

Access to Mental Healthcare Services for Black Women during Perinatal Period – A Scoping Review

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Abstract

Background: Black women in Canada are at higher risk of poor mental health outcomes; this is associated with disparities such as poor access to healthcare and aggravated by racial discrimination and poor living conditions.

Objectives: This study aims to investigate the extent and nature of literature on access to mental healthcare services for Black women during the perinatal period in regions outside of Africa and the Caribbean.

Methods: We conducted a systematic article search using Medline, Cumulative Index for Nursing and Allied Health Literature (CINAHL); PsycINFO; ProQuest Public Health Database. The search strategy based on the following aspects: 1) Perinatal mental health, specifically maternal mental health 2) People of color, specifically Black people of African descent, or the African diaspora 3) Experiences with mental healthcare, specifically access and utilization. Arksey & O'Malley's framework for conducting scoping reviews was chosen. The included studies met the following criteria: 1) articles that focused on Black Women during perinatal period living in regions outside of African and the Caribbean, 2) studies with topics related to mental health services among Black women during perinatal period.

Results: n=12 articles met the inclusion criteria. The following themes were identified from the analysis of literature: 1) Disparities in utilization of mental healthcare services, 2) Spirituality, Faith, and Religion, 3) Accessibility of mental healthcare services.

Conclusion: There is a paucity of evidence about the mental health of prenatal and postnatal Black women living outside Africa and the Caribbean in countries other than the US, the UK, and Canada.

Keywords: Black women, healthcare access, mental health, perinatal period

1. Introduction

The perinatal period can increase susceptibility to the onset or recurrence of mental illnesses such as depression and anxiety (Smith et al., 2011). For this project, we defined the perinatal period as the time during pregnancy to the first year after the baby is born. Pregnant women are susceptible to experiencing adverse mental health issues due to significant physiological and hormonal changes that take place throughout different stages of pregnancy (Alipour et al., 2018). 23% of mothers who recently gave birth in Canada reported signs and symptoms of poor mental health (Statistics Canada, 2021). According to reports from the U.K. and USA, Black women are at a higher risk of dying from pregnancy-related complications, with a four-fold increase in mortality rates (Adhopia, 2023).

Immigrant mothers in developed countries are more prone to postpartum mental disorders compared to nonimmigrant women (Vigod et al., 2016; Falah-Hassani et al., 2015). There is a higher risk of experiencing poor mental health outcomes by Black women and infants in Canada due to disparities in healthcare access and racial discrimination, compounded by poor living conditions (McKinnon et al., 2016). Further, poor mental health during pregnancy could influence an infant's health outcomes. For example, of the infants born to Black mothers in the United States and Canada, 12.7% and 8.9%, respectively, were preterm, compared to 8.0% and 5.9% of infants born to white mothers, respectively (McKinnon et al., 2016).

Social determinants of health, such as racism, gender discrimination, and socioeconomic status, are linked to

mental health and access to mental healthcare (Alegría et al., 2018). Living in poverty can expose mothers to the risk of developing mental health disorders and make existing symptoms, such as postpartum depression (PPD), worse (Lau & Adams, 2023). Chalmers and Omer-Hashi (2002) postulate that Black women in Canada face cultural insensitivity, such as a lack of a role in decision-making, which could prevent access to mental health services and contribute to poor mental health. Further, lack of support and stressful life events during pregnancy may increase the risk of mental illness during this period (Smith et al., 2011). The above disparities are exacerbated by the increased challenge for Black people in Canada of finding family physicians, who serve as gateways to mental healthcare (Fante-Coleman & Jackson-Best, 2020).

Jidhong et al. (2021) indicated that maternal depression is a major determinant of disease burden for women worldwide, and there are ethnic inequalities in accessing psychological interventions in high-income countries (HICs). In their systematic review, the authors proposed the use of culturally appropriate interventions as a beneficial approach for African and Caribbean women living in HICs as ethnic minorities. Similarly, Robertson and Wells (2023) conducted a literature review and identified programs and interventions to address PPD in African American women. The interventions included group psychosocial, individual psychosocial, internet-based, and integrated care interventions. The authors reported that culturally appropriate interventions were shown to be promising in addressing PPD in African American women.

The experiences of anti-Black racism increase cultural biases that could impact access to mental health services. In their study examining the prevalence of racial discrimination and microaggressions experienced by Black individuals in Canada, Cénat and colleagues found that 53% of Black participants experienced significant racism when interacting with healthcare providers, with women experiencing significantly more racial discrimination than men overall (Cénat et al., 2022). Etowa et al. (2017) examined the 'Strong Black Woman' construct arising from both cultural pride and racial discrimination among African Nova Scotian women, finding that Black women would go to the extent of denying their own needs and self-care, which could negatively impact their well-being (Etowa et al., 2017). In a similar study, Woods-Giscombe et al. (2016) aimed to understand the barriers that prevent African American women from seeking mental health services using the Superwoman Schema (SWS) framework to represent the characteristics of strength typically associated with African American women. These characteristics include the ability to suppress emotions, resist feelings of vulnerability and dependence, succeed despite limited resources, and prioritize caregiving over self-care. The study found that the SWS, along with perceived stigma, religious and spiritual concerns, and the wish for a culturally sensitive provider, significantly influence the utilization of mental healthcare services by African American women (Woods-Giscombe et al., 2016).

The cumulative impacts of colonialism, racism, and biases within the healthcare system have negatively impacted the health and well-being of Black women and have made it harder for Black women to access mental health services. However, there is a shortage of empirical studies that examine the access to mental healthcare for Black women, particularly during the perinatal period. This study aims to investigate the extent and nature of literature on access to mental healthcare services for Black women during the perinatal period in regions outside of Africa and the Caribbean.

2. Method

A scoping review is a valuable method to evaluate the quantity and diversity of literature accessible on a specific topic and gives a precise or broad comprehension of its emphasis (Munn et al., 2018). Arksey and O'Malley (2005) recommend a five-step process for conducting a scoping review, which includes identifying the research question, relevant studies, study selection, data extraction/charting, summarizing, and reporting results. This review employed the Arksey and O'Malley (2005) five-step methodology to investigate the literature on mental health services access during the perinatal period for Black women residing outside Africa and the Caribbean. For this study, the perinatal period is defined as the period during pregnancy, and twelve months after the child is born.

2.1 Stage 1: Identification of Research Question

The following question guided this review: What is the extent and nature of literature on access to mental healthcare services for Black women during the perinatal period in regions outside of Africa and the Caribbean?

2.2 Article Selection

The nursing science librarian conducted a systematic search across multiple databases in order to identify relevant articles. Following a preliminary search of the literature to identify key terms and concepts we constructed a search strategy based on the following aspects: 1) Perinatal mental health, specifically maternal mental health 2) People of color, specifically Black people of African descent, or the African diaspora 3) Experiences with mental health care, specifically access and utilization. Four databases were searched from inception date to May 17, 2023,

retrieving a total of n=10086 articles: Medline, Cumulative Index for Nursing and Allied Health Literature (CINAHL); PsycINFO; ProQuest Public Health Database. The systematic review software, Covidence, was used to compile article records and remove duplicates. n=7659 duplicates were removed. Results were limited to peer review; no other restrictions were applied. Details of the full search strategies for each database are included in Appendix A.

2.3 Inclusion Criteria

Two authors (AA and OS) who are nursing students, independently screened the title and abstract of n=2517 studies for eligibility, and n=2384 studies were excluded, leaving n=138 studies for full-text screening. A third author (JK), a PhD prepared nurse resolved any discrepancies between the two authors at all stages of screening. Researchers JK, AA, and OS met regularly throughout the review process to reach consensus on the decisions. Following full text screening, n=12 articles met the following inclusion criteria: 1) article focused on Black Women during perinatal period living in regions outside of African and the Caribbean, 2) study topic related to mental health services among Black women during perinatal period. Studies were excluded if they did not meet the inclusion criteria. The article selection process is depicted in Figure 1 PRISMA diagram (Page et al., 2020).

2.4 Data Extraction and Data Analysis

We extracted data from the studies selected. We developed an excel spreadsheet to document data extracted from the selected articles. We extracted data on the following: 1) title of the article, 2), authors, 3) year of publication, 4) purpose of the study, 5) methodology, 6) method, 7) sampling, recruitment, and selection process, sample size, 8) location, and 9) results. Author JK created an Excel data extraction form to record the data extracted for each eligible article. Authors JK, AA, and OS independently read the selected articles and entered data into the Excel data extraction form. The authors identified initial codes and analyzed data thematically (Braun & Clark, 2006) to address the research question.

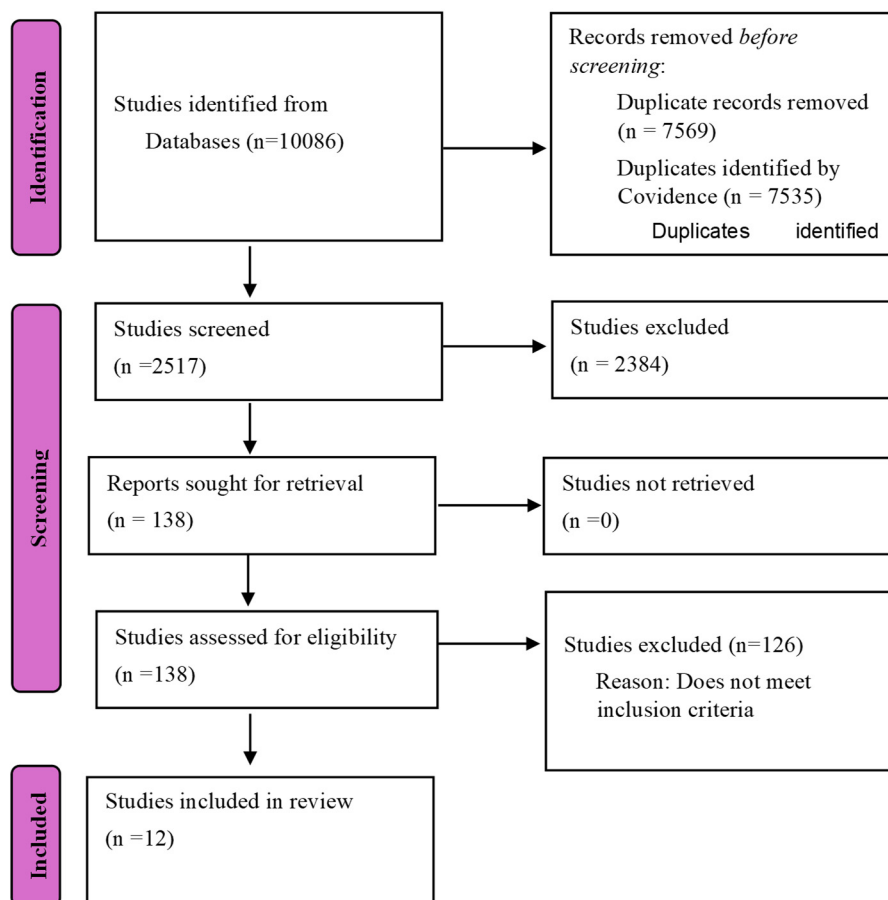


Figure 1. PRISMA diagram -Access to Mental Healthcare Services by Black Women Outside of Africa and Caribbean during perinatal period

3. Results

n=12 studies met the inclusion criteria (Figure 1). Among these studies, n=6 was quantitative, n=5 was qualitative, and n=1 was mixed-methods. Amongst the 12 studies included in the review, six were conducted in the USA (Bodnar-Deren et al., 2017; Goodman, Dimidjian, & Williams, 2013; Kemet et al., 2022; Powers et al., 2020; Sroka et al., 2023; Waldron, 2022), four of the studies were from the UK (Amoah, 2021; Edge, Baker, & Rogers, 2004; Gardner et al., 2014; Nyashanu, Siebert, & Serrant, 2018), and two were from Canada (Ayela, 2008; Baiden, 2021). The following themes were identified from the literature: 1) Disparities in utilization of mental healthcare services, 2) Spirituality, Faith, and Religion, 3) Accessibility of mental healthcare services. Table 1 shows the summary of the articles included and the themes.

Table 1. Summary of results

Author & Year of Publication	Article	Location	Theme
Amoah, 2021	Predicting Perinatal Low Mood and Depression for BAME Women - The Role of Treatment, Perceived Public, and Internalised Stigma	UK	Disparities in utilization of mental healthcare services Accessibility of mental healthcare services
Ayela, 2008	Incidence of postpartum depression in African Canadian women attending a prenatal program in Toronto, Canada	Canada	Disparities in utilization of mental healthcare services
Baiden et al., 2021	Black African Newcomer Women's Perception of Postpartum Mental Health Services in Canada.	Canada	Disparities in utilization of mental healthcare services Spirituality, Faith, and Religion
Bodnar-Deren et al., 2017	Stigma and Postpartum Depression Treatment Acceptability Among Black and White Women in the First Six-Months Postpartum.	USA	Disparities in utilization of mental healthcare services Spirituality, Faith, and Religion
Edge et al., 2004	Perinatal depression among black Caribbean women.	UK	Disparities in utilization of mental healthcare services Spirituality, Faith, and Religion Accessibility of mental healthcare services
Garner et al., 2014	The experience of postnatal depression in West African mothers living in the United Kingdom: A qualitative study.	UK	Spirituality, Faith, and Religion
Goodman et al., 2013;	Pregnant African American women's attitudes toward perinatal depression prevention.	USA	Disparities in utilization of mental healthcare services Accessibility of mental healthcare services
Kemet et al., 2022	"When I think of mental healthcare, I think of no care." Mental Health Services as a Vital Component of Prenatal Care for Black Women.	USA	Accessibility of mental healthcare services
Nyashanu et al., 2018	Experiences of first-time mothers with postnatal depression among black sub-Sahara African communities in the West Midlands, England	UK	Accessibility of mental healthcare services
Powers et al., 2020	Trauma, Psychiatric Disorders, and Treatment History Among Pregnant African American Women.	USA	Disparities in utilization of mental healthcare services Accessibility of mental healthcare services

Waldron et al., 2022	Perspectives on Mental Illness Stigma Among African Immigrant Pregnant and Post-Partum Women in an Urban Setting: A Brief Report	USA	Spirituality, Faith, and Religion
Sroka et al., 2023	Depression screening may not capture significant sources of prenatal stress for Black women.	USA	Accessibility of mental healthcare services

3.1 Theme 1: Disparities in Utilization of Mental Healthcare Services

Seven studies (Amoah, 2021; Ayela, 2008; Baiden, 2021; Bodnar-Deren et al., 2017; Edge et al., 2004; Goodman et al., 2013; Powers et al., 2020), contributed to the theme; *disparities in utilization of mental healthcare services*. In their research, Amoah (2021) found a high prevalence of possible depression among the participants, with 62% of women scoring within the range indicative of potential depression on the EPDS scale. The results of this study indicate that perinatal symptoms in women of black ethnicity have a positive and significant correlation with trait and internalized stigma. Additionally, perceived public stigma positively and significantly correlates with internalized stigma (Amoah, 2021). A similar finding showed that while self-stigma (personal shame) showed no significant association with race across the therapies, stigma related to disclosing treatment to friends, family, community, and workplace differed between Black and white postpartum mothers (Bodnar-Deren et al., 2017). In this study, Black mothers were less likely to report feeling ashamed to disclose their use of prescription medicine, mental health counseling, herbal remedies, or spiritual counseling for PPD across various social circles (Bodnar-Deren et al., 2017).

Another study in the UK found that, when compared to white British women, Black Caribbean women living in the UK are more prone to experiencing various social risks for depression and less likely to receive treatment for depression or postnatal depression (Edge et al., 2004). Edge et al. (2004) further revealed that the reluctance among Black Caribbean women to consult their General Physician about depressive symptoms, and their resistance to psychiatric labeling, was partially based on their perceptions of unequal and inappropriate treatment of Black people within mental health services; while most white women in the UK received community-based treatment, Black Caribbean women were referred to psychiatric services in secondary care (Edge et al., 2004). Comparably, in Canada, Black women described discrimination from health care providers, inadequate health education during antepartum about PPD, stigma, and misinformation about mental illness as barriers to the utilization of mental health services (Baiden, 2021).

Further, there is a high prevalence of perinatal depression and psychiatric disorders among African American women, predisposing them to risks such as early preterm delivery (Goodman et al., 2013; Powers et al., 2020). A Canadian study that investigated Black women during prenatal and postnatal period, found 23.8% of participants indicated a positive screen for (PPD), and 33% had a Postpartum Depression Screening Scale (PDSS) score consistent with significant symptoms of PPD (Ayela, 2008). In this study, low income is a predictor of PPD (Ayela, 2008). However, Edge et al. (2004) found that Black Caribbean women expressed concerns about becoming addicted to antidepressants and being labeled with psychiatric diagnoses, which acted as barriers to seeking help. These beliefs can have a significant impact on seeking support for PPD.

3.2 Theme 2: Spirituality, Faith, and Religion

Five studies, (Baiden et al., 2021; Bodnar-Deren et al., 2017; Edge et al., 2004; Gardner et al., 2014; Waldron, 2022) contributed to the theme; *Spirituality, Faith, and Religion*. With the absence of support from older females as a custom back in Africa, a study from Canada revealed that Black African immigrant women, utilize mental strength, positivity, faith in God, and spirituality to maintain a sense of mental well-being during the postpartum period (Baiden et al., 2021). In the UK, Black Caribbean women had less postnatal support from their partners and families compared to White British women (Edge et al., 2004). The lack of postnatal support increases the vulnerability of Black women to postnatal depression (Edge et al., 2004). In another study, Black mothers tended to prefer spiritual counseling over mental health counseling and prescription medication and are less likely to have trust in the medical system and experience satisfaction in care (Bodnar-Deren et al., 2017). The study posits that married women with access to commercial insurance would be more likely to accept prescription medication mental health counseling and have less confidence in spiritual counseling. Further, the low treatment rate for PPD was attributed to structural barriers such as lack of access, transportation, childcare, and cost of treatment (Bodnar-Deren et al., 2017). Similarly, cultural beliefs, racial discrimination, and temporary immigration status affect Black women's decision making regarding postpartum mental health service usage (Baiden et al., 2021).

Cultural background made it challenging to express feelings of depression, negatively affecting Black women's willingness to seek help for fear of stigma (Gardner et al., 2014). Moreover, Waldron (2022) found that stigma toward mental health was associated with the label of being 'crazy' or being judged. In their study, Edge et al. highlighted the concept of "Strong Black Women," suggesting that Black women are expected to be strong and independent, which may lead to a lack of seeking support (Edge et al., 2004). Additionally, spiritual, emotional, and practical support from black-led churches and faith communities were embraced by these women (Edge et al., 2004).

3.3 Theme 3: Accessibility of mental healthcare services

Eight studies, (Amoah, 2021; Baiden et al., 2021; Edge et al., 2004; Goodman et al., 2013; Kemet et al., 2022; Powers et al., 2020; Nyashanu et al., 2018; Sroka et al., 2023) contributed to this theme. Depression screening tools may not be enough to identify Black women at risk for perinatal morbidity and mortality related to psychosocial stress. Powers et al. (2020) and Sroka et al. (2023) suggest improved screening processes that evaluate past traumatic experiences and thoroughly assess risks to determine the need for interventions and support, considering that treatment relies heavily on self-reported information. Stigma, lack of resources, misdiagnosis, and underdiagnosis are barriers to mental health services. Identifying and treating trauma disorders, especially PTSD, with culturally responsive care is crucial (Powers et al., 2020).

One study highlighted the importance of expanding mental healthcare services beyond pharmacological treatment. Goodman et al. (2013) found that most women in their study were interested in professional mental health services as well as a range of other services. Preferred treatment approaches included mindfulness and interpersonal techniques to improve their well-being, manage stress, and prepare for parenting, even when preventing depression is not a primary concern (Goodman et al., 2013). The study also found knowledge about depression and treatment and access to practical care options would encourage women's participation in preventative programs (Goodman et al., 2013).

In the USA, barriers to accessing mental health services include lack of access to care, availability of mental health providers, insurance coverage, provider distrust, and racial disparity (Kemet et al., 2022). Thus, culturally competent care is essential for all mental health-trained providers (Kemet et al., 2022). Further, health professionals often fail to diagnose and treat women's symptoms of depression, mistaking them for stress, anxiety, or inadequate support from partners. Women may also be reluctant to be labeled as "depressed," leading to misdiagnoses being accepted and women not receiving proper treatment for their depression (Edge et al., 2004). Edge et al. (2004) highlights the significant role of historical, cultural, and socioeconomic factors in shaping the perceptions and responses to perinatal depression among Black Caribbean women, underscoring the need for further investigation to fully understand factors beyond healthcare stigma influencing treatment acceptance. Designing culturally sensitive interventions and support systems is crucial to addressing multifaceted challenges faced by this demographic in seeking mental health care (Edge et al., 2004).

One study suggested that Black African immigrant women, while acknowledging the importance of postnatal mental health service utilization, advocate for a holistic approach involving both physical and spiritual interventions (Baiden et al., 2012). Spiritual healing, practiced back in their home countries, was embraced as the preferred nonmedical treatment (Baiden et al., 2021). Comparably, Amoah (2021) suggests that Black, Asian and Minority Ethnic (BAME) women may feel more comfortable discussing mood-related concerns at home or online before seeing their healthcare providers, providing valuable insights into effective support mechanisms for the women.

In a British study, most of the Black African first-time mothers associated loneliness and moments of depression with their changing roles as new mothers (Nyashanu et al., 2018). Nyashanu et al. (2018) suggest a framework for researching stigmatized issues, such as depression, that could contribute to improved design and delivery of mental health services for Black women. Goodman et al. (2013) further underscore the importance of involving women in discussions about incorporating support from loved ones to promote engagement in preventive interventions.

4. Discussion

Three themes were developed from this review's result: a) disparities in utilization of mental health services, b) Spirituality, Faith, and Religion, and c) accessibility of mental healthcare services. The review reveals that most of the included studies were published within the last 10 years, with a growing number of recent publications on the topic in the last five years noted. Most of the studies were conducted in the US; this could be due to the high population of African Americans and other Black immigrants in the United States as compared to the UK and Canada (Colby & Ortman, 2015, p. 9; Bécares et al., 2012; Livingstone & Weinfeld, 2018, p. 131). Overall, this

review contributes to evidence in the literature confirming the presence and intersection of multifactorial risks, including gendered racial inequities, discrimination, sociocultural barriers, and financial issues impacting the access to and utilization of mental health care services among prenatal and post-partum Black women living outside Africa and the Caribbean. This observation supports Lau and Adam's (2023) assertion that the racial disparities existing in perinatal care considerably affect birth and postpartum mental health outcomes. The authors, therefore, caution that addressing the systemic racism faced by Black mothers with mental health issues such as post-partum depression (PPD) is critical.

4.1 Utilization of Mental Healthcare Services

In this review, we noted that a high prevalence of depression was identified as the major mental health condition affecting prenatal and postpartum Black women living outside Africa and the Caribbean. Depression was related to stigma (Amoah, 2021), unequal treatment (Edge et al., 2004), and low income (Ayela, 2008), resulting in a greater reluctance to disclose the use of mental health counseling, medical treatments, and spiritual counseling among pre- and postpartum Black mothers compared to their white counterparts (Amoah, 2021; Bodnar-Deren et al., 2017; Edge et al., 2004). This finding is congruent with Lau and Adam's (2023) study evaluating predictors of PPD and their effect on postpartum women of different racial identity groups living below the poverty line in the US. Postpartum mothers who identified as Black had an 8.3% higher probability of PPD than white mothers, with the main predictor of PPD being racism (Lau & Adam, 2023). Consequently, the racism that they experience predisposes black women to be less likely to receive treatment or screening for PPD, which could also lead to poor health maternal and child health outcomes. Shedding light on the effect of PPD on maternal and child health outcomes, a quantitative study conducted by Johnson et al. (2021) explored the role of mothers' personal and contextual risk factors on breastfeeding rates, with a special emphasis on understanding breastfeeding among African American mothers at six months postpartum. The results indicated that risk factors such as demographic and social support risk, childhood trauma history, and PPD were associated with lower breastfeeding at six months postpartum. Racial and gender stress resulting in depression was also identified as a risk of poor birth outcomes in well-educated pregnant African American women (Jackson et al., 2012). High rates of depression in Black pregnant women, no matter their educational or income level, pose a risk to the health of mothers and their babies.

In addition to the high rates of PPD, the intersection of gendered racism, inequality, low income, class, and unequal opportunities to access mental health, result in poor health outcomes for Black mothers and their children (Garnett et al., 2014; Howell, 2023; Mehra et al., 2020). Mehra et al. (2020) used an eco-social and intersectionality framework and a biopsychosocial model of health to understand Black pregnant women's experiences of gendered racism during pregnancy. The authors reported that a major stressor for the women was the gendered racism experienced during pregnancy in the form of stereotype stigmatization of Black motherhood, such as seeing mothers as having too many children or as low-income individuals with housing problems and devaluing their Black pregnancies. This implies that understanding and addressing the systemic racism and other stressors Black mothers with mental health issues face are critical in optimizing mother and infant health outcomes.

4.2 Spirituality, Faith, and Religion

This review revealed that in the absence of support from older female relatives that Black African immigrant women in Canada received when they were in Africa, they relied on utilizing psychological and spiritual strategies such as mental strength, staying positive, faith in God, and connecting with spirituality to maintain their mental well-being during the postpartum period (Baiden et al., 2021). The findings align with results of interviews Keefea et al. (2016) conducted with Black American and Latino women, who described how their faith, church participation, and spiritual practices helped in coping with PPD. The authors developed six themes from their study: a) relief from stress, b) feeling valued and less alone, c) experiencing gratitude, d) developing perspective and accepting God's guidance, e) changing and developing relationships, and f) preventing self-harm (Keefea et al., 2016). Further, the mothers who observed their faith and engaged in spiritual practices experienced shifts in their perspectives on the negative thoughts, feelings, and stressors related to PPD, with more positive perspectives leading to positive changes in their lives (Keefea et al., 2016). This review also revealed that in the UK, Black Caribbean women received less postnatal support from their partners (Edge et al., 2004), and that in Canada, Black women's decision-making on using mental health services were influenced by their cultural beliefs, experience of racial discrimination, and temporary immigration status (Baiden et al., 2021).

Some cultural beliefs, such as "labeling as being crazy" and expectations of Black women to be strong (Waldron, 2022), were also barriers to expressing feelings of depression and willingness to seek help for fear of stigma (Gardner et al., 2014; Edge et al., 2004). This is congruent with Sampson et al. (2014) who report that PPD is also stigmatized and perceived as a sign of weakness in ethnic groups of African American mothers, despite being a

highly prevalent mental health condition in this population. Similarly, an integrated review by Beck (2023) identified five themes that described the PPD experiences of U.S. born Black and Hispanic women:

a) struggling with an array of distressing symptoms, b) cultural stigma as a powerful roadblock, c) complicating barriers to seeking much-needed professional help, d) support as a lifeline or “Just Pulling Yourself up by Your Bootstraps,” and e) preferences for help with PPD (Beck, 2023). The authors added that the cultural stigma of mental illness, in addition to a lack of knowledge of PPD, were strong barriers to women of color in seeking appropriate and timely professional mental health care. This suggestion also aligns with the proposal by Sampson et al. (2014) that individual and community education are critical in addressing the misperceptions of PPD in this population.

The above explications highlight the complex and multidimensional factors that contribute to mental health issues in Black women living outside Africa and the Caribbean during their prenatal and postnatal periods, including ethnicity and cultural background, spiritual, social, and transnational positionality. Hence, consideration of these dimensions in mental healthcare interventions would play a huge role in addressing the mental health issues of this population. Edgea and MacKianb (2010) also explained the multifactorial nature of the risk that contributes to the low rate of Caribbean women seeking help during and after pregnancy. The authors indicated that despite high levels of known psychosocial risks that contribute to perinatal depression among Caribbean women, this population remains invisible among those seeking help for depression during and after pregnancy (Edgea & MacKianb, 2010). In this light, the authors explored the women’s models of help-seeking by finding common ground between service users and providers to enable the women to receive the care and support they need. The findings of the study revealed that whether or not the women perceive depressive feelings as ‘symptoms’ that require external validation and intervention is a representation both of the social embeddedness of the mothers and of how ‘help-givers’ perceive the mothers’ particular needs (Edgea & MacKianb, 2010). The authors further explained that the approaches to health-seeking behaviors within health promotion and practice that focus on individuals as the fulcrum for change tend to overlook the embeddedness of the mothers within reflexive communities. The authors suggested that alternative approaches that would enable the women to receive care and the appropriate support they need include government interventions to reduce inequalities in access, care, and treatment and to deliver more responsive and culturally appropriate mental health services.

The explications of Edgea and MacKianb (2010) align with the result of this review that Black mothers tend to prefer spiritual counseling over mental health counseling or treatment and are less likely to trust healthcare or experience satisfaction with the care delivery (Bodnar-Deren et al., 2017). On the other hand, our review also revealed that mothers with access to commercial insurance would be more likely to accept treatment and mental health counseling, but they have less confidence in spiritual counseling. Additionally, the findings of the review revealed that aside from the cultural risk factors, other factors that contribute to the low treatment rate for PPD in mothers were attributed to structural barriers such as lack of access, transportation, childcare, and cost of treatment (Bodnar-Deren et al., 2017). These findings highlight the intersections of ethnicity/cultural background, gendered sexism, and social location, resulting in poor accessibility to healthcare services to improve the mental health and well-being of prenatal and postnatal Black women (Garnett et al., 2014; Lett, Dowshen, & Baker, 2020; Okoro, Hillman, & Cernasey, 2022). This calls for a multidimensional approach to support prenatal and postpartum mothers in utilizing and accessing the appropriate interventions fashioned to meet the complexities of their unique needs. This suggestion is also congruent with Sims’s (2014) explication that pregnant African American women are more likely to experience multiple complex health issues, such as depression than their European American counterparts. Sims (2014) advocates for using the lens of complexity theory when addressing health concerns of pregnant African American women to ensure various strategies are implemented to address depression through preventive care delivery and promotion of access to appropriate mental health services.

4.3 Accessibility of Mental Healthcare Services

The findings of this review show that most of the included studies (eight studies) report on the accessibility of mental health services for Black women during and after their pregnancy. Generally, it was noted in this review that the rate of accessing healthcare services among Black and Caribbean women living outside Africa is low due to multiple social risk factors ((Gardner et al., 2014; Edge et al., 2004; Waldron, 2022). The risk factors include but are not limited to inadequacy of depression screeners in identifying Black women at risk for perinatal psychosocial stress, stigma, lack of resources, misdiagnosis or underdiagnosis, and barriers to mental health services (Powers et al., 2020; Sroka et al., 2023). To curb the risk factors, Nelson, Ernst, & Watson-Singleton (2022) cautioned that when screening for PPD, it may also be important to make inquiries about poor hospital treatment and stressors related to the experiences of the risk factors. In their study examining the relationship

between risk factors such as perinatal complications, poor hospital treatment, and positive screening for postpartum depressive symptoms of Black women, the authors found that poor hospital treatment was associated with a positive screen for PPD, anhedonia, and depressed mood (Nelson et al., 2022). Perinatal complications, Gestational diabetes, and preterm birth were also associated with a positive screen for depression and depressed mood, with perinatal complications also potentially increasing the risk for PPD among Black women (Nelson et al., 2022).

Other risk factors identified in this review that influence accessing mental health services by Black women include lack of access to mental healthcare, insurance coverage, availability of mental health providers and provider distrust, and racial disparity (Kemet et al., 2022). Health professionals misdiagnosing and treating the women's depression symptoms as stress or anxiety, lack of support from the women's partners, and the women's reluctance to be labeled as "depressed" were also risk factors revealed in the review (Edge et al., 2004). The above findings of the study also shed light on the intersectional experience of low income, lack of support from partners, discrimination, and stress, resulting in invisibility and underreporting or misdiagnosis of mental health problems in Black women, which could also result in a negative impact on their health outcomes (Garnett et al., 2014; Howell et al., 2023; Lett et al., 2020; Mehra et al., 2020; Okoro et al., 2022; Wilson et al., 2019). Similarly, Okoro et al. (2022) postulated that Black/African American women, especially those with socioeconomic disadvantage, experience intersectional invisibility emanating from the implicit bias of healthcare providers, stereotypes, and systemic structures that promote discriminatory practices in healthcare services. The authors explicated the need for healthcare provider education that focuses on addressing stereotypical assumptions and biases within the levels of healthcare interventions to alleviate the intrinsic structural racism in healthcare policies and procedures.

Further, Dailey and Humphrey (2010) indicated discrimination and social conflict, trauma exposure, and economic stress as sources of stress that contribute to levels of antepartum depressive symptoms in African American women. The authors, therefore, highlighted the importance of using universal prenatal screening and comprehensive strategies to help address the impact of social stressors on the mental health of pregnant African American women. Similar to this suggestion by Dailey and Humphrey (2010), our review presented approaches to improve the accessibility of mental health services for prenatal and postpartum Black women. The approaches include a) improved screening processes that evaluate past traumatic experiences and thoroughly assess risks to determine the need for interventions and support (Powers et al., 2020; Sroka et al., 2023), b) using culturally responsive care (Powers et al., 2020), and c) expanding mental healthcare services beyond pharmacological treatment to include services to improve well-being, stress, parenting, mindfulness, and interpersonal techniques (Goodman et al., 2013).

Leis et al. (2011) also highlight the importance of including the use of the home visitation setting as a context for delivering knowledge and shaping positive attitudes and behaviors of Black women with respect to their mental health practices. Similarly, it was noted in this review that access to practical care options and knowledge about depression and treatment would encourage women's participation in preventative programs (Goodman et al., 2013). Another preventive program that encouraged women's participation is the ROSE program, which is based on interpersonal therapy that focuses on enhancing social support, familial communication, managing transitions, and factors associated with perinatal depression and major depression among Black women across ethnic groups (Crockett et al., 2008). Crockett and colleagues (2008) examine the initial acceptability, feasibility, and effectiveness of the ROSE Program on a group of low-income, rural African American pregnant women at risk for PPD. The authors reported that the ROSE Program improved postpartum functioning in the group of low-income, rural African American pregnant women. This implies that utilizing interventions that allow for the participation of Black women enhances their acceptance of accessing the intervention. However, our review noted that further investigation is needed to fully understand the factors influencing treatment acceptance among racial groups (Edge et al., 2004).

Matthew et al. (2021) identified five key pathways to address racism and inequities in Black women's mental health care, which include educating and training practitioners, investing in the Black women mental health workforce, investing in Black women-led community-based organizations; valuing, honoring, and investing in the community and traditional healing practices; and promoting integrated care and shared decision making. These pathways highlight critical resources needed to improve the quality of maternal mental health care for Black birthing populations. The pathways reflect culturally oriented care and are congruent with this review's findings, which indicate that culturally competent care is important for all mental health-trained providers (Kemet et al., 2022). This review also showed that in the face of loneliness and moments of depression due to the changing roles of being a new mother (Nyashanu et al., 2018), a culturally sensitive approach for researching stigmatized issues could positively contribute to the design and delivery of mental health services for Black women. Further, it was noted in the findings of this review that designing culturally sensitive interventions and support systems is vital to

addressing the multifaceted challenges faced by Black women in seeking mental health care during and after their pregnancy (Edge et al., 2004).

This implies that using culturally competent care would promote collaborative decision-making with Black women in using mental health services. This idea is congruent with the findings of this review, which suggest that Black African immigrant women acknowledge the importance of using postnatal mental health services and are advocating for a holistic approach to care that involves both physical and spiritual interventions. This is because spiritual healing was readily accepted by the mothers as it was practiced back in Africa or the Caribbean (Baiden et al., 2021). It was also noted by Hawkins et al. (2021), in a study examining the association between family involvement during pregnancy and psychological health among Black women, that higher family involvement was associated with lower depressive symptoms. Additionally, family involvement may serve as a protective factor for pregnant Black women (Hawkins et al., 2021). This aligns with the findings of our review, which suggests that BAME women may feel more comfortable talking about their mood-related concerns at home or online before discussing them with their healthcare providers, and this strategy provides valuable insights into an effective support system for the women (Amoah, 2021).

5. Implications

This study highlights the need for improving mental healthcare delivery for Black women in the diaspora. Employing collaborative decision-making with Black women is crucial to ensure their empowerment and well-being. Black women experience increased stress and anxiety during the perinatal period due to the intersection of multiple factors such as racism, stigma, and the perpetuation of stereotypes through the “Strong Black Woman” depiction. Improving the delivery of care during the perinatal period requires addressing mental health issues, such as stress and anxiety, in a way that fosters trust and culturally appropriate care. To achieve this, investing in developing better infrastructure for health and mental health services in Black communities is crucial. This includes facilitating access to resources and addressing the underrepresentation of Black-led or Black-serving organizations. Supporting Black-led clinics could help alleviate barriers to access mental health care services by Black women, and improve their uptake of mental health services. Implementing culturally responsive interventions to address mental health among Black women has the potential to improve health outcomes, enhance access to mental health services, and improve the quality of care. This can be achieved by going beyond standardized assessment tools and asking culturally appropriate questions during mental health assessments. Developing and implementing a culturally appropriate screening tool for mental health can help achieve this goal.

6. Conclusion

In summary of the above discussion, three themes were developed from the evidence from the 12 studies included in this review 1) Disparities in utilization of mental healthcare services, 2) Spirituality, Faith, and Religion, 3) Accessibility of mental healthcare services. The studies included in the review were conducted in the US, UK, and Canada. This implies that there is a paucity of evidence about the mental health of prenatal and postnatal Black women living outside Africa and the Caribbean in countries other than the US, the UK, and Canada. More evidence from other countries with Black and Caribbean populations is needed in this area. The findings of the study revealed that utilization of mental health services is low amongst prenatal and postnatal Black women living outside Africa and the Caribbean, and sociocultural risk factors pose tremendous barriers to accessing mental healthcare services. Additionally, the review highlights the intersectionality embedded in the multifactorial risk factors that Black women experience, which impede their accessing and utilization of mental health services (Garnett et al., 2014; Howell et al., 2023; Lett et al., 2020; Mehra et al., 2020; Okoro et al., 2022; Wilson et al., 2019). Evidence from the literature advocates for the importance of implementing holistic and culturally oriented mental health interventions to address the multidimensional/multifactorial issues to improve the well-being of Black women and their babies living outside Africa and the Caribbean (Lau & Adam, 2023; Sims, 2014).

Authorship Contribution

JK, and JN searched for the literature. JK, AA, and OS selected the articles, analyzed the data. JK resolved conflicts during the selection of articles. All authors drafted the manuscript and edited several versions and approved the final manuscript.

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The data that support the findings of this study are available on request.

Competing Interests Statement

The authors declare that there are no competing or potential conflicts of interest.

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Appendix A

Search Strategies by Database

Database: Ovid MEDLINE

Date of search: May 17, 2023

- 1 exp African Continental Ancestry Group/
- 2 exp Pregnancy/
- 3 exp Peripartum Period/
- 4 exp Postpartum Period/
- 5 exp Mental Disorders/
- 6 exp Delivery of Health care/
- 7 exp Patient care management/
- 8 exp Mental Health Services/
- 9 exp "Treatment Adherence and Compliance"/
- 10 exp "Health Services Needs and Demand"/
- 11 (black* or african* or caribbean or afro* or "person of colo?r" or "people of colo?r" or colo?red or "darkskin*" or BIPOC or ((racial or ethnic) adj2 minorit*).mp.
- 12 ((immigrant* or emigrat* or migrant* or migrat* or refugee* or "asylum seekers" or diaspor* or "first\$generation" or "second\$generation" or "second generation" or "first generation" or "foreign\$born" or "foreign born" or newcomer*) adj5 (algeria* or angola* or benin* or botswana* or "burkina faso" or burundi* or cameroon* or "cape verde" or "central african republic" or chad or comoros or congo or "cote d'ivoire" or "ivory coast" or Djibouti or Guinea* or Eritrea* or Ethiopia* or Gabon or Gambia* or ghana* or Kenya* or Lesotho* or Liberia* or Madagascar or Malawi* or Mauritania* or Mauritius or Morocco or Mozambique or Namibia* or niger or nigeria* or rwanda* or "sao tome and principe" or senegal* or seychelles or "sierra leone" or somalia* or "south africa" or sudan* or swaziland or tanzania or togo or Tunisia or uganda* or Zambia* or Zimbabwe or "Dominican Republic" or Haiti or Jamaica or Barbados or Dominica or Grenada or "Saint Lucia" or trinidad* or Bahamas).mp.
- 13 ("Mental health" or "Mental illness" or Depressi* or Anxiety or "Stress, psychological" or Wellbeing or "Mental disorder*" or "Mental disease*" or "Psychological disorder*").mp.
- 14 (Perinatal or Postpartum or Peripartum or Prenatal or Postnatal or Pregnan* or matern* or Antenatal or Antepartum).mp.

15 (“Mental health services” or “Psych* service*” or Therap* or Counsell* or “Mental health care” or “mental health treatment” or “Healthcare professionals” or Screening).mp.

16 ((access* or barrier* or seek* or deficienc* or experienc* or utilization or provision or perception* or attitude* or acceptance) adj4 (care or treatment or service* or healthcare)).mp.

17 (seek* adj2 help).mp.

18 15 or 16 or 17

19 2 or 3 or 4 or 14

20 1 or 11 or 12

21 6 or 7 or 8 or 9 or 10 or 18

22 5 or 13

23 19 and 20 and 21 and 22

Database: Proquest Public Health Database

Date of search: May 17, 2023

1 MESH(“African Continental Ancestry Group”)

2 MESH(Pregnancy) OR MESH(“Peripartum Period”) OR MESH(“Postpartum Period”)

3 MESH(“Delivery of Health care”) OR MESH(“Patient care management”) OR MESH(“Mental Health Services”) OR MESH(“Treatment Adherence and Compliance”)

4 MESH(“Mental Disorders”)

5 noft((black* OR african* OR caribbean OR afro* OR “person of colo?r” OR “people of colo?r” OR colo?red OR “dark-skin*” OR BIPOC OR ((racial OR ethnic) NEAR/2 minorit*))

6 noft((immigrant* OR emigrat* OR migrant* OR migrat* OR refugee* OR “Asylum seekers” OR Diaspor* OR “first-generation” OR “first generation” OR “second generation” OR “second-generation” OR “foreign born” OR “foreign-born” OR newcomer*) NEAR/5 (algeria* or angola* or benin* or Botswana* or “burkina faso” or Burundi* or Cameroon* or “Cape Verde” or “Central African Republic” or chad or Comoros or Congo or “cote d’ivoire” or “Ivory Coast” or Djibouti or Guinea* or Eritrea* or Ethiopia* or Gabon or Gambia* or ghana* or Kenya* or Lesotho* or Liberia* or Madagascar or Malawi* or Mauritania* or Mauritius or Morocco or Mozambique or Namibia* or niger or nigeria* or rwanda* or “sao tome and principe” or senegal* or seychelles or “sierra leone” or somalia* or “south africa” or sudan* or swaziland or tanzania or togo or Tunisia or uganda* or Zambia* or Zimbabwe OR “Dominican Republic” or Haiti or Jamaica or Barbados or Dominica or Grenada or “Saint Lucia” or trinidad* or Bahamas))

7 noft(“Mental health” OR “Mental illness” OR Depressi* OR Anxiety OR “Stress, psychological” OR Wellbeing OR “Mental disorder*” OR “Mental disease*” OR “Psychological disorder*”)

8 noft(Perinatal OR Postpartum OR Peripartum OR Prenatal OR Postnatal OR Pregnant* OR matern* OR Antenatal OR Antepartum)

9 noft(Therap* OR Counsell* OR healthcare OR “health care” OR “Screening” OR (seek* NEAR/2 help) OR ((access* OR barrier* OR seek* OR deficienc* OR experienc* OR utilization OR provision OR perception* OR attitude* OR acceptance OR Psych* OR “mental health”) NEAR/4 (care OR treatment OR service* OR healthcare)))

10 1 OR 5 OR 6

11 9 OR 3

12 7 OR 4

13 8 OR 2

14 10 AND 11 AND 12 AND 13

Database: Cumulative Index for Nursing and Allied Health Literature (CINAHL) via EBSCOhost Date of search: May 17, 2023

1 TI ((black* or african* or caribbean or afro* or “person of colo?r” or “people of colo?r” or colo?red or “dark-skin*” or BIPOC or ((racial or ethnic) N2 minorit*))) OR AB ((black* or african* or caribbean or afro* or “person of colo?r” or “people of colo?r” or colo?red or “dark-skin*” or BIPOC or ((racial or ethnic) N2 minorit*))) OR SU ((black* or african* or caribbean or afro* or “person of colo?r” or “people of colo?r” or colo?red or “dark-skin*” or BIPOC or ((racial or ethnic) N2 minorit*)))

2 TI ((immigrant* OR emigrat* OR migrant* OR migrat* OR refugee* OR “Asylum seekers” OR Diaspor* OR “first-generation” OR “first generation” OR “second generation” OR “second-generation” OR “foreign born” OR “foreign-born” OR newcomer*) N5 (algeria* or angola* or benin* or Botswana* or “burkina faso” or Burundi* or Cameroon* or “Cape Verde” or “Central African Republic” or chad or Comoros or Congo or “cote d’ivoire” or “Ivory Coast” or Djibouti or Guinea* or Eritrea* or Ethiopia* or Gabon or Gambia* or ghana* or Kenya* or Lesotho* or Liberia* or Madagascar or Malawi* or Mauritania* or Mauritius or Morocco or Mozambique or Namibia* or niger or nigeria* or rwanada* or “sao tome and principe” or senegal* or seychelles or “sierra leone” or somalia* or “south africa” or sudan* or swaziland or tanzania or togo or Tunisia or uganda* or Zambia* or Zimbabwe OR “Dominican Republic” or Haiti or Jamaica or Barbados or Dominica or Grenada or “Saint Lucia” or trinidad* or Bahamas)) OR AB ((immigrant* OR emigrat* OR migrant* OR migrat* OR refugee* OR “Asylum seekers” OR Diaspor* OR “first-generation” OR “first generation” OR “second generation” OR “second-generation” OR “foreign born” OR “foreign-born” OR newcomer*) N5 (algeria* or angola* or benin* or Botswana* or “burkina faso” or Burundi* or Cameroon* or “Cape Verde” or “Central African Republic” or chad or Comoros or Congo or “cote d’ivoire” or “Ivory Coast” or Djibouti or Guinea* or Eritrea* or Ethiopia* or Gabon or Gambia* or ghana* or Kenya* or Lesotho* or Liberia* or Madagascar or Malawi* or Mauritania* or Mauritius or Morocco or Mozambique or Namibia* or niger or nigeria* or rwanada* or “sao tome and principe” or senegal* or seychelles or “sierra leone” or somalia* or “south africa” or sudan* or swaziland or tanzania or togo or Tunisia or uganda* or Zambia* or Zimbabwe OR “Dominican Republic” or Haiti or Jamaica or Barbados or Dominica or Grenada or “Saint Lucia” or trinidad* or Bahamas)) OR SU ((immigrant* OR emigrat* OR migrant* OR migrat* OR refugee* OR “Asylum seekers” OR Diaspor* OR “firstgeneration” OR “first generation” OR “second generation” OR “second-generation” OR “foreign born” OR “foreign-born” OR newcomer*) N5 (algeria* or angola* or benin* or Botswana* or “burkina faso” or Burundi* or Cameroon* or “Cape Verde” or “Central African Republic” or chad or Comoros or Congo or “cote d’ivoire” or “Ivory Coast” or Djibouti or Guinea* or Eritrea* or Ethiopia* or Gabon or Gambia* or ghana* or Kenya* or Lesotho* or Liberia* or Madagascar or Malawi* or Mauritania* or Mauritius or Morocco or Mozambique or Namibia* or niger or nigeria* or rwanada* or “sao tome and principe” or senegal* or seychelles or “sierra leone” or somalia* or “south africa” or sudan* or swaziland or tanzania or togo or Tunisia or uganda* or Zambia* or Zimbabwe OR “Dominican Republic” or Haiti or Jamaica or Barbados or Dominica or Grenada or “Saint Lucia” or trinidad* or Bahamas))

3 TI (“Mental health” OR “Mental illness” OR Depressi* OR Anxiety OR Stress OR Wellbeing OR “Mental disorder*” OR “Mental disease*” OR “Psychological disorder*”) OR AB (“Mental health” OR “Mental illness” OR Depressi* OR Anxiety OR Stress OR Wellbeing OR “Mental disorder*” OR “Mental disease*” OR “Psychological disorder*”) OR AB (“Mental health” OR “Mental illness” OR Depressi* OR Anxiety OR Stress OR Wellbeing OR “Mental disorder*” OR “Mental disease*” OR “Psychological disorder*”) OR SU (“Mental health” OR “Mental illness” OR Depressi* OR Anxiety OR Stress OR Wellbeing OR “Mental disorder*” OR “Mental disease*” OR “Psychological disorder*”) OR AB (“Mental health” OR “Mental illness” OR Depressi* OR Anxiety OR Stress OR Wellbeing OR “Mental disorder*” OR “Mental disease*” OR “Psychological disorder*”)

4 TI (Perinatal OR Postpartum OR Peripartum OR Prenatal OR Postnatal OR Pregnant* OR matern* OR Antenatal OR Antepartum) OR AB (Perinatal OR Postpartum OR Peripartum OR Prenatal OR Postnatal OR Pregnant* OR matern* OR Antenatal OR Antepartum) OR SU (Perinatal OR Postpartum OR Peripartum OR Prenatal OR Postnatal OR Pregnant* OR matern* OR Antenatal OR Antepartum)

- 5 TI (Therap* OR Counsell* OR healthcare OR "health care" OR "Screening" OR (seek* N2 help) OR ((access* OR barrier* OR seek* OR deficienc* OR experienc* OR utilization OR provision OR perception* OR attitude* OR acceptance OR Psych* OR "mental health") N4 (care OR treatment OR service* OR healthcare))) OR AB (Therap* OR Counsell* OR healthcare OR "health care" OR "Screening" OR (seek* N2 help) OR ((access* OR barrier* OR seek* OR deficienc* OR experienc* OR utilization OR provision OR perception* OR attitude* OR acceptance OR Psych* OR "mental health") N4 (care OR treatment OR service* OR healthcare))) OR SU (Therap* OR Counsell* OR healthcare OR "health care" OR "Screening" OR (seek* N2 help) OR ((access* OR barrier* OR seek* OR deficienc* OR experienc* OR utilization OR provision OR perception* OR attitude* OR acceptance OR Psych* OR "mental health") N4 (care OR treatment OR service* OR healthcare)))
- 6 (MH "Help Seeking Behavior") OR (MH "Mental Health services+") OR (MH "Health Services Accessibility") OR (MH "Attitude to Medical Treatment") OR (MH "Health Services Needs and Demand")
- 7 (MH "Mental Disorders+") OR (MH "Mental health+")
- 8 (MH "Pregnancy+") OR (MH Postnatal period)
- 9 (MH "Black Persons")
- 10 S1 OR S2 OR S9
- 11 S4 OR S8
- 12 S3 OR S7
- 13 S5 OR S6
- 14 S10 AND S11 AND S12 AND S13; Limit to Scholarly, Peer-Reviewed Journals

Database: APA PsycINFO via EBSCOhost

Date of search: May 17, 2023

- 1 TI ((black* or african* or caribbean or afro* or "person of colo?r" or "people of colo?r" or colo?red or "dark-skin*" or BIPOC or ((racial or ethnic) N2 minorit*))) OR AB ((black* or african* or caribbean or afro* or "person of colo?r" or "people of colo?r" or colo?red or "dark-skin*" or BIPOC or ((racial or ethnic) N2 minorit*))) OR SU ((black* or african* or caribbean or afro* or "person of colo?r" or "people of colo?r" or colo?red or "dark-skin*" or BIPOC or ((racial or ethnic) N2 minorit*))) OR KW ((black* or african* or caribbean or afro* or "person of colo?r" or "people of colo?r" or colo?red or "dark-skin*" or BIPOC or ((racial or ethnic) N2 minorit*)))
- 2 KW ((immigrant* OR emigrat* OR migrant* OR migrat* OR refugee* OR "Asylum seekers" OR Diaspor* OR "first-generation" OR "first generation" OR "second generation" OR "second-generation" OR "foreign born" OR "foreign-born" OR newcomer*) N5 (algeria* or angola* or benin* or Botswana* or "burkina faso" or Burundi* or Cameroon* or "Cape Verde" or "Central African Republic" or chad or Comoros or Congo or "cote d'ivoire" or "Ivory Coast" or Djibouti or Guinea* or Eritrea* or Ethiopia* or Gabon or Gambia* or ghana* or Kenya* or Lesotho* or Liberia* or Madagascar or Malawi* or Mauritania* or Mauritius or Morocco or Mozambique or Namibia* or niger or nigeria* or rwanda* or "sao tome and principe" or senegal* or seychelles or "sierra leone" or somalia* or "south africa" or sudan* or swaziland or tanzania or togo or Tunisia or uganda* or Zambia* or Zimbabwe OR "Dominican Republic" or Haiti or Jamaica or Barbados or Dominica or Grenada or "Saint Lucia" or trinidad* or Bahamas)) OR TI ((immigrant* OR emigrat* OR migrant* OR migrat* OR refugee* OR "Asylum seekers" OR Diaspor* OR "first-generation" OR "first generation" OR "second generation" OR "second-generation" OR "foreign born" OR "foreign-born" OR newcomer*) N5 (algeria* or angola* or benin* or Botswana* or "burkina faso" or Burundi* or Cameroon* or "Cape Verde" or "Central African Republic" or chad or Comoros or Congo or "cote d'ivoire" or "Ivory Coast" or Djibouti or Guinea* or Eritrea* or Ethiopia* or Gabon or Gambia* or ghana* or Kenya* or Lesotho* or Liberia* or Madagascar or Malawi* or Mauritania* or Mauritius or Morocco or Mozambique or Namibia* or niger or nigeria* or rwanda* or "sao tome and principe" or senegal* or seychelles or "sierra leone" or somalia* or "south africa" or sudan* or swaziland or tanzania or togo or Tunisia or uganda* or Zambia* or Zimbabwe OR "Dominican Republic" or Haiti or Jamaica or Barbados or Dominica or Grenada or "Saint Lucia" or trinidad* or Bahamas)) OR AB ((immigrant* OR emigrat* OR migrant* OR migrat* OR refugee* OR "Asylum seekers" OR Diaspor* OR "first-generation" OR "first generation" OR "second

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6 DE “Postpartum Depression”) OR (DE “Postpartum Psychosis”) OR (DE “Mental Disorders+”)

7 DE “Perinatal period”) OR (DE “Postnatal period”) OR (DE “Antepartum Period”)

8 (DE “blacks”) OR (DE “african cultural groups”)

9 (DE “Mental Health Screening”) OR (DE “Mental Health Services+”) OR (DE “Health Care Utilization+”) OR (DE “Health Care Seeking Behavior+”) OR (DE “Help Seeking Behavior”) OR (DE “Health Care Access+”) OR (DE “Health Service Needs”)

10 S1 OR S2 OR S8

11 S5 OR S9

12 S4 OR S7

13 S3 OR S6

14 S10 AND S11 AND S12 AND S13; Limit to Academic Journals

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