such constructions" (Gray &

Thomas, 2006, p. 82). Cultural differences, such as unknown cultural norms in their adopted country, could affect newcomer women's decision to seek primary mental health care (Crooks et al., 2011). Further, compared to Canadian-born women, female newcomers are unlikely to seek mental health services due to several sociocultural challenges (Kirmayer et al., 2011). These challenges include culturally constructed gender roles, cultural beliefs concerning mental health, and stigma attached to mental illness (Ahmed, Bowen, & Feng, 2017; Mamisachvili et al., 2013; O'Mahony et al., 2013).

According to Andermann (2010), culture and gender may influence mental wellness by providing the context in which mental health and mental health services are viewed by a specific society. Apart from culture, some studies point to the intersectionality of mutually reinforcing factors, such as race, immigration status, and gender on mental health and well-being for newcomer women (Mckenzie, Hansson, Tuck, & Lurie, 2010; Weerasinghe, 2012). However, few studies have examined postpartum newcomer women's perception of mental health services and the impact of culture to provide insight into their low levels of utilization of these services as well as to improve program planning for this unique group of women. Crooks et al. (2011) emphasize that culture is worthy of attention in exploring factors that influence the mental well-being of newcomer women moving to Canada. In addition, few studies have been conducted with newcomer Black women, specifically from African countries, contributing to their under-representation in maternal mental health related studies.

Adserà and Ferrer (2013) report that immigrant women initially have a lower birth rate following migration which rises afterwards to 20 percent higher than Canadian born women. As Canada continues to receive more immigrants, there is a need to conduct

more research exploring mental health service utilization by newcomer Black women from African countries after childbirth. This qualitative study explored Black African newcomer women's perception about the postpartum mental health and mental health service utilization, and the barriers and facilitators they may face in accessing these services.

Significance of the Study

Canada has become more culturally diverse with people emigrating from non-Western countries (Statistics Canada, 2016); this means that nurses and other health professionals will care for more people who identify as visible minorities. Recent immigrants to Canada experience a decline in their mental well-being after migration (Ahmad et al., 2005; Sethi, 2013). Black African women who have recently moved to Canada and given birth shortly afterwards may be at risk of mental stress and need mental health services. To the best of my knowledge, there is no published study that focuses solely on the maternal mental health of Black newcomer women from African countries living in Canada during the postpartum period. This qualitative research provides a platform for Black African immigrant women to discuss their motherhood experiences in Canada, voice their mental health needs, and articulate their perceptions of mental health service use after childbirth. The results have the potential to highlight the impact of sociocultural factors on newcomer Black African women's utilization of postpartum mental health services.

This study provides an empirical contribution to the improvement of mental health care for immigrant mothers. Results from this study can help formulate strategies to reduce the underutilization of mental health services among newcomer mothers. The findings may also inform specific nursing protocols to address Black African newcomer

women's mental health needs after childbirth in Canada. The findings will provide nurses and other health care providers with knowledge and insights regarding the factors that influence the use of postpartum mental health services by newcomer women from Africa. This information could be used to develop immigration health and settlement policies that are culturally safe to meet the postpartum mental health needs of newcomer African women. Thus, this research contributes to nursing knowledge with respect to how to improve care for postpartum mothers from African countries. Accordingly, findings may shape healthcare practice and health policy, making the Canadian healthcare system more culturally sensitive and safe to maintain the postpartum mental health of newcomer Black African women. Given that inclusive health care is pivotal in the sustainable integration of immigrants, the findings from this study will facilitate the realization of Canada's goal of integration and multiculturalism (Liston & Carens, 2008), and making communities all-inclusive. Moreover, in an era of increasing international migration, the findings from this study may also be useful to other countries across the world.

Purpose of the Study

The purpose of this study was to explore sociocultural factors that impact on Black African immigrant women's perception of mental health and mental health service utilization within a year after childbirth in Canada. Although the study recognizes that several inter-connected factors inform these women's decision-making to access mental health care, it focuses specifically on the cultural aspects of their postpartum experiences; because, little is known about postpartum care and maternal mental health of Black African immigrant women in the Canadian nursing literature.

Research Questions

This study was guided by the following questions:

1. What are newcomer women's perceptions and understanding of mental health and mental health service utilization during the postpartum period?
2. How does culture impact on newcomer women's willingness to use mental health services after childbirth?
3. What are the perceived barriers and facilitators to the use of mental health services by newcomer women from African countries?

Definition of Terms

For the purposes of this study, a newcomer woman is defined as an immigrant woman from an African country who has been living in Canada for not more than five years (Statistics Canada, 2010). An "immigrant" in this study refers to a woman who voluntarily leaves her country of origin to settle in Canada. This definition does not include newcomer women who were forced to migrate to Canada because of war, famine, or persecution as several studies emphasize the mental health needs of refugees as compared to other immigrants. Furthermore, this study sought to explore postpartum mental health in relation to voluntary immigration. "Postpartum period" refers to the period up to one year after childbirth. A Black African immigrant woman is defined as an immigrant woman who migrated from Africa to Canada and identifies as Black. Mental health in this study is defined according to the World Health Organization (2014) as "the state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (para.1).

Declaration of Self

In undertaking this study, I acknowledge that the research process has been affected by my personal and professional background. I identify as a newcomer Black

African woman since I migrated from Ghana to Canada and have lived in Canada for the past two years. I am a registered nurse from Ghana. My assumptions and beliefs are based on my personal experiences as a newcomer immigrant from an African country and being a recent mother in Canada. I was pregnant in my third trimester and had a baby during the course of this research. Given my status as a Black newcomer woman and a recent mother, the participants freely provided data that was significant to the study. Additionally, I was able to ask relevant questions to elicit in-depth information and uncovered some themes that emerged from the data. However, due to my assumptions and personal experiences as a newcomer woman and mother, I may have missed important data by not asking certain questions because I either assumed that it is common knowledge or was biased to an emerging theme. I assume that newcomer mothers have a stressful motherhood experience in Canada and after childbirth may not be willing to use mental health services due to cultural health beliefs, stigma, and difficulty in navigating the health system. I believe a mentally healthy newcomer mother is one who can adapt to the combined stress of moving into a new country and having a baby in a way that does not put her and the baby's life in danger.

As a nurse, I do not believe in the metaphysical causes of mental illness. As a Black African mother, I have a preference for cultural norms surrounding motherhood and postpartum healing. To deal with these biases, I consulted with my supervisor and research advisory committee member and engaged in reflective journaling through the research process. I have some experience as a research assistant in a multi-site mixed-method study on infertility in Ghana where I conducted and transcribed qualitative interviews. Having taken a methodological course at Western University focused on the

politics and practices of qualitative interviews, I have research knowledge about how to conduct qualitative interviews.

Overview of Thesis

This thesis is written in an integrated article format and consists of three chapters. The first chapter provides background information on maternal mental health after childbirth with a focus on newcomer Black women living in Canada who recently immigrated from an African country. The significance of the study, as well as its purpose and research questions are outlined in the first chapter. The second chapter provides an in-depth account of the research study which serves as an unpublished manuscript. Chapter two includes the background, literature review, purpose, research questions, methodology, research findings, discussion, implications, and study strengths and limitations. Chapter three presents a discussion on significant findings and their implications for nursing research, practice, education, and policy. The final chapter also provides a summary and recommendations.

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CHAPTER 2

INTRODUCTION

Globally, about 3.3% of people live outside their home countries (United Nations Population Fund (UNFPA), 2015). Canada is recognized as one of the developed countries which takes in many immigrants (Hiebert, 2016). In 2014, more than 260,000 immigrants settled in Canada, with a total of over 11 million newcomers forecasted to become residents of Canada by the year 2031, if current immigration trends and public policies continue (Hudon, 2015). Statistics Canada (2015) reveals that women make up about half the number of immigrants moving and resettling into the country. Furthermore, there is an increasing diversity in the population moving to Canada (Statistics Canada, 2017). Since the 1970s, there has been a shift in migration patterns, with more immigrants moving to Canada from non-European countries than previously, particularly from African countries (Hudon, 2015). According to Statistics Canada (2016), approximately 3.9 million people living in Ontario identify as visible minorities with 16.2% being of African and Caribbean descent.

Background

The World Health Organization (2018) reports that, approximately 13% of recent mothers experience mental stress globally. Previous studies reveal that newcomers living in Canada experience a decline in their mental well-being following a move to Canada (Ahmad et al., 2005; Sethi, 2013). Compared to their Canadian-born counterparts, newcomer mothers face an unsatisfactory health status following childbirth and are more likely to be mentally unwell after delivery (Gagnon et al., 2013; Stewart, Gagnon, Saucier, Wahoush, & Dougherty, 2008). Furthermore, immigrant women who identify as visible minorities reportedly experience high depressive symptoms following childbirth

(Mechakra-Tahiri, Zunzunegui, & Seguin, 2007). Etowa (2012) describes childbirth as a “life experience [which is] bitter-sweet [and a] spiritual event [conveying] a sense of responsibility” with the birth of a child (p.31). For African Black women, childbirth is not only a biological process, but also rooted in cultural and spiritual beliefs that are unique to their perinatal journey.

Moving to a new country and giving birth shortly thereafter are both life-changing events for newcomer women. Specifically, forming new social connections and assimilating into a new country and culture may take time. In addition to separation from family and significant social connections, several factors may contribute to newcomers’ decline in mental wellbeing following migration to Canada. These factors include financial difficulties, lack of social support, challenges in accessing social and health services, and unfulfilled hopes and dreams about perceived new life in Canada (Ahmed, Stewart, Teng, Wahoush, & Gagnon, 2008; Ganann, Sword, Thabane, Newbold, & Black, 2016; Sethi, 2013). This means that African newcomer women who have recently given birth in Canada may be at risk of mental stress and in need of mental health services.

Newcomer women immigrate into Canada based on qualifying categories under Canada’s immigration program. Immigrant women who apply for permanent residency are accepted into family class, economic class, and refugee application categories (Statistics Canada, 2016). Consequently, family members can join their relatives under the family class, immigrants are nominated under the economic class for their potential to contribute to Canada’s economy, and immigrants with legitimate reasons against returning to their home countries are permitted to stay under the refugee application category (Statistics Canada, 2016). Furthermore, immigrant women can apply for

temporary residency as visiting immigrants, workers, or students (Statistics Canada, 2016). The specific category to which immigrant women belong determines their health status and the level of health care they are qualified to receive (Gagnon et al., 2013). O'Mahony and Donnelly (2010), in an extensive review of literature, reveal that immigrant women's susceptibility to inequalities are reinforced by immigration policies in Canada. For example, a permanent resident (PR) status accords a newcomer woman with universal health coverage in Canada. However, some inequalities may also occur as a result of many immigrant women being dependent on their male partners for immigration status (O'Mahony & Donnelly, 2010).

In Canada, Black immigrants are the third largest group of immigrants who identify as visible minorities, with the majority having African ethnic roots (Statistics Canada, 2018). In addition, more Black immigrants are moving into Canada than in the past (Hudon, 2015). According to Statistics Canada (2017b), in 2016 due to current immigration policies, African newcomers contributed to an unprecedented 13.4% of international immigrants to Canada, replacing European newcomers for the second position. Moving into a new country means leaving behind family, friends, familiar systems, and a customary way of life, along with perceptions, beliefs, and practices regarding health and health care. According to Miskurka, Goulet, and Zunzunegui (2010), immigrant women from Sub-Saharan Africa are more susceptible to maternity related mental issues.

Stigmatization of mental illness is present in many societies across the world and because of underlying cultural factors and insufficient information on mental health, it negatively affects the patient and utilization of mental health care services (Corrigan, Druss, & Perlick, 2014). A qualitative study with 32 immigrant women who identify as

visible minorities from Asia, Africa, Latin/South America, and non-English speaking countries in Eastern Europe was conducted in Halifax, Nova Scotia (Weerasinghe, 2012). Findings from this study highlighted discriminatory behaviors towards immigrant women of color by health care professionals because of “audible and visible personal attributes related to [their] visible minority statuses” (Weerasinghe (2012, p. 26). Although Canada has a comprehensive health coverage system, there are disparities in access to and the use of mental health services among vulnerable populations (McDonald et al., 2017).

Research shows that a large portion of visible minorities in Canada underutilize mental health services despite being prone to high stress levels due to systemic and individual factors (Fenta, Hyman, & Noh, 2006; Grace et al., 2016; McKenzie, Hansson, Tuck, Lurie, 2010). McKenzie et al. (2010) indicate that individual factors such as language difficulties and a lower educational level and systemic factors such as institutionalized racism contribute to the underutilization of mental health services by visible minorities in Canada. In a cross-sectional study of 342 recent Ethiopian immigrants living in the Greater Toronto Area (GTA), Ethiopian women, as compared to Ethiopian men, accessed formal mental health services less and informal mental care more (Fenta, Hyman, & Noh, 2006). Sociocultural factors such as mental health beliefs, social stigma, and racial prejudice by healthcare professionals were identified as probable causes of the underutilization of mental health services (Fenta, Hyman, & Noh, 2006). Additionally, cultural differences and discrimination may result in a recent immigrant being unable to integrate into a new society. Black newcomer mothers who are discriminated against may find it difficult to fully integrate (Mckenzie, Hansson, Tuck, & Lurie, 2010). The inability to fully integrate may make them unlikely to access health and social services including seeking postpartum mental health care (Mckenzie, Hansson,

Tuck, & Lurie, 2010). Stigmatizing assumptions and the stereotyping of Black newcomer mothers may also affect their use of mental health services and their integration.

Culture is characterized “as a complex interplay of ethnic, religious, linguistic, political, historical, and geographic factors, rather than a simple or static concept” (Valibhoy, Kaplan, & Szwarc, 2017, p. 37). Accordingly, mental health practitioners are encouraged to exhibit cultural safety and sensitivity towards their clients (Valibhoy, Kaplan, & Szwarc, 2017). Valibhoy, Kaplan, and Szwarc, (2017), in their study with 16 young refugees living in Australia, emphasize that treatment strategies should include both the sociocultural context and individual-related factors (Valibhoy, Kaplan, & Szwarc, 2017).

Andermann (2010) notes that, culture and gender may determine mental wellness by providing the background against which a specific society views mental health and mental health services. Besides culture, some studies point to the intersectionality of mutually reinforcing factors, such as race, immigration status, and gender on mental health and well-being for newcomer women (Mckenzie, Hansson, Tuck, & Lurie, 2010; Weerasinghe, 2012). There is a paucity of literature examining postpartum newcomer women’s perception of mental health services and the influence of culture to provide an understanding into their underutilization of these services as well as to enhance program planning for this unique group of women. Crooks, Hynie, Killian, Giesbrecht, and Castleden (2011) stress that culture is noteworthy in exploring factors that impact the mental well-being of newcomer women moving to Canada. However, few studies have been conducted with newcomer Black women, specifically from African countries, contributing to their under-representation in maternal mental health related studies.

Immigrant women initially have a lower birth rate following migration and later, have fertility rates 20 percent higher than Canadian born women (Adserà & Ferrer, 2013). As Canada becomes even more diverse through immigration, it is necessary to conduct more research exploring mental health service utilization by newcomer Black women from African countries following childbirth. This qualitative study explored newcomer African Black women's perception of mental health and the use of mental health services especially following childbirth as well as the barriers and facilitators they may face in accessing these services.

Significance of the Study

Canada has become more culturally diverse with more people emigrating from non-Western countries; this means that nurses and other health professionals will care for more people who identify as visible minorities. Black African newcomer women who have recently given birth in Canada may be at risk of mental stress and in need of mental health services. However, there is a paucity of research that focuses solely on the maternal mental health of newcomer Black women from African countries during the postpartum period in Canada. Newcomers living in Canada experience a decline in their mental well-being following migration (Ahmad et al., 2005; Sethi, 2013). This qualitative research provides a platform for Black African immigrant women to discuss their motherhood experiences in Canada, voice their mental health needs, and articulate their perceptions of mental health and mental health services after childbirth. The findings identify sociocultural factors likely to contribute to newcomer African women's perception and use of mental health services after childbirth. In addition, the findings provide nurses and other health care providers with knowledge and insights regarding the barriers and facilitators of access to, and use of, mental health services by Black

newcomer women from Africa after having a baby. This study presents an empirical contribution to the improvement of postpartum care for immigrant mothers. Hence, the results may inform healthcare practice and health policy, making the Canadian healthcare system more culturally sensitive and safe to meet the postpartum mental health needs of newcomer Black African women. Given that adequate health care is a crucial element in the sustainable integration of immigrants, the findings from this study will contribute to the attainment of Canada's goal of integrating all immigrants (Liston & Carens, 2008) and making communities all-inclusive. Moreover, in an era of increasing international migration, the findings from this study may also be useful to other countries across the world.

Literature Review

A literature review was conducted to determine what is known about postpartum mental health and health service utilization by newcomer women in Canada and to identify the key gaps in knowledge. The following electronic databases were accessed: PubMed, ProQuest, CINAHL, MEDLINE, Scopus, and PsycINFO. A search on the Western University Libraries website was done to access other journals such as Journal Storage (JSTOR) for literature that may not have been included in the electronic databases. JSTOR is an academic search engine and provides digitized versions of older publications. The search terms included were, *maternal mental illness, postpartum depression, newcomer women, immigrants, mental health services, Black women, Canada, and culture*. The criteria for inclusion of articles were: discussed postpartum mental health, written in English, peer-reviewed, and published between 2000 and 2018. This year range was used to provide a review of the most current literature, as well as to determine how literature on maternal mental health has changed over time. Due to a

paucity of literature on African newcomer women in Canada, literature in this review included samples comprising newcomer women from non-Western countries living in Canada. Additionally, studies that employed qualitative and quantitative methods were included. Only Canadian studies were reviewed because, though newcomer women in other Western countries may have similar issues, Canada has unique immigration, settlement, and healthcare policies. A total of 421 papers were accessed. The abstracts of the studies with headings that contained the keywords were read, and studies that did not meet the eligibility criteria or were duplicates were excluded. As well, multinational research (involving Canada and another country) was not included. Finally, 18 relevant studies were included in the literature review. Out of the 18 studies, six were quantitative studies, nine were qualitative, two were secondary analysis of previous studies, and one was a mixed-methods study. Findings from the literature were categorized into three themes outlined as follows: 1) risk factors for maternal mental illness among newcomer women in Canada, 2) impact of sociocultural factors on newcomer women's perception of utilization of mental health services during the postpartum period, and 3) perceived barriers and facilitators to the use of mental health services as a newcomer woman.

Risk Factors for Maternal Mental Illness among Newcomer Women in Canada

A newcomer woman's mental wellbeing may be significantly affected by the stress associated with moving into a new country (Ahmed, Bowen, & Feng, 2017). In their analysis of data from the Quebec Longitudinal Study of Child Development, Mechakra-Tahiri, Zunzunegui, and Seguin (2007) argue that newcomer women belonging to visible minority groups have a higher risk of suffering from postpartum depression as compared to those in majority groups. The mental health of newcomer women in Canada is affected by numerous structural factors following childbirth.

Ahmed, Stewart, Teng, Wahoush, and Gagnon (2008) conducted a qualitative study with 10 newcomer women living in Toronto who showed depressive symptoms in the postpartum period to examine the women's knowledge on maternal mental illness and use of mental health care and support services. The new immigrant mothers identified factors that contributed to poor maternal mental health as lack of family support, separation from mothers and other female relatives, inadequate time for personal grooming, financial constraints of caring for a new child, and the physical changes of the body following childbirth (Ahmed et al., 2008). Similarly, in a longitudinal cohort study by Dennis et al. (2017) with 549 women in Toronto, Chinese immigrant women identified to be at risk of postpartum mental illness, were young overworked mothers with difficulty in getting their infants to sleep, while adapting to a new culture.

A qualitative study, conducted with 30 immigrant women in Canada, revealed that newcomer women face economic barriers such as unemployment, difficulty in obtaining lucrative jobs, dependency on male partners for financial support, and marginalization by employers and colleagues, that together increase the stress in transitioning successfully into motherhood in a new country (O'Mahony et al., 2013). Importantly, the researchers' findings also indicate that most of these women were experienced and licensed professionals in their home countries whose credentials are not recognized in Canada, thus leading to further mental and financial stress (O'Mahony et al., 2013). A newcomer woman with a low level of education and without a strong support system may be vulnerable to depression after childbirth (Mechakra-Tahiri et al., 2007). However, Ganann, Sword, Black, and Carpio (2012) in their secondary analysis of data on 1,045 women reveal that immigrant mothers were found likely to be more educated than Canadian-born women.

O'Mahony et al. (2013) suggest that immigrant women are greatly distressed by an uncertain immigration status and its consequences. Newcomer women are placed in vulnerable positions by immigration policies, further reinforcing systematic gender and racial prejudice (O'Mahony, Donnelly, Este, & Bouchal, 2012; O'Mahony & Donnelly, 2013). In a secondary analysis of a prospective cohort study of 519 immigrant mothers in Toronto, Ganann et al. (2016) assert that more recent immigrants are susceptible to symptoms of maternity-related mental illness following childbirth. For example, recent immigrant mothers may have a small number of social contacts and insufficient information on health and support systems in Canada, consequently experiencing emotional strain after childbirth (Ganann et al., 2016). However, Dennis, Merry, and Gagnon (2017) argue that an immigrant woman may not be directly predisposed to postpartum mental illness by her immigration status. Rather, the effects of immigration such as having partners living outside Canada, decreased access to health care and lack of health insurance are shown to be significant predictors of postpartum mental illness (Dennis, Merry, & Gagnon, 2017).

In their analysis of data from a longitudinal survey of immigrants carried out in 2011, Robert and Gilkinson (2012) identified gender as a factor associated with mental health. For example, privileges accorded to boys begin at birth; and, since boys are culturally and socially preferred in certain cultures, immigrant women who give birth to girls are at risk of heightened emotional stress (Ahmed, Bowen, & Feng, 2017; Morrow et al., 2008). Newcomer women from countries in which women are culturally assigned subordinate roles in relationships may be at higher risk for mental stress (Alvi et al., 2012; Ganann et al., 2016; O'Mahony & Donnelly, 2013). Further, immigrant mothers who are culturally expected to respect their male partners' decisions unquestionably, face

more mental stress after childbirth (Alvi et al., 2012). In a quantitative study by Alvi et al. (2012), 91 women in Southeastern Ontario, of which 66 were immigrants, were interviewed to investigate the impact of structural factors on the mental health status of immigrant and Canadian-born women in Canada. The findings showed that newcomer mothers' mental health status after childbirth are impacted by gender roles. Additionally, a longitudinal study by Zelkowitz et al. (2008) on 119 pregnant immigrant women living in Montreal found that lack of traditional postpartum help from female relatives creates tension on immigrant women's intimate relationships, resulting in mental stress.

Male partners of immigrant newcomer women will be expected to take on culturally constructed female roles of caring for the baby, resulting in a change in cultural gender dynamics and a strain in the relationship (Zelkowitz et al., 2008). In their ethnographic narrative study, Morrow et al. (2008) interviewed three groups of immigrant women living in Vancouver to explore their experiences with postpartum mental stress and report that social isolation and lack of a strong support system are major sources of emotional distress after childbirth. Immigrant women are often unable to maintain the culturally prescribed custom of older female relatives caring for them after delivery, which leads to "women turn[ing] to their husbands who may be ill-prepared for this role" (Morrow et al., 2008, p.610). As a result, recent immigrant mothers with limited support systems are susceptible to postpartum mental illness because of the gendered expectations that they are responsible for primary child care (Morrow et al., 2008). Nonetheless, it is worth noting that the participants interviewed for this study are from South-east Asian countries and hence their cultures may vary from Black newcomer mothers from African countries.

Impact of Sociocultural Factors on Newcomer Women's Perception of Utilization of Mental Health Services during the Postpartum Period

Newcomer women's perceptions of mental health and the use of mental health services after childbirth are significantly affected by cultural norms and beliefs. In a critical ethnographic study by O'Mahony et al. (2012), 30 immigrant and refugee women were interviewed to investigate their understanding of postpartum depression and attitudes towards the use of mental health services. Findings indicated that although newcomer women are aware of maternal mental illness such as postpartum depression, it is not culturally defined in the home countries for most of these women. As a result, most migrant women do not attach enough significance to the disorder and the need to seek mental health care (O'Mahony et al., 2012). In a later qualitative study which applied a postcolonial feminist viewpoint, O'Mahony et al. (2013) found that culture, religion, racial prejudice, among other socioeconomic factors impact the help-seeking attitudes of non-Western immigrants in dealing with maternal mental stress. An exploratory qualitative study conducted with 17 immigrant women in Toronto found that immigrant women may feel reluctant to access mental health services during the postpartum period due to the long-standing cultural belief and expectation that having babies is equated to happiness (Mamisachvili et al., 2013). As one participant described it "...you have a baby, you're supposed to be happy" (Mamisachvili et al., 2013, p. 166). Mamisachvili et al. (2013) suggest that a newcomer woman's signs and symptoms of postpartum mental illness may be interpreted as an inability to tackle the joys and stress of motherhood, rather than a health concern.

Additionally, some newcomer women from non-Western countries mistrust Western care in treating mental illnesses and may not utilize their services (Morrow et al.,

2008; O'Mahony, 2011; Vigod et al., 2016). In a population cohort-study in Ontario, Vigod, Sultana, Fung, Hussain-Shamsy, and Dennis (2016) suggested that many immigrant women do not access mental health services after childbirth due to their suspicion of Western medical treatment of mental illness. Davey (2013), based on findings from her ethnographic study on 12 Bhutanese women living in Edmonton, argues that many of these women prescribe "sharing problems and getting advice from others" as treatment for postpartum depression rather than prescribed medication (p. 90). Almost all immigrant women sampled in these cited studies emigrated from Asian countries. Thus, there is the need to establish if there are similar findings among other non-Western immigrant women such as those from African countries. Furthermore, from available studies involving Black newcomer women (Ahmed et al., 2008; Dennis, Merry, & Gagnon, 2017; Mamisachvili et al., 2013; Robert & Gilkinson, 2012), they may be more vulnerable to maternity related mental illness in Canada. However, knowledge of their perspectives on the use of mental health services after birth is limited and warrants further exploration.

Perceived Barriers and Facilitators to the Use of Mental Health Services as a Newcomer Woman

Newcomer women in certain cultures are deterred from accessing needed mental health services after childbirth due to negative sentiments attached to the concept of mental illness coupled with family involvement in the personal lives of relatives (Mamisachvili et al., 2013; O'Mahony et al., 2013). Additionally, findings from a qualitative study by Mamisachvili et al. (2013) demonstrate that, newcomer women may be suffering from postpartum mental illness in silence due to the stigma attached to mental illness in their communities when word of their mental health status "gets around"

(p.165). Newcomer women are significantly discouraged from seeking mental health services because of the stigma of being identified as mentally ill and the possibility of being ostracized by family and community members (Ahmed et al., 2008; Ahmed, Bowen, & Feng, 2017; Mamisachvili et al., 2013; O'Mahony, 2011; O'Mahony et al., 2013).

Culturally constructed gender roles also serve as barriers to the use of mental health services by newcomer women particularly if their male partners are not in favour of their use (Ahmed, Bowen, & Feng, 2017; O'Mahony, Donnelly, Este, & Bouchal, 2012; O'Mahony et al., 2013). In a mixed methods study conducted in Saskatoon, Saskatchewan by Ahmed, Bowen, and Feng (2017) with 12 newcomer Syrian refugees, the mothers expressed the likelihood of their husbands preventing them from making use of mental health services or discussing symptoms of mental distress with an 'outsider' such as a healthcare provider. Previous research reveals that immigrant women's inability to access mental health services after childbirth may also be due to their lack of knowledge of how the system works or lack of health insurance (Ahmed et al., 2008; O'Mahony, 2011; Sword, Watt, & Krueger, 2006). However, the findings from the study by Sword, Watt, and Krueger (2006) cannot be generalized to Black newcomer women in Canada because immigrant women made up half of the sample of 1,250 new mothers and out of this group, recent immigrants only made up to about a third. Newcomer mothers also report being fearful that accessing assistance from health care facilities or government's support organizations for mental stress may result in their children being taken from them for being mentally unwell for mothering (Ahmed et al., 2008).

Newcomer women with limited English and French language skills may perceive language as a barrier to accessing mental health services (O'Mahony, Donnelly, Este, &

Bouchal, 2012; Vigod et al., 2016). Newcomer women, especially those from non-English speaking countries may face challenges accessing help for any service, including mental healthcare in their first language. Ahmed, Bowen, and Feng (2017) report that newcomer mothers express their misgivings about the confidentiality and privacy surrounding the use of interpreters in accessing help for mental stress. These women's decision to access mental health services may also be impacted by the distance and costs of travelling to health care facilities (O'Mahony, Donnelly, Este, & Bouchal, 2012; Vigod et al., 2016).

A newcomer woman's decision to seek mental health services after delivery may also be influenced by her experiences with healthcare professionals (Ahmed et al., 2008; Gagnon et al., 2013; Morrow et al., 2008; O'Mahony, 2011). Results from a qualitative study conducted by Ahmed et al. (2008) with ten immigrant mothers in Toronto indicated newcomer mothers felt, that compared to doctors, nurses were more inclined to enquire about a woman's mental health postpartum as well as their physical health and that of the baby. However, newcomer mothers perceive that an unsympathetic attitude on the part of health care professionals could be a barrier to their use of mental health services during the postpartum period (Ahmed et al. 2008). In their secondary analysis of a survey including 1045 immigrant mothers, Ganann, Sword, Black, and Carpio (2012) noted that immigrant mothers who were mentally stressed emphasized a lower service satisfaction, in comparison with mentally stressed Canadian born mothers. Therefore, the use of mental health services after delivery may be facilitated by access to culturally competent and safe care for emotional needs (Ganann et al., 2012).

Summary of Existing Literature

There is evidence that immigrant and refugee newcomer women in Canada are

susceptible to maternal related mental illness (Dennis et al., 2017; Zelkowitz et al., 2008). Factors, such as a lack of social support, stigma, cultural differences, difficulty in finding employment, poverty, gender inequalities, discrimination at the workplace, uncertain immigration status, and language barriers have been reported as contributing to the mental health of newcomer women (Ahmed et al., 2008; Alvi, Zaidi, Ammar, & Culbert, 2012; Dennis, Merry, & Gagnon, 2017; Gagnon, Carnevale, Mehta, Rousseau, & Stewart, 2013; Ganann, Sword, Thabane, Newbold, & Black, 2016; Mamisachvili et al., 2013; Morrow et al., 2008; O'Mahony, Donnelly, Bouchal, & Este, 2013; O'Mahony, Donnelly, Este, & Bouchal, 2012; Sword, Watt, & Krueger, 2006). Furthermore, economic concerns such as childcare costs, low income levels, and financial commitments to their families living in their home countries, are risk factors for maternity related mental illnesses, such as postpartum depression, among newcomer women (Ahmed et al., 2008; Dennis, Merry, & Gagnon, 2017; Morrow, Smith, Lai, & Jaswal, 2008; O'Mahony et al., 2013). Culture plays a significant role in shaping newcomer women's perception about the use of mental health services after childbirth (Ahmed et al., 2008; Ahmed, Bowen, & Feng, 2017; Mamisachvili et al., 2013; Morrow et al., 2008; O'Mahony, 2011; Vigod et al., 2016). Besides culture, immigrant mothers accessing mental health services face socioeconomic challenges such as, navigating the system, low income and educational level, discrimination, and an illegal or temporary immigration status (O'Mahony et al., 2012; O'Mahony et al., 2013).

Several barriers to accessing mental health care among postpartum immigrant and refugee women have been identified from the literature review with very few facilitators. Most of the studies aimed at exploring barriers to the use of mental health facilities by newcomer women in the postpartum period. There is a paucity of literature on maternal

mental health of newcomer Black women from African countries during the postpartum period in Canada. To the best of my knowledge, none of these studies in Canada focused specifically on Black newcomer mothers thus supporting the significance of this study. Furthermore, most studies involved participants from mostly Asian and Middle Eastern countries, with none focusing primarily on newcomer Black women from African countries. There is a likelihood that cultural beliefs surrounding maternal mental health in African countries and African women's perceptions of mental health and its associated services will differ. Thus, newcomer Black women from African countries was the focus for this study to uncover their perception about mental health and mental health service utilization as new mothers in Canada.

Purpose Statement

The purpose of this study was to explore sociocultural factors that impact on Black African immigrant women's perception of mental health and mental health service utilization within a year after childbirth in Canada. Although the study recognizes that several inter-connected factors inform these women's decision-making to access mental health care, it focuses specifically on the cultural aspects of their postpartum experiences; because, little is known about postpartum care and maternal mental health of Black African immigrant women in the Canadian nursing literature.

Research Questions

This study was guided by the following questions:

1. What are newcomer women's perceptions and understanding of mental health and mental health service utilization during the postpartum period?
2. How does culture impact on newcomer women's willingness to use mental health services after childbirth?

3. What are the perceived barriers and facilitators to the use of mental health services by newcomer women from African countries?

Methodology

This study used a feminist ethnographic approach to explore sociocultural factors affecting the use of postpartum mental health services among newcomer Black women from African countries, who reside in Southern Ontario. The purpose of this study was to provide an understanding of the factors that shape Black African newcomer women's perception of postpartum mental health and the use of mental health services thus justifying the choice of feminist ethnography as the study's methodology.

Ethnography is defined as “the study of the socio-cultural contexts, processes, and meanings within cultural systems” (Whitehead, 2005, p.5). Ethnography examines a group of people with a similar socio-cultural background and is guided by the principle that a phenomenon can be comprehended only in context (Morse, 1994). African immigrant women come from various regions of Africa with diverse languages and cultures. However, they may share several socio-cultural similarities with respect to maternal health practices and expectations such as familial support. The use of ethnography in nursing research has advanced since the 1960s (Allen, Chapman, Francis, & O'Connor, 2008). Using ethnography to describe Black African newcomer women's postpartum experience is valuable as it provides a context to understand African newcomer women's perception of mental health and the utilization of mental health services following childbirth. This study classifies as a legitimate ethnography because:

1. It is situated in the cognitive aspects of culture and
2. in-depth ethnographic interviews were used to explore the sociocultural context of Black African newcomer women's perception of mental health and mental health services after childbirth. Though traditional

ethnographers use participant observation to explore the cultural context of a phenomenon, a number of ethnographers argue that in-depth ethnographic interviews are sufficient to study the cognitive aspects of culture (Forsey, 2010; Hall, Doloriert, & Sambrook, 2012; Hockey & Forsey, 2012).

Several studies highlight the sociocultural contexts, including gender, that position newcomer women living in Canada as being at risk for mental illness during the postpartum period; these contexts also serve as barriers to the use of mental health services (Alvi et al., 2012; Ganann et al., 2016; O'Mahony & Donnelly, 2010; O'Mahony & Donnelly, 2013). Similarly, this may mean that Black African newcomer women are at risk for mental illness during the postpartum period. Thus, to understand the perspective of African newcomer women concerning the use of mental health services after childbirth in Canada, it is necessary to consider the sociocultural context and focus on the specific social situation of being an African newcomer, Black, a recent mother, and a woman. This justifies the decision to specifically use feminist ethnography. I chose to use feminist ethnography as the methodology for this study with references to Dana-Ain Davis, Christa Craven, Richelle D. Schrock and similar minded feminist ethnographers (Davis & Craven, 2016; Im, 2013; Schrock, 2013).

Feminist ethnography as a research methodology constructs understanding from women's lives in distinct cultural contexts by exposing power imbalances experienced by being a woman (Schrock, 2013). A feminist lens was important to this study because many newcomer women may be from societies with cultural norms where they are expected to be subservient due to their gender and be dependent on their male partners for a secure immigration status, and they may be victims of gendered racism. Schrock (2013) describes feminist ethnography as a "productive methodology and an invaluable

tool for feminism” (p. 58). This means that, feminist ethnography as a methodology helps the researcher to produce information on women’s existence in a cultural context and highlights inequities that they face, in order to provide evidence to support activism (Schrock, 2013). The United Nations Population Fund (UNFPA, 2018) identified immigration as a feminist issue that affects the health status of women, given that women are more likely to be treated unfairly because of their gender and immigration status. Most feminist studies aim to reveal experiences that marginalize women in a sociopolitical context and assist in empowering them (Im, 2013). Thus, a feminist ethnography fits, as the intent of the study was to examine the sociocultural contexts of mental health service utilization and unpack power imbalances specific to Black African newcomer mothers in Canada receiving postpartum services.

Nursing knowledge and development has undergone a significant evolution over the years. Recently, Chinn and Kramer (2011; as cited in Snyder, 2014) suggest the *emancipatory way of knowing* in nursing, which recognizes the potential advocacy role nurses can play because of the power they wield as healthcare providers. Similarly, feminist ethnography as a methodology may promote the generation of emancipatory knowledge by providing Black African newcomer women the platform to voice their perspectives, reveal inequities, and press for change.

Methods

Setting

This study was conducted in Southern Ontario. According to Hudon (2015), Ontario has the largest number of female immigrants in Canada, with 53.7% living in the province. Furthermore, Southern Ontario includes cities such as Toronto which has a female population of 1,359,475 with female immigrants accounting for almost half of it

(Hudon, 2015). Also, based on logistics, since I reside in this part of the province, it facilitated recruitment and data collection.

Sampling

According to Roper and Shapira (2000), “ethnographic research is usually theoretical or purposive” (p. 47). Participants were recruited using purposive and snowball sampling methods. Polit and Beck (2012) note that purposive sampling helps the researcher to select participants with a specific experience and who would best strengthen the researcher’s understanding of the phenomenon by providing rich data. Snowball sampling describes the method where study participants identify other potential participants for the study. It is especially useful in recruiting participants who may be difficult to locate or access (Polit & Beck, 2012). According to Woodley and Lockard (2016), snowball sampling could be used by “womanist, feminist, and multicultural scholars to study marginalized populations without further marginalizing them through the use of social networking” (p.324). Black African newcomer women in this study were encouraged to contact their friends and neighbours who met the eligibility criteria for potential participation. If interested, participants were encouraged to contact the researcher directly.

In conducting an ethnography, the number of participants to include in the study should be enough to “answer the research question” and until the point of data saturation, when there is no new information being reported (De Chesnay, 2014, p.44). For this study, a sample size range of 10-15 participants was originally proposed. However, when it was determined that no new information would be gleaned from participants, recruitment ceased resulting in a final sample size of 10 participants.

Inclusion and Exclusion Criteria

Participants who were eligible for the study included: (1) immigrant Black women from Africa, (2) living in Canada for not more than five years, (3) who are within the one-year postpartum period (4) were 18 years and above, (5) have not accessed mental health services, (6) reside in Southern Ontario and (7) communicate clearly and comprehensibly in English. Black African newcomer women who have not accessed mental health services were eligible because they provided data relevant to the research questions. In addition, this study focused on those not utilizing mental health services.

Participants who were pregnant at the time of recruitment were excluded because they were unable to provide information about the postpartum period. Participants who self-identified as mentally ill or were diagnosed with a mental illness were also not eligible because they may have already accessed mental health services. Despite the stigma and secrecy surrounding mental health among this population, it was unlikely that participants will hide their diagnoses to enable them to participate in this study. Black African newcomer women who had experienced a still birth, infant death or had a baby(ies) with major health problems, such as congenital heart defects, were also excluded to avoid introducing other complexities.

Recruitment

Posters (see Appendix A) providing information about the study including the purpose, eligibility criteria, and researcher's contact information were placed on the notice boards in some churches with predominantly Black congregation and hair salons which Black women frequent. Permission was sought from hair salon managers and church pastors to place the posters. Emails with the same information were sent to executives of associations of African nationals. These associations, such as, The

Ghanaian Association of London and Middlesex (GALM) and The African Community Services of Peel, provide information and assistance to African newcomers for a smooth resettlement and integration, organize social events, and provide subsidized services and social support to African immigrants. GALM and The African Community Services of Peel were contacted because they are active African associations in Southern Ontario. Posters were also circulated to women leaders in the Church of Pentecost branches in North York, downtown Toronto, and London, the Ghanaian Presbyterian Church of Toronto, and All Nations Gospel Church in St Catharines. Specifically, these churches have a predominantly Black congregation. In addition, Black community health and obstetric nurses disseminated the posters to help recruit participants.

Using snowball sampling, women who consented to be interviewed were asked to identify and inform others who they knew might be eligible to participate about the study. Interested participants contacted me voluntarily through my contact information provided on the posters or through gatekeepers. Six of the women who agreed to participate in the study were recruited through snowball sampling from participants.

As a newcomer woman from an African country living in Southern Ontario, I am an active member of an African church in Toronto and a student member of an association of African nationals in London. Thus, I contacted the above-mentioned gatekeepers using my social networks and personal connections through e-mails, telephone calls and/or face to face meetings. The gatekeepers in my network also helped me connect with some other gatekeepers. I sought the consent of these gatekeepers to contact them through emails, by telephone, or scheduled meetings to co-ordinate their recruitment efforts. Furthermore, a social media version of the recruitment poster was

created and shared on WhatsApp group pages whose membership included newcomer women.

In conducting research, the language used in discussing the research and its connotations must be considered (Davis & Craven, 2016). In seeking informed consent from potential participants for the study, the language and tone of voice used did not in any way suggest that it was compulsory to participate but rather it was voluntary. In addition, there was some difficulty in recruiting participants as a result of the negative connotation attached to *mental health/illness*. Thus, in recruiting, words like *mental stress, stress, and emotional stress* were used instead. Once a potential participant contacted me, a letter of information with a detailed description of the study, benefits and risks and consent form to participate in the study, was emailed to them or they were provided a hard copy form in person (see Appendix B). Written informed consent was obtained before interviews were conducted. Participants had the option of participating in a face to face interview or telephone interview. Participants who opted for a telephone interview (Appendix C) provided verbal consent and had the letter of information read to them prior to consent and emailed to them as well. For participants who opted for a face to face interview, a time and place mutually agreed upon was set for the initial meeting. I provided an honorarium of a \$10 Tim Hortons' gift card to participants in appreciation of their time to take part in the research.

Data Collection

Data collection was undertaken using semi-structured, in-depth interviews either by telephone or in-person using an interview guide (see Appendix D). The format was determined by participants' preference. A short demographic questionnaire was also given to participants to provide demographic information (Appendix E). All interviews

were conducted from July 2018 to October 2018. Davis and Craven (2016) suggest that any ethnographic method of data collection can be used in feminist ethnography but recommend that the process of interviewing and analysis of data should be consistent with the feminist paradigm. According to Hesse-Biber (2007), in-depth interviews in feminist research grants access to the voices of under-represented women and serves as a task of constructing knowledge together, through which the researcher and participant discover hidden meanings. Moreover, Hockey and Forsey (2012) posits that the use of interviews in ethnographic research can attain the features of participant observation. In fact, the use of interviews captures the intangible elements of culture, thus “the interview is an important form of participatory research” (Hockey & Forsey, 2012, p. 85). This study focused on the cognitive aspects of culture, which cannot be explored using participant observations. Hence, justifying the use of in-depth ethnographic interviews. To further buttress this point, Forsey (2010) indicates that “listening is at least as significant as observation to ethnographers. Ethnography is arguably more aural than ocular” (p. 561). Similarly, Hall, Doloriert, and Sambrook (2012) assert that the cultural context of a population can be studied and understood to a large extent using interviews. Furthermore, Black African newcomer women belong to a marginalized population, hence using in depth ethnographic interviews provided a platform to center their voices.

The interviews were conducted in a conversational manner, and audio-recorded with the consent of the participants. I encouraged participants to select places where they felt empowered to talk freely, informing them that these places must be quiet, without distraction from family members or the public, private, safe and comfortable for both of us. Five women opted for face to face interviews and the remaining five preferred to be interviewed by telephone. All face to face interviews were done in the homes of the

participants at their request. The interviews were about an hour in duration. Some newcomer women spoke more comfortably after the interviews when the audio recorder was turned off and so, conversation continued after the interviews and notes made in my journal with the consent of the participants. Recruitment and data collection continued until data saturation had been reached and it was determined no additional information was forthcoming from participants (Polit & Beck, 2012).

A reflexive journal was kept for recording the researcher's assumptions, ideas, and thoughts throughout the research process. Schrock (2013) emphasizes that the feminist ethnographer needs to identify, foresee, and examine the ways in which their presence affects participants and engage in reflexivity to neutralize this. Similarly, Davis and Craven (2016) divulge that reflexivity directs the researcher in analyzing the researchers' insider or outsider status and how it affects the study. To illustrate, my insider status as an African newcomer and a recent mother may have gained the trust of some participants to be more open. On the other hand, as a nurse, my knowledge of postpartum mental health and available treatment options may have earned me the outsider status. This means that, some participants may have withheld information regarding their preferred treatment strategies.

Field notes were also written to capture non-verbal behaviors such as long pauses, looking away, sighing, hand-wringing, and smiles or laughter observed during the interviews. Participants were asked to choose a pseudonym to ensure confidentiality and to protect their identities in the data analysis, results, and any dissemination of findings.

Data Analysis

Data collection and data analysis were conducted concurrently. The analysis was focused on perceptions of mental health service utilization and the sociocultural factors

affecting the use of postpartum mental health services. Thematic analysis guided by Braun and Clarke (2006) was used for data analysis. Thematic analysis involves reviewing data and identifying interpretations of recurrent subjects and was used because it is inductive and data-driven (Braun & Clarke, 2006). In other words, thematic analysis focuses on highlighting the voice of the participant instead of the researcher's. Furthermore, thematic analysis has been used in various feminist and ethnographic studies, therefore, it fits the methodology employed in this study (Gustafsson, Kristensson, Holst, Willman, & Bohman, 2013; Madraga, Nielsen, Morrison, 2018; Rendon & Nicolas, 2012). This means that, because thematic analysis focuses on highlighting the voice of the participant, it reduces the power differentials between the researcher and the participant and minimizes researcher bias.

According to Braun and Clarke (2006), thematic analysis is carried out by the researcher first getting acquainted with the data through transcribing, re-reading, and noting initial thoughts. Next, codes are created from related elements of the data and organized into themes. Codes are defined as labels, usually single phrases which provide a description to parts of data (Elliot, 2018). The identified themes are then analyzed for relevance to the coded transcripts, fine-tuned and labelled for specificity and clarity (Braun & Clarke, 2006). Finally, an account is written of the process, with direct quotations from the data to illustrate the themes, connecting it with the research questions and existing literature (Braun & Clarke, 2006).

To conduct data analysis as outlined by Braun and Clarke (2006), I first transcribed the audio recordings of the interviews verbatim. I read the transcripts while listening to their recordings to ensure completeness and accuracy. I re-read the transcripts several times before open coding so that I was able to immerse myself in the data to be

sensitized to comprehend what participants told me (Braun & Clarke, 2006; Seale, 2004). I first used open coding of the transcripts and then organized similar codes into labelled categories. Initially, each transcript was coded line by line, assigning words or labels that best describe segments of text. Subsequently, similar codes were grouped together into categories and then into potential themes. Categories are defined as higher level codes which broadly describe a group of codes and themes are even broader and provide a richer description (Elliot, 2018). After searching for themes, I reviewed the potential themes; combining themes with similar meanings and removing those that were not sufficiently descriptive (Braun & Clarke, 2006). The final themes identified were then defined and labelled, using words that accurately capture their meanings (Braun & Clarke, 2006). Throughout the research process, I kept a reflexive journal to record my thoughts, ideas, biases, and assumptions (Seale, 2004).

Approaches for Ensuring Adequacy

I used the Hall and Stevens (1991) criteria for adequacy to ensure that the process and outcomes of research are well founded, rigorous, and rational. Hall and Stevens (1991) recommends that the criteria for achieving adequacy include reflexivity, rapport, credibility, honesty, and mutuality. In conducting this feminist ethnographic study, I was aware that, the researcher needs to recognize the effects of her/his position in order not to exploit an already marginalized group of women (Davis & Craven, 2016). Hall and Stevens (1991) suggests that reflexivity evaluates how the researcher impacts the research process by purposefully focusing on her/his interactions with participants and highlighting shared features that may affect data collection and analysis. I have provided a detailed declaration of my knowledge, background, and assumptions that may have

affected participants' responses in the interviews and data analysis. I kept a reflective journal where I wrote my reflections during the research process.

Feminist ethnography allows participants to engage with the researcher to provide a trusting and safe space for sharing personal information to answer the research questions (McNamara, 2009). Notably, McNamara (2009) mention that the sharing of personal information is common in research involving women. Admittedly, several participants asked about my background after seeing me or hearing me speak, hence I informed them that I was an African newcomer woman and a recent mother. To ensure that the results are reflective of the women's voices, the interviews were transcribed verbatim and I included the direct quotes of all women in the results section. Furthermore, to ensure credibility, I used member checking by asking participants to clarify what they were saying or what they meant. For example, during interviews, I asked follow-up questions to ensure that participants provided more insight to their responses, for better understanding. Participants were given the opportunity to see preliminary results to provide feedback. Also, to reduce bias in data analysis, I met with my supervisor and committee member to discuss the data analysis and themes. We discussed potential themes that emerged and the process of categorizing to ensure that the labels sufficiently describe and define the meaning of these themes. This action reduced bias by ensuring that the researcher's biases, experiences, and assumptions do not overshadow the voice of the participants.

To create rapport and promote mutuality with participants, I engaged in casual conversation with participants before and after each interview. For example, I asked participants about their well-being, and that of their babies to make conversation and create rapport. This action reflects rapport building and mutuality because, it helped build

trust and made participants comfortable to engage with me. To prevent deception, I provided all participants with consent forms explaining every detail of the research, including risks and benefits, and discussed the study with them to ensure understanding (Hall & Stevens, 1991). For example, I asked participants to provide their understanding of the purpose of the study and encouraged them to ask questions pertaining to the study before, during and after the interviews.

Ethical Considerations

Ethical approval was obtained from Western University's Health Sciences Research Ethics Board prior to conducting the study (Appendix F). All participants were provided with a consent form with full explanation of the purpose of the study using clear and simple English language to ensure full comprehension by participants prior to data collection. The risks and benefits of the study were communicated orally and in a written form to participants before data was collected. Participants who opted to be interviewed through telephone had the informed consent form emailed to them. All participants were informed that they were entitled to refuse participation, withdraw from the study at any time or not answer questions without repercussions such as being barred from accessing health services. One participant withdrew from the study at the start of the interview. She stated that *"African women do not face mental illness after childbirth, so I don't see why you are asking all this."*

In addition, participants were informed that interviews will be recorded with an audio recorder with their permission. For confidentiality, participants' data were kept on a personal password-protected computer and pseudonyms used for anonymity. Data was accessible only by me, my thesis supervisor and committee member. Subsequently, the audio files were erased after transcription of the recordings. Signed consent forms were

kept safe in a locked file cabinet located off-campus, kept separate from the raw data, and inaccessible to unauthorized persons. Participants were informed that the information they provided may be made available to my supervisor and thesis committee member. Participants were also informed that I am legally required to report cases of child abuse to the appropriate law enforcement agencies.

Additionally, I created a mutually respectful relationship with participants by being empathetic, nonjudgmental, and respectful of participants' beliefs. I did this by chatting with participants before the start of the interview, conducting the interviews as conversations, and listening actively to the words and tone of voice used by participants. Though the topic was considered sensitive, it did not elicit stress among participants. Participants were encouraged to take breaks during the interviews if they were tired. The participants were also informed that if they had become upset or emotional during an interview, the interview would be stopped, they would be encouraged to seek medical attention or counselling, and a list of mental health resources and counselling services in the area would be provided. The interview would continue if the participant verbalized that she could go on. No participant showed signs of distress from participation in this research. I recognize that, considering the silence and stigma surrounding mental illness in this community, the women may not show or verbalize signs of distress immediately. In view of this, the mental health resources and counselling services provided, targeted ethno-racial populations and so were culturally appropriate to these women.

Findings

Characteristics of Participants

All 10 participants emigrated from the Sub-Saharan region of Africa and have lived in Canada for two to five years. Participants ranged in age from 25 to 40 years. Nine participants had post-secondary education and one had a high school certificate. Participants were recruited from cities in the Greater Toronto Area and Niagara Region, as well as from London. Seven participants had no family living here in Canada. Half of the participants were first-time mothers. Two of the women were Muslims and eight were Christians. Table 1 provides demographic data about the study participants.

Themes

Thematic analysis of the data provided by the participants identified three themes: 1) Postpartum Sanity, 2) Help-seeking and treatment preferences, and 3) Barriers and Facilitators, which together describe the African newcomer women's perception of mental health and mental health service utilization within a year of childbirth in Canada; as well as influencing factors. The theme *Postpartum sanity*, discusses Black African newcomer women's perception and understanding of postpartum mental health and what they do to stay composed and in charge of their minds. *Help-seeking and treatment preferences* addresses Black African newcomer women's help-seeking and treatment

preferences to maintain their mental health and well being after childbirth. The final theme, *Barriers and Facilitators*, addresses perceived influential factors regarding the use of mental health services by newcomer Black women from African countries.

Table 1

Demographic Characteristics of Participants

Name	Employment level	Marital status	Immigration status	No. of years in Canada	Months after childbirth
Ada	Student	Married	Study permit	3	9
Adoma	Full time	Married	Permanent Resident	4	7
Akoto	Full time	Single	Work permit	5	8
Akua	Unemployed	Married	Sponsored spousal study permit	4	4
Fatima	Unemployed	Married	Permanent Resident	5	12
Mayy	Part time	Married	Spousal work permit	3	5
Naana	Maternity leave	Married	Permanent Resident	3.4	6
Olivia	Maternity leave	Married	Permanent Resident	5	1
Sadia	Full time	Married	Permanent Resident	2	12
Sandy	Maternity leave	Married	Permanent Resident	3	2

Postpartum Sanity

Postpartum sanity for these women involves being composed, stable, and in charge of your thoughts and actions after giving birth. The participants described what they did to stay mentally well after childbirth and in control of daily life responsibilities of being a mother. As Ada remarked, staying mentally well involves being able to manage caregiving tasks associated with the mother role: “...*ability to feed the baby regularly. The ability to do extra job like keeping the house clean. The ability to go to market, to manage your home. You know, taking care of the other ones.*” All the women commented that, being a woman and a mother, anything which affects your ability to nurture can lead to mental stress. Some women described their mental wellness being determined by the wellbeing of their infant. Adoma explained: “*[m]entally sane is someone with peace of mind and does things as a normal human being will do... As a mom, if my baby is okay, I’m in a good state of mind.*” As stated by Ada, achieving postpartum sanity is striking a balance between “*the ability to manage our family, manage our own health, and manage our career.*” A few women regarded mental stress as an illness. Postpartum depression was the only familiar maternal mental illness that the women identified. Four of the women, Adoma, Olivia, Fatima, and Naana noted that they felt sad and experienced episodes of uncontrollable crying in the first week after childbirth, when they were home alone. However, they all confirmed that these feelings were short-lived, and nurses told them it was normal to feel that way in the first few days postpartum.

The women discussed many ways in which they controlled their minds to maintain their mental wellbeing and sanity after childbirth. Mental illness was described, by some participants, as a phenomenon that can be controlled by one’s willpower and

faith in God. Speaking on faith in God as an anchor, Sandy remarked: “[W]hat is your anchor? What is giving you the strength and the hope? That’s why most mothers fall into depression.” Some women commented that to maintain their sanity after childbirth, they are required to stay positive, distract themselves, get adequate rest, talk to people, and have good nutrition. Akua shared having self-control was important: “You try to control yourself. It’s not everything that you have to be emotional about.” Sandy concurred stating: “Ideally, it will be good to go and talk to somebody but if you’re able to control yourself, you don’t need anybody.” Naana advised focusing on your baby: “Just concentrate on the baby and the more you do that, you tend to develop love.” Ada described how she distracts herself: “I try to put on movies, I’ll put on music...To make me forget certain things and make me feel okay. I take my rest and I also eat good food.” According to Sadia, it was important to keep busy and distract yourself because: “You don’t get time to think about some things that you don’t need to think about.”

Further, Akoto mentions the importance of not thinking too much about one’s mental health: “That’s why I’m saying not thinking too much. Because mental illness, some of them are too much thinking. When you think too much, you get that problem.” The women were of the view that stress related to becoming a new mother and being a recent Black African immigrant was normal and “part of life.”

Help-seeking and Treatment Preferences

All the women commented on preferring the option of using non-medical treatments over seeking formal mental health services. For instance, women mentioned spousal support as being significant in managing postpartum mental stress. The women talked about the role their partners played in providing support postpartum. Fatima emphasized having her husband’s help, to lessen any stress, rather than seeking medical

treatment: “[t]he treatment is you trying to get your husband involved in whatever you’re doing to help you, then you’ll be less stressed and then things will work out.” Similarly, in commenting on the significance of spousal support, Naana stated:

“If he’s there to help take care, to feed one of them or to bath one of them, it helps. He does that before going to work..... He’s very helpful. If not, since I don’t have any relatives here, I know I’ll be really feeling the depression a lot.”

Many of the women acknowledged that moving to Canada caused a change in gender roles, with their partners needing to be more supportive than they would have been back in their home countries. Sadia, noting the role of fathers in Canada, said: *“Here in Canada, the husbands have a lot of role to play...husbands here are supportive, it won’t be only you the wife taking care of the child and husband will be in other place with his friends.”* In comparing the father’s role postpartum in her home country and in Canada, Fatima remarked:

“Culture back home, the man is not supposed to do anything. You the woman and your family, after giving birth, they do everything, and the man sits home. You, with your family feeds him and everything. That’s the culture. But here, it has changed a lot because the man has to go to the kitchen and get you something to eat.”

Spiritual treatment was preferred postpartum by many of the women. For Sandy, spiritual treatment is important because, *“the spirit also needs rest.”* Fatima commented that she would rather have spiritual treatment because *“it’s a very strong thing.”* To illustrate, she recounted a story of her friend who went back home for the treatment of postpartum mental illness. Fatima’s friend was a Ghanaian newcomer woman who delivered a baby in Canada. Fatima revealed that her friend was being treated spiritually

and with herbs. However, Fatima cautioned that spiritual treatment could worsen the situation: *“you’ll need to do those prayers and sometimes it worsens your case.”* Black African newcomer women suffering from postpartum mental illness *“...really need support, treatment, and advice from friends and family”* (Sadia).

Most of the women recognized the significance of using mental health services when experiencing stress after childbirth. One woman advised that: *“...if there’s any need to seek help at any point [they] shouldn’t hesitate to do that.”* They expressed no explicit misgivings about the use of mental health services after childbirth. Adoma supported the use of mental health services stating: *“I think it’s a great idea. Everyone should do it.”* The women stated that they are willing to use mental health services in Canada as compared to if they were in their home countries. Akoto disclosed that back home, she had the option of spiritual treatment, but in Canada, the only treatment option she knew about was medical. Speaking on this, Akoto said: *“[i]f it were to be back home, you’ll say take it spiritual. But here, it will be, is it medical or how do you say it?”* However, she continued that, the decision to access medical mental health services after childbirth was up to the individual: *If you don’t want to then you don’t.”*

Holistic postpartum mental health care, a combination of medical and non-medical intervention was advocated by several women. Sandy highlighted the importance of holistic care to meet both physical and spiritual needs: *“[y]ou should seek your physical well-being, you should seek your mental well-being and your spiritual well-being. I think it shouldn’t be one specific place because it takes all to make you whole.”*

Similarly, Olivia reported:

For me, the physical and spiritual will be very good. Because with the physical, sometimes we need to be taken to the hospital for some treatment and to get

someone to look at you and to see if there's something wrong with you. And if you need any medication, they will be able to help. And so physical is one of the important things. And spiritual, there are certain things we need to allow God to come in.... So, I'll say physical and spiritual is the best. It's the good option or the good choice."

Barriers and Facilitators

The women discussed perceived influential factors regarding their use of mental health services. Barriers to the use of mental health services encompassed health beliefs, immigration status, and racial discrimination. Increasing awareness of maternal mental health and the access to services and support were facilitators of maternal mental health service utilization.

Barriers. The women described health beliefs and stigma surrounding mental illness as barriers to the use of mental health services after childbirth. Several women disclosed that beliefs surrounding mental illness and mental health services prevent women from seeking such health services. Olivia opined that cultural beliefs regarding postpartum mental illness may make it difficult for an African newcomer woman to see the need for accessing mental health services: *"in our culture, there are certain things that we don't believe.. after you give birth...there are certain things that can lead to mental problems...we'll have to accept the fact that certain things happen...and you get the help you need."* Sandy commented that in her home country, the family's negative reaction acts as a barrier to talking about mental health to a health provider: *"it's not that easy to go to a doctor and talk about it. You can't go to the doctor and talk about it, because of the family."*

Additionally, a newcomer woman's perceptions and beliefs regarding the use of mental health services was mentioned as being shaped by the media, general society, and her social network. Speaking on this, Sandy stated: *"I think that even the media, the people you have around. So definitely, I'll say societal matters are part, the people you have around. They all form part of what you think and what you feel..."* Furthermore, the belief of the nonexistence of postpartum mental illness among some women may serve as a barrier to their use of maternal mental health services. One participant withdrew from the study at the start of the interview due to her belief that maternal mental illness among African women did not exist: *"African women do not face mental illness after childbirth, so I don't see why you are asking all this."* On the other hand, Akoto asserted that the refusal of medical mental health services as a choice of treatment for postpartum mental illness is based on one's own belief in its efficacy: *"whatever your beliefs are, the treatment works...If you believe that the spiritual will help you, fine, that's where your belief is. And if you believe that the medical will help you, fine, that's where your belief is."*

Some women remarked that health beliefs concerning the causes of postpartum mental illness leads to further stigmatization. For example, Fatima was convinced that mental illness was stigmatized back home unlike in Canada because of the belief that it was communicable: *"It's not a stigma [here]. Nobody will see you like back home; some even see them as contagious. It's not like that here."* Adoma, on women who suffer from postpartum mental illness disclosed that: *"They think that they are being bewitched"*. Akua confirmed that: *"Okay, so let me say also with mental health, in Ghana, there's this stigmatization..here you don't see mentally ill people around, but I think there's stigmatization."*

Immigration status was mentioned as another barrier to newcomer women's use of mental health services after childbirth. Akua who has lived in Canada for four years, disclosed: *"[w]hen I came in here to Canada, I didn't have insurance. Insurance... gives you access to go to the hospital easily. Because of that, I was always careful. I took very good care of myself. Like I don't fall sick."* Mayy stated: *"being on the study permit, you're not allowed this health card, this health benefits, right?"* Additionally, Mayy stated that the healthcare provided for immigrants *"is not that strong as compared to ... [Canadian] citizens."* In contrast, a number of women mentioned that the healthcare system *"...works nicely."*

However, the stress in navigating the health system was mentioned by many women as a challenge to accessing mental health services. The women stated that this stress was a result of being new immigrants and experiencing transportation difficulties to access health care. Describing her transportation difficulty in accessing a public health nurse for postpartum support, Fatima said: *"I'm asked to visit her, and she gave me the address...I'm not driving, I'm going to take this baby and I have two extra kids and travel with them with the bus to this far place."* Fatima was unable to go for the appointment. Ada commented on the stress of being a new immigrant: *"If you're new here, it's even worse."*

A few women described the discrimination they faced receiving maternal care. Mayy recounted her experience, after she declined to take an epidural for her pain during labor. She revealed:

"What I want to say is my experience. I wouldn't like any woman or anybody to go through that. Why will a doctor just tell me that I should hurry up and give birth because he needs to go and take care of his babies, his children at home"

...But I'm screaming in labor, I'm in pain and then a doctor will just come to me and say that oh I shouldn't scream. How do you expect me to deliver, because I'm in pain?"

Mayy felt discriminated against because she declined to take the epidural.

Speaking further on the healthcare providers' attitude towards her decision, Mayy said:

"Some will tell you that 'hey can you take epidural? Like, are you crazy, why don't you want to take epidural?'. They were kind of rude." Adoma, in discussing the racial

discrimination she experienced with health providers, stated: *"Oh race! I don't want to talk about it... we face a lot of discrimination over here. Sometimes, it might not come out of their mouths, but it says it all on their faces, from their reactions."* Adoma also

described she felt mental stress as a result of discriminatory actions of some nurses :

"Sometimes, when you go to the hospitals, some of the nurses look down on you because you're a black woman. So, when you think about all these things, it can also cause you to be mentally unstable." Speaking out on racial discrimination, Naana said: *"go somewhere*

with the bus and no one wants to sit by you... Sometimes, it might even affect having a

doctor." Fatima felt that: *"[s]ometimes when you go to the hospital, you'll see clearly*

somebody who is a different color is treated differently from you." Some women talked

about how others thought their infant caring practices were odd and not correct. For

example, Naana remarked:

"I remember that I went to Wal-Mart one time and I had a baby at my back with a cloth and someone walked to me and said I'm killing the baby. Because the legs are open so I'll break the ribs and thighs. And the woman made sure that I took the baby out of the cloth from my back. I was like "this is normal in my country, it's fine.""

Facilitators. African newcomer women mentioned that healthcare professionals need to create awareness among new mothers about mental health and the availability of mental health services postpartum to facilitate utilization. Olivia remarked that such information was necessary because: *“Sometimes you’re not aware that it’s the problem.”* Sandy also said: *“Most of us don’t understand what mental health is.”* Ada suggested some strategies that healthcare professionals can formulate to inform newcomer women about mental health and available services: *“create awareness.... In the hospitals where they’re going for antenatal. Tell them...that there are these structures on the ground in case you’ll need any of the services...let them know that things like this can happen.”*

The women revealed that common topics discussed by health providers before delivery are recognizing labor, management of labor pain, breastfeeding, and antenatal nutrition. Most of the women stated that postpartum mental health is never discussed by healthcare professionals before delivery. Sadia remarked: *“I think during antenatal they should introduce something like informing people about after birth depression... They only talk about labor and pregnancy... people need to be informed in all stages... during pregnancy, delivery and after delivery.”*

Some women mentioned health providers providing them with information about mental health in the postpartum period. Akua commented on nurses talking to her about mental health issues: *“For instance, just after having a baby. The nurses at the hospital will talk to you about this mental health issue.”* Adoma described being given contact information about services for postpartum depression: *“When I was leaving the hospital, they gave me some numbers to call. The public health. They have avenues for postpartum depression that you can go and seek help if you want to.”*

Some women preferred helplines and online services to remain anonymous,

“everyone will know who [they are] and how [they] feel.” Several women also commented that healthcare providers must reach out to newcomers who have recently had a baby instead of waiting for them to report to the hospital for mental health needs. Sandy said healthcare providers: “*should make it accessible by reaching out to them... I think that’s what you should do if you really want to help people. Somebody will be walking up and down and they don’t even know that they need help.*” Naana suggested that postpartum mental health assessment for newcomer mothers should be a mandatory program similar to the newborn screening program:

“Like when a newborn is born, they have series of checks before they have gone home. It should just be part of it, you don’t have to wait for that person to come to you and say: “Dr I feel lonely, I’m feeling hard on my baby, I feel my baby is” You don’t wait for that, just give the information out and then when they build that friendliness with you....they will just walk over to you.”

Akoto advised newcomer women to access postpartum support for their mental wellbeing because: “*It’s not as if you’re the one paying. It’s the government who’s paying. So, why don’t you take that opportunity.*” In addition, the women stressed sharing their pregnancy and postpartum experiences with others and connecting with peers also promotes mental wellbeing. Naana’s doctor recommended that she speaks with her friends who were mothers after she revealed to her doctor that she was feeling depressed after childbirth. Naana said that: “*...through the conversation, your problems will be answered, it just comes naturally...That’s what helped me at that time.*”

Discussion

This study used feminist ethnography to explore sociocultural factors that impact African newcomer women’s perception of mental health and mental health service

utilization within a year of childbirth in Canada. Ten African newcomer women volunteered to be interviewed for this study. Three main themes emerged from the semi-structured interviews through thematic analysis, namely, *Postpartum sanity*, *Help-seeking and treatment preferences*, and *Barriers and facilitators*.

Postpartum Sanity

It is evident from results of this study that Black African newcomer women maintain sanity after childbirth by staying in charge of their minds and turning to their faith in God. Additionally, staying mentally well after childbirth for these women was centered around having peace of mind, infant caregiving, and the baby's health. Society's expectations about being mothers, primary caregivers, and nurturers may affect newcomer women's decision to access postpartum mental health services (Mamisachvili et al., 2013). This expectation may be especially true for African newcomer women as the women in this study consider postpartum mental well-being as the ability to be composed and in charge of your mind without affecting your ability to nurture. Black African newcomer women's understanding of staying strong and being composed to prevent postpartum mental stress may be linked to the Strong Black Woman (SWS) schema. For instance, one participant withdrew from the study and questioned the need for this study since in her view, African women do not experience mental issues after childbirth. This viewpoint highlights how mental health is poorly recognized and spoken about among Black African newcomer women. Thus, the ability to conceal mental issues may be mistaken for resilience. According to Woods-Giscombe (2010), African American women present themselves as strong women and conceal vulnerability, such as emotional distress as a result of the Superwoman role or the SWS schema. To explain further, Abrams, Hill, and Maxwell (2018) note that, the cultural pressure for Black

women to display strength may lead to not recognizing mental health symptoms and to their reluctance to use mental health services when facing mental stress.

Additionally, the women were of the view that, normalizing stressors associated with the transition to motherhood improves postpartum sanity. In other words, stress related to becoming a new mother and being a recent Black African immigrant was perceived to be normal and part of life. Thus, being composed would prevent postpartum mental illness. For this reason, these newcomer women may not consider medical mental health services as essential. Their perception that the incidence of mental illness can be controlled by mental toughness through coping strategies, positive thinking, resilience, and faith in God presents a challenge for healthcare providers offering postpartum mental health services to this population.

Help-seeking and Treatment Preferences

Postpartum support from informal sources was identified as being significant in reducing the incidence of postpartum mental illness among Black African newcomer women. Postpartum support from partners and family was highly preferred compared to the use of formal mental health services. In their home countries, postpartum support is provided by older female relatives who pass down cultural rituals and norms for postpartum healing and wellbeing. However, moving to Canada means that Black African newcomer women are needing to rely more on their male partners for support. It is essential to note this change since it shows the adjustment in their customary postpartum support because of migration. These findings are similar to previous research which show that newcomer women prefer postpartum support in the forms of partner and informal social support (Guruge et al., 2015; O'Mahony et al., 2012).

Studies confirm that recent immigrants in Canada maintain non-Western interventions, informal social support, and coping mechanisms for managing signs and symptoms of postpartum mental illness (Guruge, Thomson, George, & Chaze, 2015; O'Mahony & Donnelly, 2010; Thomson, Chaze, George, & Guruge, 2015). Consistent with the findings of Wittkowski, Patel, and Fox (2017), the women in this study suggested that self-help strategies are important in managing postpartum stress. Black African newcomer women prefer using non-medical treatments, such as informal support, praying, and spiritual medicine, if faced with postpartum mental stress. Although they readily recommend Western mental health services to others; they considered using self-help, spiritual, non-medical mental health treatment or a combination of treatments for themselves. Nurses and other healthcare professionals must recognize that African newcomer women are less likely to use medical mental health services for their postpartum mental health needs. Hence, a comprehensive assessment, including questions surrounding perception of postpartum mental health and treatment preferences, should be carried out at the perinatal visits. This would help plan patient-centered postpartum mental health care and support. For instance, the nurse can tailor postpartum care to meet clients' treatment preferences and beliefs so far as they do no harm.

Findings from this study, reveal the importance Black African newcomer women attach to spirituality and their faith in God for healing. According to Cooper (2016), mental health treatment strategies targeting Africans would only be successful if health beliefs shaping their help-seeking and treatment preferences are respected. Postpartum mental health services targeting Black African newcomer women must incorporate spirituality and faith to promote holistic and patient-centered care. Community health nurses could partner with Black pastors and women leaders from the various faiths in

awareness creation campaigns on postpartum mental health among Black African communities in Canada. Examples of women's leaders who can be engaged include female church elders and deaconesses. Additionally, the women in this study mentioned that nurses and healthcare providers should reach out to Black African newcomer women to facilitate their use of postpartum mental health services. Health care professionals could connect with Black newcomer women in nonmedical settings by providing mental health services in the women's homes, community centers, and churches and other religious centers (Abrams, Hill, & Maxwell, 2018). Also, the women in this study advocated for more postpartum home visits or phone calls to build rapport with nurses and promote postpartum mental wellbeing.

Barriers and Facilitators

The results identified a number of sociocultural factors which may either hamper or facilitate postpartum mental health service utilization by Black African newcomer women. Immigration status is one identified factor that may serve as a barrier to Black African newcomer women's access to postpartum mental health services. Our findings reflect those from other studies, a permanent immigration status accords African newcomer women the privilege of universal health coverage in Canada (Dennis, Merry, Gagnon, 2017; O'Mahony et al., 2012; O'Mahony & Donnelly, 2013). Therefore, Black African newcomer women without a permanent immigration status, who are willing to use postpartum mental health services to manage postpartum stress may be unable to do so due to costs.

Another factor that may influence postpartum mental health service utilization is postpartum education. The women in this study spoke about the heavy emphasis of postpartum health care on breastfeeding and care of the baby, and how education on

postpartum mental wellbeing was insufficient and almost non-existent. Postpartum mental health education must begin in pregnancy and continue after childbirth. In addition to postpartum education, the women asserted that healthcare professionals should provide postpartum mental health services that are subsidized, anonymous, non-judgmental, and holistic. Nurses must also provide a confidential and private setting to render mental health services to ensure trust and empathy, towards the goal of achieving optimum health outcomes.

Based on findings from this study, mental illness is highly stigmatized. Some of the women spoke about the stigma surrounding mental illness in their home countries. The conceptualization of health and disease are molded by the cultures from where these newcomer women are migrating from (Davey, 2013). There is scarce literature on mental health in developing countries, yet, available evidence reveal that mental illness is stigmatized in developing countries (Semrau, Evans-Lacko, Koschorke, Ashenafi, & Thornicroft, 2015). Stigmatization of mental illness contributes to the negative connotation attached to the word “mental illness” among the women in this research.

In my reflections throughout the research, I noted that the women preferred the use of “mental stress” or “stress” to “mental illness”. This finding illustrates the significance of language, how it is used, and interpreted in maternal mental health care. Nurses and other healthcare professionals need take note of the words used in postpartum mental health education and their meanings in African cultures. For example, “emotional health” can be used instead of “mental illness.” Also, “postpartum wellness support” or “postpartum stress management” can be used to describe postpartum mental health services targeting Black African immigrants. Szeto, Luong, and Dobson (2013) note that

language used for mental health should be examined further as it can potentially affect people's attitudes towards mental illness.

Black African newcomer women's perceptions of postpartum mental health is linked to their understanding of mental health services after childbirth. Cultural beliefs regarding pregnancy, childbirth and motherhood, and stigmatizing interpretations surrounding mental illness from their home countries may contribute to their understanding of mental illness and treatment preferences. Some cultural beliefs and stigma related to mental illness from their home countries contributed to the women's reluctance to use mental health services postpartum. Mental illness is considered infectious or attributed to witchcraft in the cultures these women belong to and the use of mental health services was limited among childbearing women. Also, such perceptions on maternal mental health calls for attention to the social norms on motherhood as a cheerful period, masking or belittling contrary emotions. An immigrant woman in the qualitative study by Mamisachvili et al. (2013, p. 166) aptly described: "...you have a baby, you're supposed to be happy."

Findings from other literature confirm that inadequate knowledge and awareness of postpartum mental illness are culturally influenced barriers that hamper the use of mental health services by immigrant women because culture shapes the conceptualization and treatment preferences of maternal mental illness (Ahmed, Bowen, & Feng, 2017; Mamisachvili et al., 2013; McKenzie et al., 2010; O'Mahony et al., 2012; O'Mahony et al., 2013; O'Mahony & Clark, 2018; O'Mahony & Donnelly, 2010; Teng, Blackmore, & Stewart, 2007). According to Teng, Blackmore, and Stewart (2007), culturally influenced barriers to newcomer women's utilization of postpartum mental health services in Canada are the "most complicated and difficult to address" (p. 97). Measures of cultural

competency are recommended to be embedded in integration, resettlement, and mental health programs to address the mental health needs of Black African newcomer women (Robert & Gilkinson, 2012). Cultural competency would enable nurses and other healthcare providers provide appropriate postpartum mental health and support services specific to newcomer women's culture. This means that, mental health services and support strategies targeting Black African newcomer women must be culturally tailored to include nonmedical treatment options and informal support.

Postpartum depression was the only postpartum mental illness that was frequently referred to by the women. While acknowledging that their knowledge about postpartum mental illness is insufficient, participants emphasized the need for postpartum mental health awareness. Notwithstanding the high educational attainment of the women in this study, with nine out of the ten having tertiary education, their mental health knowledge was low. O'Mahony et al. (2013) emphasize that educated newcomer women may be unaware of postpartum mental illness and mental health services. This implies that awareness creation on maternal mental health should not target women with low educational levels alone. Furthermore, nurses and other healthcare professionals should not assume that a higher educational level equates mental health knowledge. For instance, Sword, Watts, and Krueger (2006) found that, more than half of immigrant women in Canada reported that there was inadequate health education during the postpartum period.

Newcomer women may be unaware of how to navigate the system to seek formal postpartum support and mental health services (Ganann et al., 2012). Likewise, the women in this study observed that accessing the system was stressful due to their status as newcomers and transportation difficulties. Based on findings from this study, the Canadian healthcare system needs to enhance postpartum mental health awareness among

Black African newcomer women. Postpartum mental health education should be incorporated into perinatal care. There are numerous postpartum mental health resources, including helplines, webchats, and support groups, available in Ontario. Therefore, these resources should be introduced to recent immigrants from the first antenatal visit to the postpartum period. Some of the women in this study emphasized the need for peer support groups. In addition, maternal health nurses and other healthcare professionals should create peer or buddy support groups where women provide postpartum support and assist recent immigrants to access health and support resources in proximity to their homes.

These findings suggest that Black African newcomer women's reluctance to use mental health services after childbirth may be influenced by their experience of discrimination in the healthcare system. Prejudicial experiences of newcomers accessing healthcare services in Canada prevent them from accessing healthcare services (Edge & Newbold, 2013; McKenzie et al., 2010; O'Mahony & Donnelly, 2010). Several women in this study recounted experiences where they felt discriminated against because of their skin color or judged because of their cultural practices and beliefs. Black African newcomer women who faced discrimination or experienced cultural insensitivity when accessing maternal health services may be reluctant to access postpartum mental health services since they may distrust healthcare professionals. Maternal health nurses and other healthcare providers must recognize their biases and reflect on how it affects the therapeutic nurse-patient relationship. Healthcare policies against discrimination and cultural insensitivity should be developed and implemented.

Previous research has identified lack of language skills and gender role as barriers to the newcomer women's utilization of postpartum mental health services in Canada

(Guruge, McKenzie et al., 2010; O'Mahony & Donnelly, 2010; O'Mahony et al., 2012; O'Mahony et al., 2013). African newcomer women in this study did not mention language as a barrier to their use of postpartum mental health services. This can be attributed to the demographics of the sample because nine of the ten women had tertiary education and participation in the study required being able to speak English. However, reflections from this study underscore the cultural nuances in communication as pertaining to mental health. Consequently, the language used in postpartum mental health education should be reviewed and revised to facilitate the utilization of postpartum mental health services.

O'Mahony et al. (2013) noted that male partners of immigrant women prevented them from accessing postpartum mental health services. African newcomer women in this study never mentioned this. Only Fatima and Mayy mentioned that women were expected to be submissive to men because men were the heads of the house. This was not mentioned in relation to their decision to use postpartum mental health services. Though inclusion criteria for the study by O'Mahony et al. (2013) included non-European newcomer women, only two were Africans, thus may account for the difference. Black African newcomer women are in charge of the management of their households including overseeing the health and care of the baby and other children, and cooking and cleaning the house. This leads to newcomer women being unable to schedule appointments with postpartum support and mental health services because they are overburdened with household chores and need time off to take care of their mental health needs (O'Mahony & Donnelly, 2010).

It is important to note that traditional gender roles have been impacted by migration. Black African newcomer women in this study depend on their husbands and

partners for postpartum support after immigration. Similarly, women in a critical ethnographic study by O'Mahony et al. (2012), disclose the importance of postpartum support from their male partners following migration. These findings are significant because the provision of such postpartum support is not the normative behavior for most African men. Black African newcomer women are traditionally cared for and supported by older female relatives after childbirth in their home countries. Comparably, based on evidence from the study on 106 immigrant women, Zelkowitz et al. (2008) stress that, the absence of traditional female postpartum support in Canada precipitates "expectations of spousal support that are divergent from the spousal role in the country of origin" (p. 9). In the same way, women in this study admit that they have turned to their husbands and partners for support because of separation from their families and consequently traditional postpartum support. Nurses and healthcare providers must involve the spouses and partners of Black African newcomer women in postpartum mental health education. This would create awareness of maternal mental illness, equip spouses and partners with the resources to provide support to reduce postpartum mental stress, and encourage mental health service utilization.

Strengths and Limitations

Every study has strengths and limitations that need to be acknowledged. To the best of my knowledge, this is the first study that explored sociocultural factors affecting postpartum mental health utilization with a sole focus on Black African newcomer women in Canada. Most importantly, this study using feminist ethnography, calls attention to the voice of Black African newcomer women on the subject of maternal mental health.

However, findings from this study cannot be generalized to all Black African newcomer women or other racialized immigrant women in Canada. This is because a sample size of 10 women residing in Southern Ontario participated in this study. Thus, newcomer women in other provinces in Canada were not included. Furthermore, all participants in this study spoke and understood English, thus non-English speaking Black African newcomer women were excluded. Furthermore, due to my assumptions and personal experiences as a newcomer woman and mother, I may have missed important data by not asking certain questions because I either assumed that it is common knowledge or was biased to an emerging theme. However, this was mitigated by ensuring reflexivity and credibility in the conduct of the study.

Implications for Research

Postpartum mental health research among Black African newcomer women is underrepresented in literature. This study can be replicated in other provinces in Canada with Black African newcomer women or newcomer women from other racialized groups. Also, it can be repeated in non-urban parts of Canada. Further research needs to be conducted with French-speaking African Black newcomers or African Black newcomer women who are unable to read or write. Additionally, further research needs to be carried out with Black African women who have lived in Canada for more than five years to determine the impact of the length of stay in Canada on the perception of mental health and the willingness to use postpartum mental health services. The stigma associated with mental illness should be explored more in depth with this population. Furthermore, research with the partners of these women needs to be carried out to understand their perspective and gain insight into how best to involve them.

Implications for Education and Practice

Based on the factors associated with maternity related mental illness among newcomer women, Dennis, Merry, and Gagnon (2017) opine that every immigrant woman regardless of their reason for migrating should be assessed for postpartum depression after childbirth. For instance, due to the stigma attached to mental illness, Zelkowitz et al. (2008) suggest that health professionals should pay attention to medically inexplicable symptoms, especially physical symptoms, as these may sometimes mask mental distress. Collins, Zimmerman, and Howard (2011) note that health care professionals may frequently miss the symptoms of postpartum mental illness in newcomer women because they are culturally defined. Some of the women in this study mention “thinking too much” as a symptom of postpartum mental illness. This means that, during assessment, health care professionals who do not probe to find out if these women spend time “thinking too much”, may miss a symptom.

Cultural competency should be included in nursing curriculum to educate nursing students who may be caring for more patients from diverse cultures as compared to previous generations. Furthermore, practising nurses should be encouraged to take professional classes on cultural competence and culturally safe nursing. This would ensure that a culturally competent nursing care is provided, because assessment would reveal manifestations of postpartum mental illness for appropriate interventions. Culturally safe care in this context means care that safeguards the cultural beliefs of Black African newcomer women without losing their cultural identity. Morrow et al. (2006) emphasize that, knowledge of postpartum immigrant women’s cultural beliefs and values, can be used to plan treatment strategies that are effective and culturally safe.

Nurses must build therapeutic relationships with African newcomer women to build trust and rapport. Teng, Blackmore, and Stewart (2007) interviewed 16 health care professionals in Toronto who emphasized that a communicative and trustful relationship with healthcare workers was important in facilitating mental health service utilization by recent immigrant women. Postpartum mental health providers could encourage social connections with newcomer women through peer groups. Also, nurses and other healthcare professionals need to reflect on and recognize their prejudices when caring for racialized immigrant clients. Nursing education should include anti-discriminatory practices and anti-racism policies enforced in hospitals, and other healthcare and social support centers in Canada. Such recommendations for practice will help make Black African newcomer women equal partners in mental health care.

Strategies are needed to help create awareness of maternal mental health knowledge and services among this group of newcomer women. Informing newcomer women of available mental health services in the community should be a mandatory component of maternal health services. All the women in this study mentioned the need for postpartum mental health education in their communities. Furthermore, postpartum depression was the only maternal mental illness they expressed having knowledge of. The Registered Nurses' Association of Ontario (RNAO, 2018) has best practice guidelines for perinatal depression: *Assessment and Interventions for Perinatal Depression*. This guideline for best nursing practice extensively covers perinatal depression, yet postpartum anxiety and postpartum psychosis are only briefly discussed. Moreover, RNAO has no other best practice guidelines specifically for postpartum anxiety and psychosis. Based on the insufficient knowledge on postpartum mental illness among these women, there should be increased emphasis on postpartum mental health

education. In addition, best practice guidelines should be formulated specifically for postpartum anxiety and psychosis to guide nurses in the provision of an evidence-based care for these specific conditions.

The partners of Black African newcomer mothers should also be involved in postpartum health and support. Furthermore, public health professionals should partner with Black pastors and women leaders from the various faiths in postpartum mental health awareness creation. For instance, community health nurses can collaborate with predominantly Black churches to organize forums on postpartum mental health on church programs during Mothers' Day celebrations.

Conclusion

In conclusion, Black African newcomer women in Canada are vulnerable to postpartum mental illness. However, little is known about postpartum mental illness due to inadequate postpartum health education and a stigmatizing cultural conceptualization of mental illness. In addition, these women may be unwilling to use medical mental health services. Several sociocultural factors may impact Black African newcomer women's preference of mental health services after childbirth. These women's willingness to access mental health services are also affected by the cultural beliefs carried along from their home countries. Several recommendations are made to ensure Black African newcomer women receive culturally congruent and non-discriminatory care to meet their postpartum mental health needs. It is also recommended that nurses and other healthcare professionals partner with these newcomer women and women leaders of religious groups for appropriate postpartum mental health care.

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CHAPTER 3

IMPLICATIONS AND CONCLUSION

The purpose of this study was to explore sociocultural factors that impact Black African immigrant women's perception of mental health and mental health service utilization within a year after childbirth in Canada. Questions were asked about Black African newcomer women's perceptions and understanding of the significance of mental health services during the postpartum period, the impact of culture, and perceived barriers and facilitators to the use of mental health services. Ten newcomer women from African countries residing in Southern Ontario participated in this study. Three themes, namely, postpartum sanity, help-seeking and treatment preferences, and barriers and facilitators emerged.

Black African newcomer women shared their perceptions and understanding of the significance of mental health services during the postpartum period. Postpartum sanity uncovers their perception and understanding of postpartum mental health and what they do to stay composed and in charge of their minds. Also, participants spoke on how cultural beliefs impact on their willingness to use mental health services after childbirth by weighing available options of treatment and support. Black African newcomer women's willingness to access mental health services are affected by the stigmatizing cultural beliefs carried forward from their home countries. Furthermore, the participants discussed the perceived barriers and facilitators to their use of mental health services by newcomer women from African countries. Immigration status, racial discrimination while accessing health care services, and treatment preferences were identified barriers to postpartum mental health utilization. Creating awareness about postpartum mental health

services and delivering appropriate postpartum mental health services facilitate Black African newcomer women's willingness to access postpartum mental health services.

Implications for Nursing Practice and Policy

The findings from this study uncover the gap that exists in the awareness and knowledge of postpartum mental health and services among Black African newcomer women. Results from this study also reveal the need for culturally appropriate postpartum mental healthcare for this population. Additionally, this study shows that Black African newcomer women who face racial discrimination while accessing maternal health care are unlikely to use maternal mental health services. These women also have preferences to cope with postpartum mental health that differ from Western medicine.

The participants in this study mentioned the need for increasing the awareness of postpartum mental health among women during pregnancy. Ahmed, Stewart, Teng, Wahoush, and Gagnon (2008) emphasize that creating awareness of postpartum mental illnesses among newcomer women must focus attention on the negative effects for the whole family. Maternal mental health education should be individual, culturally congruent, and cognizant of mental health stigma. Nurses need to explain maternal mental health brochures to these women during pregnancy and after childbirth. Although most of the women had tertiary education, they noted their inadequate knowledge on postpartum mental illness. Nurses must also provide appropriate information about where these women can go, and the phone numbers to call, if they need postpartum mental health care and support.

Additionally, in this study, postpartum depression was the only referenced postpartum mental illness, indicating that there may be little or no awareness of postpartum mental illnesses including postpartum anxiety and psychosis. The Registered

Nurses' Association of Ontario (RNAO, 2018) has best practice guidelines for perinatal depression: *Assessment and Interventions for Perinatal Depression*. Perinatal depression is extensively covered in these guidelines for best nursing practice and has guidelines for assessing, preventing, and managing perinatal depression. However, postpartum anxiety and postpartum psychosis are only briefly discussed. Perinatal mental health care must include awareness creation of all postpartum mental illnesses, thorough assessments, and patient-centered interventions. Furthermore, findings from this study reveal the significance of faith in and drawing strength from God to be mentally well after giving birth for these women. Community health nurses can partner with pastors and women leaders from Black churches and other religions in mental health awareness campaigns targeting African newcomer women.

According to O'Mahony and Donnelly (2013), nurses and other healthcare professionals must be perceptive of the challenges that newcomer women face to provide culturally appropriate care for these women. The women in this study are adjusting to motherhood and adapting to a new country. They make choices based on their understanding of mental health and treatment preferences of mental illness while navigating an unfamiliar health system for services and support. Robert and Gilkinson (2012) recommend that cultural competency is included in mental health programs for newcomer women. Maternal health nurses and other healthcare providers must recognize that the manifestation of postpartum mental illness among this population may be covert due to the embarrassment and stigma that they are unable to maintain their composure, be in charge of their minds, and nurture and care for their babies and families. These viewpoints may be linked to the Strong Black Woman schema where Black women show mental strength and toughness. According to Abrams, Hill, and Maxwell (2018), Black

women display such strength due to cultural influences, resulting in their silence about mental stress and reluctance to use mental health services when facing mental stress. Therefore, nurses caring for this population should create rapport and build trust before conducting screening and assessment for postpartum mental illness among this population.

Based on findings from this study and as confirmed by Guruge, Thomson, George, and Chaze (2015), social support is significant in maintaining postpartum sanity among Black African newcomer women. Some participants expressed the need for peer support groups where they can share experiences on motherhood in Canada and using Canadian health and support services. Therefore, nurses and other healthcare providers caring for these women should incorporate the use of peer support groups in postpartum mental healthcare. These peer support groups could have Black African newcomer women who can act as peer educators on postpartum mental health and also provide assistance in navigating the healthcare system. These women can be educated by trained maternal and mental health nurses. The use of peer support groups comprising African newcomer women may significantly reduce postpartum mental stress and influence their decision to use mental health services after childbirth.

Furthermore, Black African newcomer women indicate a preference for informal social support after childbirth, especially from partners. The women in this study mention that women whose partners provide postpartum support may have a significantly improved mental well-being. Therefore, nurses and other healthcare providers must involve partners in postpartum support by including them in perinatal classes. Prenatal and postpartum health education should include postpartum mental health, baby's care and well-being, and recognizing when and where to seek help. Discharge planning after

childbirth needs to be family centered to include the partners of Black African newcomer women.

Racial discrimination, experienced in any healthcare setting can discourage newcomer women from accessing and using mental health services in the postpartum period (Fenta, Hyman, & Noh, 2006; Mckenzie, Hansson, Tuck, & Lurie, 2010). Several Black African newcomer women who participated in this study revealed experiencing discriminatory behaviors from health providers when accessing maternal health services as well as carrying out everyday child caring tasks. One participant mentioned that, discriminatory experiences could prevent African newcomer women from using mental health services after childbirth. Nurses and healthcare professionals must continually reflect on the impact of their reactions, conversations, and personal principles on newcomer women's well being (O'Mahony & Donnelly, 2013; O'Mahony, Donnelly, Bouchal & Este, 2013). Nurses can also advocate for anti-discriminatory care through developing health care and immigration policies that are fair and equitable.

Nurses must build therapeutic and trusting relationships with Black African newcomer women before and during pregnancy so that they become comfortable with expressing their mental health needs before and after childbirth. Participants in this study emphasized the importance of postpartum visits by public health nurses to enhance mental well being. Public or community health nurses are essential resources in providing postpartum mental health care and support through home visits (Morrow, Smith, Lai, & Jaswal, 2008; O'Mahony et al., 2013; Sword, Watt, & Krueger, 2006). Women in this study stress that nurses should reach out to them. Home visits and phone calls should be frequent and non-judgmental of Black African newcomer women's cultural rituals surrounding postpartum healing and baby's care. Nurses and healthcare

professionals will be able to provide culturally competent and safe care for these women when they sincerely listen to the voices of these women (O'Mahony et al., 2013). Black African newcomer women in this study reiterate that postpartum mental health care should be holistic. Spiritual care should be incorporated into postpartum mental health services targeting this population. For example, Black African newcomer women must be provided with the opportunity to access spiritual resources whilst accessing formal postpartum health care and support.

Implications for Nursing Education

It is imperative that cultural competency and safety is included in the pre-service education and professional development of nurses, other healthcare professionals, and social service providers (O'Mahony & Clark, 2018; Weerasinghe, 2012). This would ensure that current and future healthcare and social service providers in Canada provide culturally competent and safe care considering the changing diversity of Canada's population. One way of including cultural competency in the nursing curriculum is through service learning. This may involve providing nursing students with clinical experiences in caring for culturally and racially diverse populations. Multicultural health education is essential for preventing cultural illiteracy and prejudice among nurses and other healthcare professionals (Weerasinghe, 2012). Culturally safe care should also be taught in schools of nursing and other healthcare professions. In New Zealand, nurses are mandated to pass cultural safety training with a practising certificate, as part of their nursing registration (Richardson, Yarwood, & Richardson, 2017). Culturally safe care in this context means providing care in way that safeguards the cultural beliefs of Black African newcomer women to ensure they receive care without losing their cultural identity. As Canada is becoming even more diverse, cultural safety training should be

made mandatory and a prerequisite for nursing registration and renewal of certification. Furthermore, antiracism should be an important component in the Canadian nursing education and the training of new staff. This may eliminate disparities in African newcomer women's access of postpartum mental health services.

Implications for Nursing Research

The postpartum mental health of Black African newcomer women is under researched. Further research needs to be carried out in this area, using quantitative research methods and qualitative research methods such as phenomenology and grounded theory. To illustrate further, a phenomenological study could explore the Black African newcomers' lived experience of coping as recent mothers in a new country. A grounded theory would describe how these women navigate through the Canadian healthcare system to access maternal mental health services. The women in this study were living in Ontario, therefore this study should be replicated in other provinces.

Furthermore, this study focused on a small number of Black newcomer women in one part of Ontario, limiting the generalizability of the findings. Therefore, larger studies could be conducted involving African newcomer women from several provinces, and newcomer women from Francophone countries and other non-English speaking African countries. Other studies could focus on further understanding Black African newcomer women's treatment preferences in postpartum mental health care.

Black African newcomer women in this study revealed that immigration status impacts their ability to seek postpartum mental health services and support. Further research needs to be conducted with newcomer women with temporary resident status such as students, workers, and visitors, and also with undocumented immigrants to provide a deeper understanding of how the trajectory of acquiring a permanent resident

status, coupled with the stress of migrating into a new country and becoming a mother impacts Black African newcomer women's postpartum mental health and service utilization. African newcomer women noted the importance of postpartum support from their husbands. Finally, research needs to be conducted to understand the partner's role in African newcomer women's postpartum mental well-being and help-seeking behaviours.

Conclusion

Although African newcomer women try to maintain postpartum mental wellbeing by staying composed and in charge of their minds, they are vulnerable to postpartum mental illness. Several sociocultural factors affect these women's perception of mental health and their decision to use mental health services after childbirth. Cultural beliefs influence their preferences for postpartum mental health treatment and support. Also, Black African newcomer women have insufficient knowledge about postpartum mental illness due to inadequate postpartum health education and a cultural stigma of postpartum mental illness. This adds to their risk for mental health issues, compounded with the stress from being a new mother and adjusting to life in a new country. Postpartum mental health of African newcomer women is an under researched area. It is necessary to conduct further research in this area to inform nursing education, practice, and healthcare policies.

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APPENDICES

Appendix A: Poster



Study Title: Sociocultural Factors Affecting Mental Health Service Utilization by African and Caribbean Women following Childbirth in Canada



Bringing a new baby into the family may be difficult. Being a new mother living in a new country, it may be more difficult, and you may experience a lot of mental stress. As you care for your baby, you'll need to care for yourself too. Neglecting to care for yourself can harm you and your baby. When going through a lot of mental stress, would you use mental health services? What will influence your decision?

Are you:

- An immigrant woman from an African or Caribbean country?
- 18 years or older?

Have you:

- Lived in Canada for not more than (5) years?

Do you:

- Have a baby/babies not more than 12 months old?
- Speak English?

If YES, are you

Interested in volunteering to take part in a study that seeks to explore what influences the use of mental health services by African and Caribbean women after childbirth in Canada?

Your participation will involve:

- ✓ A one on one interview lasting about 60-90 minutes
- ✓ Interview will be audio-taped

For more information, please contact: Deborah (email address) XXX-XXX-XXXX for more information.

Appendix B: Letter of Information and Consent



Letter of Information for Participants

Study Title: Sociocultural Factors Affecting Mental Health Service Utilization by African and Caribbean Women following Childbirth in Canada

Principal Investigator: Dr. Marilyn Evans, RN PhD, Associate Professor, Arthur Labatt Family School of Nursing, Faculty of Health Sciences, Western University, London, Ontario, XXX XXX-XXXX ext. XXXXX

Co-Investigators:

- Dr. Erica Lawson, MA PhD, Associate Professor, Department of Women's Studies and Feminist Research, Western University, London, Ontario, XXX-XXX-XXXX ext. XXXXX
- Deborah Baiden, BSc. MSc Nursing student, Arthur Labatt Family School of Nursing, Faculty of Health Sciences, Western University, London, Ontario, XXX-XXX-XXXX

Hello,

1. Invitation to Participate

My name is Deborah Baiden, a second-year MSc Nursing student at Western University in London, Ontario. I am writing to invite you to participate in a study which will explore structural and cultural factors that impact on African and Caribbean newcomer women's perception and understanding of mental health service utilization within a year of giving birth. This is a student's project towards the completion of a Master's degree. I am inviting you to take part because you are a newcomer from an African or Caribbean country who recently had a baby.

1. Purpose of the Study

The purpose of this study is to learn more about: a) your perception and understanding of the significance of mental health services postpartum; b) your view on how culture

impacts on your willingness to use mental health services after childbirth; c) your perceived barriers and facilitators to the use of mental health services as a newcomer woman from an African or Caribbean country.

2. Criteria for Participation

If you are a newcomer woman from an African country or Caribbean with African heritage, who has given birth within the past year, has lived in Canada for not more than five years, and currently lives in Southern Ontario, you are invited to participate in this study. Approximately 15 to 20 newcomer women will take part in the study.

3. Study Procedures

As part of your participation, you will complete a short questionnaire on your demographics (including age range, educational level, employment status, marital status, and some information on your immigration experience) and partake in an audiotaped interview lasting about 60 to 90 minutes. The interviews will be conducted one-on-one either face to face or through telephone depending on your preference and convenience. Face to face interviews will occur at a time and location that is private, safe, and convenient for you and the researcher. A second interview may be conducted with your consent to ensure that your thoughts are clearly captured. Your consent to participate in this study includes the audiotaping of your interview and its transcription for analysis in a written format. You are invited to be involved in the data analysis of your own interviews, if you are interested, to verify that the information collected and analyzed is a complete and unbiased portrayal of your perspective and experiences. If you are interested in this, let me know at the end of the interview or contact me to inform me of your interest in participating.

4. Possible Risks and Harms

There are no risks to you in participating in this study. However, talking about your experiences since coming to Canada and having a baby may cause you to experience a wide range of emotional reactions. If you do feel upset I will pause the interview. The interview can be re- scheduled if you like. If you appear to be mentally distressed, you will be encouraged to stop the interview and seek medical attention. The interview will continue if you verbalize that you could go on, but if you are unable to, I will encourage you to visit your family doctor or the nearest health facility for support. I will also provide a list of mental health resources in the area that you can access. I will call you the next day, if you were distressed and unable to continue the interviews to see if you are OK.

5. Possible Benefits

Your participation in this study will enable you to reflect on your experience being a newcomer woman after recently having a baby and provide you with a platform to present your viewpoints and thoughts to others. Findings from this study may lead to the formulation and/or restructuring of policies and mental health services for you and other newcomer women who recently gave birth.

6. Voluntary Participation

You are encouraged to participate on your own free will and your refusal to participate or answer specific questions will not affect you in any way. You will sign a consent form to indicate your willingness to participate. You can withdraw from participating in this study at any time, for any reason, without any repercussion on you. In case you wish to terminate your participation from this study, all data collected from you will be

destroyed. Also, you can refuse to answer any questions asked of you in the interview. If you decide to withdraw from the study, you can contact me and let me know.

7. Privacy and Confidentiality

This study may be published in journals and presented at various conferences. Your privacy and confidentiality is assured since personal information about you will not appear in any reports, presentations or publications, and a pseudonym selected by yourself will be used throughout. The interviews will be recorded with an audio recorder and the audiotape will be erased after the interview has been transcribed. For confidentiality, all the information you provide will be kept on a personal computer, securely locked by password, and data will be accessed only by me and my supervisor and destroyed after seven years. Electronic copies of your transcripts collected for this study will be stored on a password-protected computer located in a secure locked location at the researcher's home. This information will be stored at the researcher's home for the purposes of data analysis only. The participants' information will be stored in an encrypted file on the computer. The encryption type used is the Encrypted File System (EFS). The EFS is an in-built Windows software. A password, only known to authorized personnel will be used in encryption. Written signed consents will be securely stored in a locked filing cabinet in a secure office separate from the raw data. However, per legal requirements, any information on child abuse and neglect will be reported to the Children's Aid Society. Representatives of the Western University Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of this study.

8. Compensation

You will receive a \$10 gift card to Tim Hortons in appreciation of your time.

9. Contacts for Further Questions

Questions about this study and your participation in it can be forwarded to me, Deborah Baiden. Kindly do not hesitate to contact me, either by phone at XXX-XXX-XXXX, or by e-mail at XXXXXX or my Supervisor, Dr. Marilyn Evans. Any questions on your rights as a participant can be sent to Office of Research Ethics XXX XXX-XXXX. Thank you in advance. I look forward to your cooperation and participation.

Sincerely,

Deborah Baiden

Study Title: Sociocultural Factors Affecting Mental Health Service Utilization by African and Caribbean Women following Childbirth in Canada
Consent Form

I have understood the nature of this study and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent to participate.

Print name.....

Signature:

Date:

Person obtaining consent (Print name)

Signature.....

Date.....

This letter is yours to keep for future reference

Appendix C: Telephone Script



Telephone Script

Researcher: Hello, Good morning/afternoon/evening, please may I speak with **[name of potential participant?]**

If the potential participant is not home, ask if there is a better time to call. But if she is home, continue with the conversation

Researcher: Hi, **[insert the name of the potential participant here]** this is Deborah Baiden, a second year MSc. Nursing student at Western University. How are you doing? I am calling today because you wrote down your name and contact information at **[I will mention name and location of church/ mosque/ community centre/settlement centre/ you informed another participant who reached out to you]** expressing your interest in the research study we are conducting. The study is a student project being conducted by my supervisor Dr. **Marilyn Evans, a faculty member at Western University**, and me. **We will like to talk with you about what influences your perception and understanding of the use of mental health services within a year of giving birth. It will take the form of a short demographic questionnaire and an interview which might last 60 to 90 minutes. The interview will seek information on a) your perception and understanding of the significance of mental health services postpartum; b) your view on how culture impacts on your willingness to use mental health services after childbirth and c) your perceived barriers and facilitators to the use of mental health services as a newcomer woman from an African or Caribbean country. Participation entails that you are a newcomer woman from an African or Caribbean country who has given birth within the past year, has lived in Canada for not more than five years, and currently lives in Southern Ontario.**

Are you still interested in participating in this study?

**If no: Say "thank you for your time and good-bye"*

If yes, continue to explain study details based on the letter of information

Researcher: I am now going to read you the letter of information over the phone **[clearly read the letter of information to the participant over the phone.]**

Researcher: Do you have any questions?

[Answer any questions they may have]

Researcher: Do you agree to participate in this study?

**If yes, ask them if we can continue the study now or if they will like to re-schedule a convenient day and time for the interview (to ensure the interview is conducted in a quiet/safe place where participant can freely and clearly speak).*

**If no, thank them for their time and say good-bye*

Appendix D: Semi-Structured Interview Guide

Thank you for agreeing to take part in this study. Do you have any questions before we begin?

1. Why did you decide to participate in this study?
2. Tell me, about being a postpartum newcomer woman in Southern Ontario.
Probe: What has this been like for you as a black newcomer woman?
3. What are your experiences as a mother in Canada? How does it compare with being a mother in your home country?
4. What does mental health mean to you? Probes: as a woman and a mother?
 - i. What do you think affects a new mother's mental health?
 - ii. What do you think could cause mental stress in postpartum women who have recently moved to Canada from African/Caribbean countries?
5. As a newcomer woman, what can increase or decrease your risk of suffering from mental illness after childbirth?
6. How will you define culture?
 - i. How has culture, race, and immigration affected your experiences of motherhood?
 - ii. What aspects of your culture do you think you will change or maintain to promote the mental health of postpartum newcomer women?
7. What do you think of seeking mental health care after childbirth?

Probes

- i. What makes mental health services accessible to newcomer mothers who are feeling stressed after having a baby?

- ii. What are the various ways in which you will prefer to seek treatment in case you feel mentally unwell? Probe: Physical, emotional, social, and spiritual?
 - iii. What influences your treatment choices?
8. As a newcomer woman living in Canada, how do you maintain mental wellness after childbirth? Probes: what is helpful to you? What is not helpful to you?
 9. What social experiences contributes to your perceptions and beliefs regarding mental health services? Probe: utilization
 10. If you were a healthcare professional in Canada, what strategies would you put in place to assist newcomer women to stay mentally well during the postpartum period?
 11. What will you like to tell newcomer women with similar backgrounds about accessing mental health services?
 12. Any other comments you will like to share?

Appendix E: Demographic Questionnaire

Demographic Information

1. How old are you?
 - A. Below 25 years..... B. 25 – 35 C. 36 – 45..... D. Above 45
years.....

2. What is your education level?
 - A. Below high school..... B. High school..... C. University/College.....

3. What is your employment status?
 - A. Employed (Full-time) B. Employed (Part-time or Casual) C.
Unemployed..... D. Full time homemaker..... E. Maternity
leave.....

1. What is your marital status?
 - A. Single.... B. Married..... C. Divorced..... D. Separated..... E. Common-
law partner..... F. Other

2. Which country did you migrate from?

3. What is your immigration status?

4. Where do you currently live in Canada?

5. How long have you lived in Canada?

6. Do you have family members living in Canada?.....

7. How long ago did you have your baby?

8. How many children do you have?.....

9. Do you have a family doctor?.....

Appendix F: Ethics Approval Letter



Date: 3 July 2018

To: Dr. Marilyn Evans

Project ID: 111725

Study Title: Sociocultural Factors Affecting Mental Health Service Utilization by African and Caribbean Newcomer Women following Childbirth in Canada

Application Type: HSREB Initial Application

Review Type: Delegated

Full Board Reporting Date: July 17, 2018

Date Approval Issued: 03Jul2018

REB Approval Expiry Date: 03Jul2019

Dear Dr. Marilyn Evans

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study as described in the WREM application form, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

Document Name	Document Type	Document Date
Demographic questionnaire - 04 April, 2018	Other Data Collection Instruments	04/Apr/2018
Flyer - 08 June, 2018	Recruitment Materials	08/Jun/2018
Interview guide - 04 April, 2018	Interview Guide	04/Apr/2018
letter of information - 8th June, 2018	Written Consent/Assent	08/Jun/2018
Telephone script - 07th June, 2018	Telephone Script	07/Jun/2018
Thesis Proposal - 03 April, 2018	Protocol	

No deviations from, or changes to, the protocol or WREM application should be initiated without prior written approval of an appropriate amendment from Western HSREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement - Ethical Conduct for Research Involving Humans (TCPS 2), the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP) Part C, Division 5 of the Food and Drug Regulations, Part 4 of the Natural Health Products Regulations, Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA, 2000) and its applicable regulations. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Karen Cepaul, Ethics Officer on behalf of Dr. Joseph Gilbert, HSREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

CURRICULUM VITAE

Name: Deborah Baiden

Educational Background:

Western University, London, Ontario, Canada
Master of Science in Nursing
2016- Current

University of Ghana, Legon, Accra, Ghana
Bachelor of Science in Nursing
2011-2015

Teaching and Research Experience:

Graduate Teaching Assistant
Arthur Labatt Family School of Nursing
Western University
2016- 2018

Teaching and Research Assistant
Department of Adult Health Nursing
School of Nursing, University of Ghana
2015-2016

Research Assistant
Multi-national Research project: "Involuntary childlessness: Enhancing knowledge and awareness in the Global South"
2016

Presentations:

Health & Rehabilitation Sciences Graduate Research Conference, Oral Presentation
February 2019

Guest Speaker, 1st year undergrad nursing (N1070)
Arthur Labatt Family School of Nursing
Western University
November 2017

Publication:

Baiden, D. (2018). Factors affecting the impact of barcode medication administration technology in reducing medication administration errors by nurses. *Canadian Journal of Nursing Informatics*, 13(1), Retrieved from <http://cjni.net/journal/?p=5368>

Volunteering Experiences:

Team Lead – Diabetic Foot Care Group
(ASPIRE, formerly London Inter-professional Student-led Clinic)
2017

Health Education and Screening, Odumasi
Accra Rotary Club, Ghana
February 2015

Health Screening, Kururantumi and Bawaleshie
University of Ghana Nursing Students' Association (UGHANSA), Ghana
May 2015