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Master's Thesis

Immigrant Pregnant Women's Mental Health in Germany: Perceptions and Concepts of prevention of Antenatal Depression - a qualitative study

University of Applied Sciences Hamburg
Faculty of Life Sciences
Master Program Health Sciences

Examination Supervisor: Dr. Ensel Angelica
Secondary Supervisor: Pr. Dr. Amena Ahmad
Submitted by: Germaine Marie NGO HANNA

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DECLARATION OF HONOR

I hereby declare that this thesis is my original work and that no other than the listed references have been used as sources of information.

I further declare that no part of this thesis has been previously submitted to this or any other institution.

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Hamburg, August 26, 2020 Germaine Marie NGO HANNA

PREFACE

Conducting a Master Thesis was demanding and very interesting learning process by which I significantly broaden my knowledge in the fields of public health and qualitative research. Nevertheless, writing this thesis conferred numerous challenges, which would not have been possible without the great support and assistance of several people to whom I want to show my gratitude and acknowledgement.

I would first like to praise and thank the Almighty God for His spiritual presence, the renewing energy, for the idea provided, for His protection and inspiration to complete this study successfully.

I would like to express my deep and sincere gratitude to my research supervisor, Dr Ensel Angelica for providing invaluable guidance throughout this research. She has been more than a supervisor. Her advices, counselling, support, patience and kindness have helped me through this long journey.

I would also like to thanks all the pregnant women and experts, for taking their time and opportunity to meet with me in order to gather relevant information necessary for the thesis.

Special thanks to Mrs Annette Mayer-Möbius and Pf. Thomas Ludwig for their great support.

I would like to thanks my parents, brothers and sister, for their unconditional love, spiritual support and encouragements.

Last, not the least, special thanks to my lovely husband and my daughters for being there for me, for their patience, love and comprehension.

Hamburg, August 26, 2020 Germaine Marie NGO HANNA

ABSTRACT

Title: Immigrant Pregnant Women's Mental Health in Germany: Perceptions and Concepts of prevention of Antenatal Depression - a qualitative study

Author: Germaine Marie NGO HANNA
Supervisor: Dr. Ensel, Angelica
Course: Master's Thesis in Public Health, 30 Credits

Background: Important changes in the course of life can cause huge stress and lead to depression. Migration and pregnancy as a status passage can count among these stressful life events because both imply huge changes; this places immigrant pregnant women at a higher risk for developing antenatal depression. Therefore, the objective of this study is to learn more about the mental health of immigrant women during their pregnancy.

Methods: Participants were recruited via purposeful and snowball sampling. Seven immigrant pregnant women were interviewed and three experts working as consultant for immigrants (including pregnant women). The interviews were transcribed and analysed using a phenomenological approach to capture the lived experiences of the participants. Through manual coding, the categories and sub-categories emerged via an inductive approach.

Results: The study revealed that for the interviewed women, talking about psychological health is still a taboo. The immigrant pregnant women are at risk of antenatal depression for a variety of reasons: they expressed loneliness and useless, missing family support and care especially from their mothers, facing financial insecurity and discrimination. Their husband or partner, their spiritual beliefs and social support represent their protective factors during this transition to motherhood. The women think that only a health professional who has some knowledge of their culture and conditions could provide effective counselling.

Conclusion: The immigrant pregnant women face multiple challenges which have an impact on their mental health. Further researches are needed to address and deal with mental health issues in population with a migration background in Germany. In particular more attention should be given to the mental wellbeing of pregnant immigrant women to prevent antenatal depression and its consequences. To enrich the results of this study on the mental health of immigrant pregnant women, a larger study is recommended.

Keywords: Depression, Antenatal, Migration, Immigrant, Pregnant women, Psychological Health, Discrimination.

ACRONYMS

ACTH	Adrenocorticotropic Hormone
APA	American Psychiatric Association
APP	American Psychiatric Publishing
BAMF	Bundesamt für Migration und Flüchlige
CDC	Center for Disease and Control prevention
CRH	Corticotropin-releasing Hormone
DNS	The Diagnostic and Statistical Manual of Mental Disorders
EPR	European platform for Rehabilitation
EU	European Union
HPA	Hypothalamic–pituitary–adrenal
IOM	International Organization of Migration
IVF	In vitro fertilization
MDD	Major Depressive Disorder
MeSH	Medical Subject Headings
NICE	National Institute for Health and Care Excellence
OECD	Organisation for Economic Cooperation and Development
PND	Post Natal Depression
UK	United Kingdom
UNICEF	The United Nations Children's Fund
UN	United Nation
WHO	World Health Organization

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Chapter 1: Introduction

Public health is concerned by preventing disease, prolonging life and promoting health. It aims to provide conditions to which people can maintain, improve their health and wellbeing or prevent the deterioration of their health. Public health focuses on the entire spectrum of health and wellbeing, not only the eradication of a particular disease (WHO, 2019).

Mental health is a vital and integral part of overall health and is essential to healthy human functioning. Physical and mental health are intimately related (EPR, 2017). Well-being integrates mental health (mind) and physical health (body) resulting in more holistic approaches to disease prevention and health promotion (Dunn 1973 cited in CDC 2018).

According to the WHO (2018) the burden of mental disorders continues to grow worldwide with significant impacts on health and major social, human rights and economic consequences. Depression is a common mental disorder and one of the main causes of disability in the world. 300 million people are estimated to be affected by the disease with more women than men (WHO, 2018).

Important changes in the course of life can cause a significant amount of stress. Migration and pregnancy can count among these stressful life events because they imply major changes. “The transition from ‘woman’ to ‘mother’ is a major one and it can be very stressful when combined with the transition from ‘local’ to ‘immigrant’” (Barclay and Kent, 1998 as cited in Collins et al, 2011). This place immigrant women are at higher risk of developing antenatal depression compared to the native-born women with a prevalence, between 25 and 42% (Lara et al, 2009; Zelkowitz et al, 2004, 2008).

There is a large number of studies done in Canada, the US and in Australia regarding the mental wellbeing of migrant women but in Europe and particularly in Germany, very little is known. Many studies make an emphasis on the antenatal physical care (antenatal visits, counselling, baby care, breastfeeding) but very little or no attention is given to mental wellbeing of pregnant immigrant women. Because there is a lack of literature regarding the mental health and wellbeing of immigrant pregnant women in Germany, this study is a step to cover this gap.

1.1 Structure of the thesis

The thesis is structured into six chapters. The introduction, the first chapter, introduces the topic by giving an overview, the study relevance, the research questions and the outline of the thesis. In the second chapter, the theoretical background of the topic will be presented. The methodology, which is the third chapter will detail the method used through the research, in this case, in-depth interviews. The fourth chapter will present the results of the interviews. The discussion of the results will be done in the fifth chapter. Finally, the sixth chapter will be the conclusion and recommendations for practice.

1.2 Study relevance

This study is relevant for many reasons:

- Over the last years, Germany and Europe have been witnessing the largest migration recorded in their recent history. In 2017, Germany was counting the largest total number of immigrants in Europe (Eurostat, 2019). Persons with migration background represent 26.0% of the German population (Destatis, 2019. According to the UNICEF and WHO (2013), on the German's migration profile, women from ages of 20 to 39 represent 37% of the female migrant population in 2013.
- The fertility rate of immigrant women is higher in many western countries. For example, in 2014 to 2015, the birth rates among women with German citizenship has rose from 1.42 to 1.43 whereas the birth rates of non-German citizen rose from 1.86 to 1.95 (Oltermann, 2016).
- The result of the two preceding points is that the number of children from migrants would considerably increase and because antenatal depression has huge negative impacts on children. It is a public health importance to learn about the mental health of this particular population.
- In Germany, there is an increasing number of studies on immigrants' mental health (Morawa et al, 2013; Binbay et al, 2012; Schouler-Ocak et al, 2010). Most if not all of Turkish and Polish nationalities representing the larger groups as opposed to the minorities like Africans, Asians, and others.

1.3 Aims and objectives

The aim and objectives of this study is to investigate on the mental health and wellbeing of immigrant pregnant women in Germany in order to learn about their mental health during the pregnancy period, their risks to develop antenatal depression and protective factors, and their needs from professional health providers during the pregnancy. This will allow the health providers to know more about the needs of this particular population, their risks to develop antenatal depression, and how they can support these women to prevent antenatal depression and the associated effects.

For the purpose of this study, the migrants will be narrowed to those who voluntarily decided to move to Germany (students, workers and the women who immigrated for family reunification). This exclude refugees and asylum-seekers because they are involuntary migrants who are fleeing their country due to war, political persecutions, or natural disasters and also according to the WHO (2019), there is a high prevalence of mental health disorders as post-traumatic stress disorder, depression and anxiety in this particular population. This might be due to their pre and post migration conditions. In this study, the author would like to learn about the post-migration risks for antenatal depression.

1.4 Research questions

These objectives will be achieved through the answers to the following research questions:

- How do immigrant women experience their mental health during pregnancy?
- What do they consider as risks factors and do they see themselves as at risk of developing antenatal depression due to their migration background?
- What do they consider as protective factors?
- What do they expect (needs) from health professionals?

The following chapters will be respectively the literature review on the topic, the methodology used to achieve the set objectives, the collection of data through in-depth interviews, the results, the discussion and finally, the conclusion and recommendations or further studies.

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1.5 Source of data and literature

The sources of data used during this research are primary and secondary. The primary data come from in-depth interviews of participants. The secondary data are collected through an intensive literature review using different search engines such as PubMed, Google Scholar, Research Gate and additionally, the databases of the Hamburg Universities to find relevant scientific literature. The MeSH terms used for search were “antenatal depression AND immigrant mental health”, “migration AND pregnancy”, “services AND pregnant women”. The selection criteria were time of publication (10 years) but some old articles were used when current publication on a particular aspect were not found. Another criterion of selection was the language, articles in English, French and German were selected. The abstracts of the found articles were read and selected when they were relevant to the health of immigrant pregnant women. Other relevant articles and literature were found through reference list of interesting articles.

Chapter 2: Theoretical background

Depression is a common mental disorder that affects people of all ages and is characterized by feelings of despondency and dejection, feelings of inadequacy and guilt often accompanied with a lack of energy and disturbance of appetite and sleep (Oxford dictionary, 2018). It is clinically diagnosed when 5 of 9 symptoms are recurrent for at least 2 weeks (APA, 2000).
Depression affects approximately 300 million people worldwide, it is the leading cause of disability and a major contributor to the overall global burden of disease (WHO, 2018).
Maternal depression refers generally to postpartum depression because more is known about this issue but we cannot talk about postpartum depression without mentioning antepartum/ antenatal depression. In the new classification of mental disorders, DMS-5, a new specifier "peripartum" has been introduced, it acknowledges that mood episodes can have onset either during the pregnancy or postpartum (4 weeks after delivery). 50% of postpartum major depressive episodes actually begin prior to delivery. Prospective studies have demonstrated that mood and anxiety symptoms during pregnancy as well as the "baby blues", increase the risk of postpartum major depression episodes (APP, 2014).
The birth of a child and the pregnancy itself is for many mothers and families an event that brings not only joy but also some forms of physical, mental, and psychological stress. While some mothers will manage to overcome all these stressors, some will not and then develop antenatal depression. A non-treated antenatal/antepartum depression can lead to postpartum depression.

2.1 Definition of antenatal depression or Major Depressive Disorder (MDD) and pathophysiology

Antenatal depression is a form of mental mood disorder that women experience during the pregnancy. Physiologically, dysfunction of the maternal Hypothalamic-Pituitary-Adrenal axis causing a hypersecretion of the maternal glucocorticoids especially elevated cortisol, is often implicated in the negative perinatal and developmental (child) outcomes associated with stress and depression during the pregnancy period (Owen at al, 2005; Wadhwa, 2005; Field &Diego, 2008, O'Donnelly et al, 2009). In a *normal* HPA axis, the delivery of CRH from the paraventricular nucleus of the hypothalamus triggers the stimulation of adrenocorticotropic hormone (ACTH) from the anterior pituitary and, consequently, cortisol from the adrenal cortex (Jolley et al, 2007 cited in Meltzer-Brody 2011). This hormonal system is regulated by negative feedback mediated by cortisol receptors in the anterior pituitary, hypothalamus, and

hippocampus, as well as ACTH receptors in the anterior pituitary and CRH auto receptors in the hypothalamus (Jolley et al. 2007 cited in Meltzer-Brody 2011). In *depressed patients*, it has been shown that there is a change in the regulation of the HPA axis. A hallmark feature that characterizes the HPA axis in depression is the altered response to stress and inability to maintain regulation: indeed, hyperactivity of the HPA axis is one of the most robust biological findings in major depression (Gold et al. 2002 cited in Meltzer-Brody 2011). Antenatal depression is the strongest risk factor for postnatal depression and it increases in severity from the first to the second trimester (Hoffman & Hatch, 2000; Yonkers et al. 2001).

2.2 Prevalence

According to the WHO (2015), 10% of pregnant women in developed countries and 15, 6% in developing countries experience primarily depression. The reasons for this numbers could be explained by the fact that in developed countries, perinatal depression is a medical condition that can be treated with medication or therapy and therefore all necessary resources are put in place to solve the issue (OECD/EU, 2018). Whereas in many developing countries, people do not view depression as a medical condition (Gardner et al, 2014) therefore leaving it untreated. Even when the perinatal depression is considered as an illness, there is lack of trained staff, lack of funding and affordable medication (Saraceno et al, 2007) and social stigma (O'Mahony & Donnelly, 2007).

2.3 Risks factors

Some risks factors are common in both developed and developing countries including lack of social support (Ramchandani et al., 2009). The support from the baby's father has been found to be associated with less depression in the prenatal period (Collins,Dunkel-Schetter,Lobel,& Scrimshaw, 1993; Kitamura, Toda, Shima, Sugawara, & Sugawara, 1998 cited in Zelkowitz et al.2004), as well as education level of the woman, family stress, partner conflict and societal stress (Ramchandani et al., 2009). Stressful life events, particularly chronic stressors related to low socio-economic status, are also associated with depression during pregnancy (Pajulo et al., 2001; Zayas et al., 2002 cited in Zelkowitz 2004). As contributing factors, we can include history of anxiety and depression, family history of mental illness, previous reproductive loss (infertility, IVF, miscarriage, termination, stillbirth, death of the baby), sleep deprivation, pre-existing physical illness, history of childhood trauma or neglect, isolations and lack of social connections, loss and grief issues, absence of own mother or mothering figure (PADA, 2019)

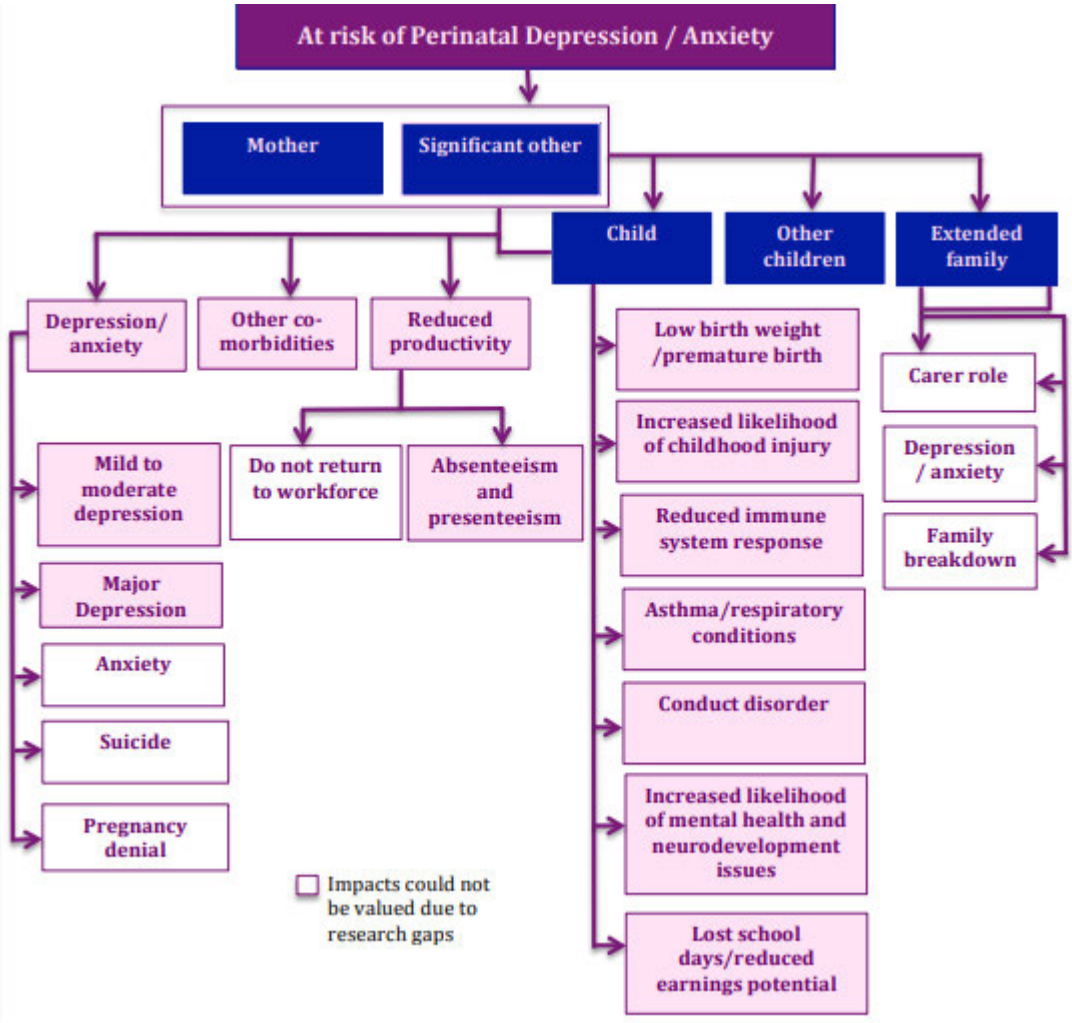
Some risks factors like poverty with gender-based risks, bias against female babies, and role restrictions regarding housework and infant care can be added in some low and middle income countries (Fisher et al., 2012).

2.4 Signs and symptoms

The signs and symptoms of antenatal depression can vary. According to the PADA (2019), they may include: panic attacks (racing heart, palpitations, shortness of breath, shaking or feeling physically 'detached' from your surroundings), persistent, generalized worry often focused on fears for the health or wellbeing of the baby, development of obsessive or compulsive behaviours, abrupt moods swings, feeling constantly sad, low or crying for no obvious reason, being nervous, 'on edge', or panicky, feeling constantly tired or lacking of energy, having little or no interest in all the normal things that bring joy (time with friends, exercise, eating or sharing partner time), sleep disturbance (too much or too little), losing interest in sex or intimacy, withdrawing from friends and family, being easily annoyed or irritated, finding it difficult to focus, concentrate or remember 'brain fog', engaging in more risk taking behaviour (alcohol, drug use), having thoughts of death or suicide.

2.5 Impacts or consequences of perinatal depression

The consequences of perinatal depression are numerous and affects not only the mother but also the baby (Hoffman & Hatch, 2000), the partner, the family and in extension the entire society.



Impacts of perinatal depression/anxiety over time
Source: PWC, 2014 at https://cope.org.au/wp-content/uploads/2013/12/PWC-2013_Final3.pdf

2.5.1 Effects on children

Maternal perinatal depression has shown to have negative effects on the children. Depressed pregnant women are at increased risk for the use of tobacco, alcohol and drugs, and poor prenatal care attendance (Lusskin et al, 2007). Untreated prenatal depression has been associated with gestational hypertension, preeclampsia, preterm birth (Lusskin et al, 2007). Other effects include high risk of low gestational age, low birth rate and other complications (Lusskin, 2007). During the postnatal phase, the negative effects include poor growth, stunting

and poor cognitive development (Bennett et al, 2015). Additional postnatal effects include abnormalities in neurological functioning, high vulnerability and poor self-esteem, negative self-attribution style, poor social skills, lack of motivation (Goodman and Gotlib 1999); increased fussiness and negative behaviours (Davis et al, 2007 cited in Andrew et al, 2015). Depressive symptoms have an impact on mother-child bond. Women who present chronic symptoms of prenatal depression show also less sensitivity (Campbell et al, 2004, 2007) which predicts higher rate of insecure attachment to their children (Campbell et al, 2004). In the postnatal phase, children show disorganized liens combined with underlying patterns of avoidant or resistant behaviour (Mills-Koonce et al, 2008). Depressive symptoms and insecure attachment style are associated with infantile colic (Akman et al, 2006).

2.5.2 Effects on partner

Many studies are done to determine the impact of partner on maternal depressive symptoms. According to Rosand et al (2011), a good relationship with the partner predicts good maternal mental status during pregnancy. Studies (Cameron et al, 2016) have revealed that 8% to 10% of men experience depression during perinatal phase and that it is positively related to maternal depression (Paulson & Bazemore, 2010). A review by Philpott et al (2019) found that 3.4 to 25% of men have anxiety during the antenatal period and the partner anxiety and depression is a risk factor. Other risk factors are lower education levels, lower income levels, lower co-parenting support, lower social support, work-family conflict and being present and supportive during a previous birth.

2.5.3 Economic impact on the society

The impact on the society refers to the economic consequences, aiming to estimate the total costs and health-related quality of life losses over the lifetime of mothers and their children. It is the financial costs to Governments and private payers (private health insurance and individuals). There are direct costs related to health care services for affected people (those with perinatal depression) and indirect costs related to productivity losses and costs of informal care (if a partner of other member of the family must stay home to care for the affected person).
According to Deloitte Access Economics (2012), in Australia for example, the total costs to government for attributable to maternal and paternal PND were estimated at $40.52 (€25.21) million. Private costs were estimated at $38.13 (€23.73) million, including $22.69 (€14.12) million to private health insurance funds and $15.44 (€9.61) million to individuals. Total costs

for maternal and paternal PND (governments and private) were estimated at $78.66 (€46.95) million.

Total indirect costs and costs to the wider economy were estimated at $354.87 (€220.87) million, these were predominantly attributable to productivity losses $310.34 (€193.11) million (Deloitte Access Economics, 2012). Another estimation by PwC (2014) of the costs due to untreated perinatal depression/anxiety on the mother, the child and the family, gives the total of $710 (€438) million over the period of 20 years. In UK also for example, the economic impact due to perinatal depression of mothers and child has been estimated by Bauer et al (2014)

Table 1: Costs of perinatal depression, impact on mothers, £ per case

Public sector	Wider society			Total
Health and social care	QALY losses	Productivity losses	Other	
1,688	18,158	2,514		**22,360**

Source: LSE & Centre for Mental Health, 2014
http://eprints.lse.ac.uk/59885/1/__lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer%2C%20M_Bauer_Costs_perinatal_%20mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

Table 2: Costs of perinatal depression, impact on children, £ per case

	Public sector			Wider society			Total
	Health and social care	Education	Criminal Justice	QALY losses	Productivity losses	Other	
Pre-term birth	974	-	-	418	22	14	
Infant death	-	-	-	22,157	-	-	
Emotional problems	1,020	-	-	4,609	2,169	-	
Conduct problems	837	-	1,974	3,396	1,797	7,446	
Special educational needs	-	3,166	-	-	-	-	
Leaving school without qualifications	-	-	-	-	1,463	-	
Total	2,831	3,166	1,974	30,580	5,451	7,460	**51,462**

Source: LSE & Centre for Mental Health, 2014
http://eprints.lse.ac.uk/59885/1/__lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer%2C%20M_Bauer_Costs_perinatal_%20mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

When calculating ongoing impacts on the mother, child and family this cost increases to $710M over a 20-year period in Australia (PWC, 2014).

2.6 Screening

According to Hübner-Liebermann et al (2012), every woman attending a gynaecologist's office should be examined with regard to her psychiatric status or at least given a self-screening questionnaire, so that she can refer to her family doctor or to an appropriate specialist.
According to Hübner-Liebermann et al (2012), although pregnancy and early motherhood are characterized by regular contact with the healthcare system (Boath et al, 2005), only 18% of pregnant women with a psychiatric illness receive a corresponding diagnosis (Kelly et al, 2001). Johanson et al (2000) found that 12% of depressed pregnant women and 26% of depressed new mothers were correctly identified. Marcus et al (2003) found depressive symptoms in 20% of the pregnant women attending a gynaecologist's office and only 13,8% of them were receiving treatment. Apart from these statistics, recognition and treatment of depression is not included in the physician training and few continuous education programs on depression are available (Wisner et al, 2008).

The NICE (2014) recommends screening the women at the first prenatal consultation and again four to six weeks post-partum. Whooley et al (1997) have developed two questions:

- During the past month, have you been bothered by feeling of down, depressed or hopeless?
- During the past month, have you often been bothered by little interest or pleasure in doing things?

Answers to these two questions determine if a clinical investigation of the formal diagnostic criteria is necessary.

2.7 Migration and antenatal depression

In this section, we are going first, to define the term "Migrant" and the different types of migrants according to the United Nations. The second part describes the impact of migration on antenatal depression.

2.7.1 Definition of migration and different types of migrants

The United Nations Migration Agency (2019) defines a migrant as any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of the person's legal status; whether the moving is voluntary or involuntary; what the causes are; or what the length of the stay is.

This term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally-defined, such as smuggled migrants; as well as those whose status or means of movement are not specially defined under international law, such as international students (IOM, 2019).

2.7.2 Impacts of migration on pregnancy

"The transition from 'woman' to 'mother' is a major one and it can be hugely stressful when combined with the transition from 'local' to 'immigrant'" (Barclay and Kent 1998 cited in Collins et al. 2011) which place immigrant women are at higher risk of developing antenatal depression compared to the native-born women with a prevalence, between 25 and 42% (Zelkowitz et al., 2004, 2008; Lara et al., 2009).

Stresses connected with the immigration process may affect physical and emotional well-being: financial worries, social isolation and separation from the extended family, discrimination and unfamiliarity with medical practices (Zelkowitz, 2004). An inability to communicate in the

language of the new country may impede access to social and health services (Hyman & Dussault, 1991 cited in Zelkowitz, 2004). Immigrant women have lower levels of social support, and it is this lack of support, rather than immigrant status per se, that is related to higher levels of reported stress (Landale & Oropesa, 2001 cited in Zelkowitz, 2004). Glasser et al, (1998) found that 34% of their sample of pregnant Israeli women were depressed, with higher rates among Russian immigrants than among native-born Israeli women. A lack of social support can place immigrant women at risk for emotional distress and psychiatric disturbance during pregnancy and the postpartum period (Brugha et al, 1998; Engle,Scrimshaw,Zambrana, & Dunkel-Schetter, 1990; Zelkowitz, 1996 cited in Zelkowitz, 2004).

It appears that immigrant women may constitute a high-risk group for depressive disorders in pregnancy and the postpartum period. There is a lack of empirical research on the risk factors for depression in this group. The risk may be related to personal disruptions associated with immigrant status. Rogler (1994) has suggested that migration involves three major transitions: changes in personal ties and the reconstruction of social networks, the move from one socio-economic system to another, and the shift from one cultural system to another. This model may help to inform research on risk factors for depression among pregnant immigrant women (Zelkowitz, 2004).

2.8 WHO guidelines for care of migrant women

Some important aspects are to consider when providing care to migrant mothers (WHO, 2018):

- Awareness of patient's background: Awareness of the potential issues related to a migrant's background allows additional health checks to be instituted to provide good quality care.
- Provision of interpretation services: better communication allows the health practitioners to establish appropriate diagnosis and thus enables good quality of care.
- Provision of information on entitlements for both users and providers of health care: Provision of universal health coverage would avoid such dilemmas, but where restrictions do occur it is important that information on entitlements to care is clear and shared.
- Provision of person-centered, culturally sensitive and preventive care: knowledge about patient's cultural beliefs would help to understand the patient's therapeutic choices and thus, better explain and advise them.

In general, while there is a lot of research on maternal and new-born health, less has focused specifically on migrants. Being a migrant can be considered a risk factor and at the same time can be a proxy for other risk factors, such as lower socioeconomic status, higher burden of disease and cultural norms in the country of origin, language difficulties or low health literacy.

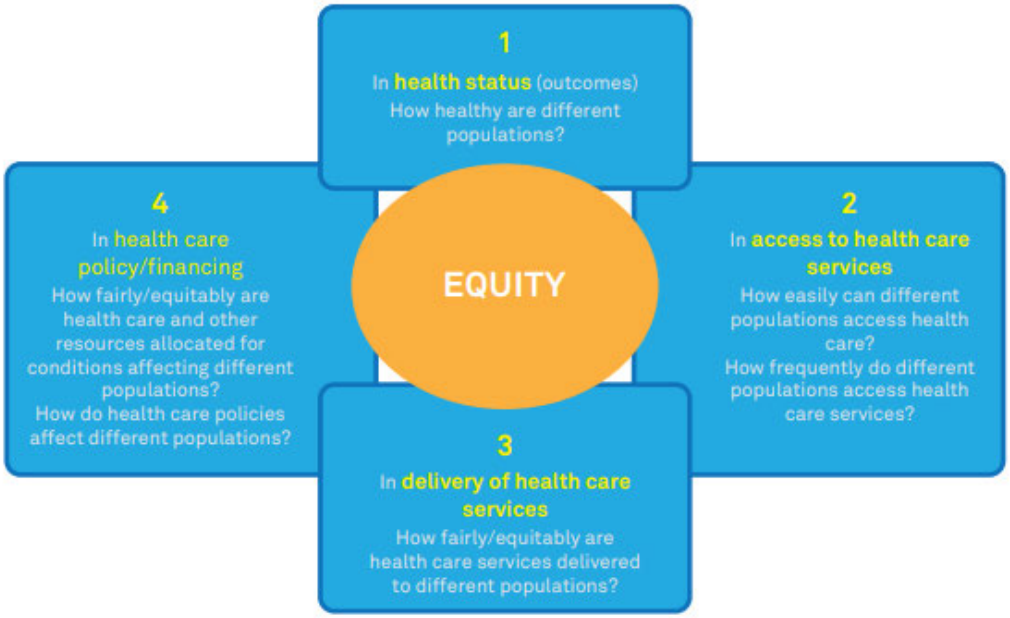
Most research shows poorer maternal and new-born outcomes in refugees and migrants, although some studies show equal or better outcomes. The main risk factors contributing to worse outcomes in migrants are socioeconomic status and education. According to (Bollini et al, 2009; Gissler et al, 2009; Gagnon, et al, 2009; Essen et al, 2000), there are also protective factors contributing to better outcomes as:

- mother's background and origin from a high-resource country with high Gender related Development Index, advanced health care system and lower burden of disease on a population level;
- high socioeconomic status or education level of the woman and, to some extent, high education level of the husband;
- knowledge of local language and solid social network/social capital;
- length of stay in the host country with more access to care and interventions for those with a longer stay; and
- Migration to a country with a strong integration policy.

2.9 Services – health equity/equality

When providing health care, equity/equality is important to consider especially when offering services to people with different educational backgrounds, cultures, languages.

Framework of equity



Source: http://www.euro.who.int/__data/assets/pdf_file/0003/388362/tc-mother-eng.pdf

2.9.1 Services offered to migrant pregnant women in Germany

The Federal Office for Migration and Refugees (2016) provides advices and information to expectant mothers and parent-to-be regarding medical, social and legal matters both before and during pregnancy. The pregnancy advice centre gives information on many issues such as:

- financial and social support available during and after pregnancy
- employment law (with regard to maternity leave, parental leave)
- abortion
- availability of confidential treatment
- help for families and children
- child care facilities

Most of the information and counselling services are free of charge and can be used anonymously and provided in a number of languages. In addition, to face-to-face counselling, there are also services available over the internet or telephone.

During pregnancy and after birth, women are entitled to receive care from a midwife or a doctor. As soon as the woman is pregnant, she should start consulting a gynaecologist every four weeks – from the 32nd week of pregnancy, the visit frequency increases to every two weeks. The costs of prenatal care are covered by the women's health insurance.

In the same way, other information regarding children and family as legal protection for working mothers, parental allowance and parental leave, child benefit and other benefits, childcare, assistance for families in crisis are also available.

In order for the women and/or parents to be entitled to these benefits, they should meet some conditions. It is stated that nationals of EU Member States, and Iceland, Liechtenstein, Norway and Switzerland are entitled to child benefit in the same way as German nationals, if they live or work in Germany. In the case of other foreign nationals, people with a permanent settlement permit are entitled to receive parental allowance. Those who have a residence permit are only entitled to child benefit if they are also entitled to work in Germany or have already legally worked there (Federal Office for Migration and Refugees, 2015).

There are charity organizations like Medibüros, Pro Familia, Donum Vitae, organizations affiliated with the Church (Caritas and Diakonie) who offer assistance to migrant pregnant women by providing individual advice and information regarding:

- health and birth: childbirth classes maternity clinics and midwives
- financial support and legal claims: social laws issues and legal claims such as maternity leave, parental leave, parental and child benefit, child support, unemployment benefit II, rights of care and access; assistance in the enforcement of legal claims in offices and authorities; application for the Foundation "Mother and Child" or "Family in Need"
- changed life situation: problems before and after birth; crises in the partnership; accompaniment after miscarriage, premature birth or stillbirth.

The Federal Family Ministry has established a hotline for pregnant women in need. They can call on +49 (0)800-4040020 and get anonymous advice, an online support chat and a search tool to find a pregnancy centre that offers anonymous advice. This service is available in 18 languages.

2.9.2 Case of immigrant pregnant students in Germany

Students are a particular group because of their residence permit which is a temporary residence permit. According to the Residence Act paragraph 16, the temporary residence permit shall allow the holders to work only during holidays or as a trainee. It entitles the holder to take up employment in total no more than 120 days or 240 half-days per year, and to take spare-time student employment. In other terms, students are part-time workers and not considered as workers and for these reasons, are exempt to many grants like parents and child benefits.

Many universities and higher education institutions in Germany have established counselling centres for social and international affairs or a family service in which, counsels and supports are offered to pregnant student women and currently studying parents in regard to: family financing, social services, childcare, part-time study, good and stress-free transition from working study life in maternity and after birth.

The higher education institutions and universities are also connected to Caritas and Diakonie and from these organizations, the pregnant students can benefit counselling services as well as financial and social support.

Chapter 3: Methodology

This chapter gives an overview of the research methods used during the project and the analysis. The different research methods and the rationale for choosing qualitative research method and in-depth interviews will be explained. Furthermore, a detailed description of the research process will be given including the study population, the inclusion and exclusion criteria, the recruitment process. The data collection and data analysis method used during the research process as well as the ethical considerations will be discussed.

3.1 Study designs

Characteristics	Qualitative method
Purpose	a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem
Approach to inquiry	Subjective, holistic, process-oriented
Hypothesis	Tentative, evolving, based on particular study
Sampling	Purposive: intent to select "small" not necessarily representative, sampling in order to get in-depth understanding
Measurement	Non-standardized, narrative (written words), ongoing
Relationship between researcher and participant	Close
Researcher's stance in relation to subject	Insider
Image to social reality	Processual and socially constructed by actor

Some characteristics of qualitative and quantitative research methods
(Source: Own representation according to: Creswell 2009, 2014; Flick et al. 2015; Diffen LLC n.d.; Shareia 2016).

Before explaining the rationale, here are some fundamental differences between the qualitative and quantitative research methods.
Qualitative research is used to explore and understand the complex interrelationships between different variables while quantitative research is interested in explanation and control (Shareia, 2016). Knowledge in qualitative method is constructed through emerging questions and procedures and the methodology is a useful tool to explore actor's meaning and interpretations (Shareia, 2016; Creswell, 2014) whereas in quantitative research, hypothesis is tested and the relationship between variables is examined using numerical data and statistical procedures (Creswell 2014; Flick 2015)

The distinction between qualitative and quantitative research is framed in terms of words and open-ended questions used in qualitative research rather than numbers and hypotheses used in quantitative research (Creswell 2014; Flick 2015). The basic philosophical assumptions researchers bring to the study, the types of research strategies used in the research and the specific methods employed in conducting these strategies are a more complete view to see the differences between the qualitative and quantitative research designs (Creswell, 2014).

Qualitative research is a design that is used to explore and understand the meaning individuals or groups ascribe to a social or human problem. Open-ended and emerging questions are used and the data are collected and analysed inductively by building from particular to general themes. The researcher makes an interpretation of the meaning of the data (Creswell 2014; Flick 2015). The final report has a flexible structure. (Creswell, 2014) Quantitative research on the other hand, is a design used for testing hypothesis or objective theories. The examination of the relationship between variables is the process used. The data are measured, quantified and analysed using statistical procedures (Creswell 2014; Flick 2015). In this method, the researchers have assumptions about testing theories deductively, building in protections against bias, controlling for alternative explanations, and being able to generalize and replicate the findings (Creswell, 2014).

3.2 Rationale for qualitative research

A qualitative research method has been chosen to gain knowledge about the experience of immigrant pregnant women. Explicitly, to learn about their mental health during their pregnancy in a foreign country, Germany; their perceptions about the risks and protective factors of prenatal depression and how they describe their needs during this period. Questionnaires and surveys used in quantitative approach would not have been appropriate to

explore people's experiences. Qualitative method is used to explore substantive areas about which little is known in order to gain a fresh and deeper understanding (Shareia, 2016). The mental health and wellbeing of immigrant pregnant women in Germany is still under-researched and for this reason, this is an exploratory study. Using qualitative research method will help to understand and learn more about this group of people, which will help to discover new aspects and issues, and finally make some recommendations.

3.3 Philosophical background: social constructivism

Social constructivists hold assumptions that individuals seek understanding of the world in which they live and work. Individuals develop subjective meanings of their experiences (Cresswell, 2014).

The research goal is to close to the participant's perception of the situation under study. The open-ended questions help the researcher to better understand and listens to participants in their daily settings. This will allow the researcher to find out about the participants' views and perceptions. Constructivist researchers often address the processes of interaction among individuals and focus on the specific contexts in which people live and work, in order to understand the historical and cultural settings of the participants (Creswell, 2014). Researchers recognize that their own backgrounds shape their interpretation, and they position themselves in the research to acknowledge how their interpretation flows from their personal, cultural, and historical experiences. The researcher's intent is to make sense of (or interpret) the meanings others have about the world (Creswell, 2014).

3.4 Research method: Phenomenology

The phenomenological research method has been chosen to understand and explore how immigrant women live their pregnancy in Germany.

Phenomenological research is a design of inquiry coming from philosophy and psychology in which the researcher describes the lived experiences of individuals about a phenomenon as described by participants. This description culminates in the essence of the experiences for several individuals who have all experienced the phenomenon (Giorgi, 2009; Moustakas, 1994 cited in Creswell 2014).

The term phenomenology is derived from the Greek ‘phainein’, which means ‘to appear’, and it was first used by Immanuel Kant in 1764. Kantian phenomenology is based on constructivist philosophy for the reason that the phenomena are constructed by cognitive subject who is human being. In constructionist view, the subject constructs what it knows, and in phenomenological view, the subject knows what it constructs which are not appearance but it has appearance in the consciousness (Rockmore, 2011 cited in Yüksel & Yildirim, 2015).

Phenomenology as a methodological framework has evolved into a process that seeks reality in individuals’ narratives of their lived experiences of phenomena (Cilesiz, 2009; Husserl, 1970; Moustakas, 1994 cited in Yüksel & Yildirim, 2015). Phenomenology includes different philosophies: descriptive or hermeneutical phenomenology, which refers to the study of personal experience and requires a description or interpretation of the meanings of phenomena experienced by participants in an investigation. - Eidetic (essence) or transcendental phenomenology used by Husserl – It analyses the essences perceived by consciousness with regard to individual experiences. - “Ecological”, genetic or constitutional phenomenology used by Husserl – It refers to the analysis of the self as a conscious entity. This type of phenomenology appeals to universal consciousness (Padilla-Diaz, 2015).

The aims of phenomenological research are to reach the essence of the individuals’ lived experience of the phenomenon while ascertaining and defining the phenomenon (Cilesiz, 2010 cited in Yüksel & Yildirim, 2015).

This research was inspired from different philosophies and the method chosen was oriented on Marying (2014).

3.5 Researcher’s role

The researcher has always been interested in women’s health and health promotion. In the process of finding the research topic, the researcher searched for the women health issues. In the list of eight most frequently illnesses posing considerable health risks: heart disease, breast cancer, ovarian and cervical cancer, gynaecological health, pregnancy issues, autoimmune diseases, depression and anxiety, health technology for women; the researcher was interested with three: Heart disease, pregnancy issues and depression and anxiety. Within the three, the researcher decided to join pregnancy issues and depression.

During the study program, the researcher did an assignment on postpartum depression, “Can family support reduce the incidence of postpartum depression?” the researcher ‘s thought was

that women in developing countries have a lower prevalence to Postpartum Depression compared to women in developed countries, because the researcher thought the family environment (extended versus nuclear) family organization respectively in developing and developed countries has an impact on how women experience postpartum period. The literature shows that depression is higher in developing countries compared to developed countries. The family support is protective factor but many other factors impact on the incidence of postpartum depression.

The researcher got interested to learn more about it but in another way. As there are many studies on postpartum depression, why shouldn't she investigate about something new or not as common as antenatal depression and learn how immigrant women who have lost an important protective factor as family support, live their pregnancy in a foreign country? Are they more susceptible to develop depression? It is after all this brain storming that the researcher realized that it was part of her personal story and that increased even more her interest on this topic.

The researcher is an immigrant mother who got her child during her Master program. The pregnancy is a joyful event, it is what she felt when it happened and tried her best to keep this happiness during the whole pregnancy period. The joy of being pregnant is not all, other important factors are to consider. Her physical health was poor for 2/3 of her pregnancy time, she had no family member to assist her. She was for a long time away from her partner and had to deal with demanding student life. Nevertheless, the baby was healthy and she did not feel any symptoms of antenatal depression. It is quite surprising when the researcher looks back at it but maybe her resilience was strong enough to cover all the other aspects of the pregnancy.

In qualitative research, it is important for the inquirer to reflect about how their role in the study and their personal background, culture, and experiences hold potential for shaping their interpretations, such as the themes they advance and the meaning they ascribe to the data. This aspect of the methods is more than merely advancing biases and values in the study, but how the background of the researchers actually may shape the direction of the study (Creswell, 2014, p 235).

According to Primeau (2003), reflexivity is a qualitative research strategy that addresses our subjectivity as researchers related to the people and events that we encounter in the field. The researcher requires information about conceptions of self and those who are being researched (Creswell, 2013). Reflexivity enhances the quality of research through its ability to extend our

understanding on how our positions and interests as researchers affect all stages of the research process (Primeau, 2003). Some might think that it is the reason why the researcher decided to choose this topic but not at all. As the researcher mentioned earlier, it was just a coincidence but it increased her interest.

The researcher's target group were immigrant women who were not born in Germany and were living in the country for studies, work or family reunification purposes. She ended up having more women from Africa and particularly from Cameroon. In this situation, it is not very easy to stay as an outsider because the researcher and the participants share the culture, language and sometimes the same purpose of residence. According to Holloway & Wheeler (2002) and Corbin Dwyer & Buckle (2009), shared views, feelings and perceptions between the researcher and the participants can affect the accuracy of information and result in a research shaped and guided by the researcher's assumptions and experiences rather than those of the participants.

Husserl proposed a concept called Epokhé, which is a Greek word meaning Doubt. According to this concept, the researcher who places him or herself within the qualitative paradigm must set aside all preconceptions, judgments or prejudices towards a particular topic in order to make an objective analysis of the information participants bring to an investigation (Padilla-Diaz, 2015). Knowing that, the researcher was focusing on not only my pre-set questions but more on their own stories and the questions were more according to what the participants were narrating. It happened sometimes that a participant told the researcher that "you know what it is, meaning you passed through so know the situation". The researcher's answer was that we all have a different experience; what matter at this moment, was her own experience.

At the same time, being an African woman as many of my participants, they could have felt embarrassing to discuss some issues or to reveal some aspects of their lives. According to Fay (1996), we tend to hide ourselves out of self-protection and guilt; for this reason, they may have hide or avoid to mention some aspects out of shame or modesty.

When the researcher decided to undertake this study, she thought many women face the same situation as herself and not all can manage it the same way as she did; so, the researcher was really interested to learn about other immigrant women stories. According to Creswell (2014), the researcher has to be explicit, the experiences may cause researchers to lean toward certain themes, to actively look for evidence to support their positions, and to create favourable or unfavourable conclusions about the sites or participants. The researcher acknowledges that she was thinking to I find women with difficulties who faced prenatal depression. Nevertheless,

this thought did not shape the selection of participants nor the questions during the interview. With the time, the researcher learned to take what was given during the data collection.

The researcher used a variety of methods to recruit the participants (see in details in the participants' recruitment) and what worked the most was the use of social network through WhatsApp. "Backyard" research (Glesne & Peshkin, 1992 cited in Creswell 2014) involves studying researchers own organization, or friends, or immediate work setting. This often leads to compromises in the researchers' ability to disclose information and raises issues of an imbalance of power between the inquirers and the participants (Creswell, 2014). When researchers collect data at their own workplace (or when they are in a superior role to participants), the information may be convenient and easy to collect, but it may not be accurate information and may jeopardize the roles of the researchers and the participants. In the beginning of the participant's recruitment, the researcher thought having friends who could take part to the research would have been great but she did not find any so did not have any close relationship with the participants before the interview which could lead to convenient, easy to collect and inaccurate information (Creswell, 2014).

3.6 Study Participants

A phenomenological framework requires a relatively homogenous group of participants (Creswell, 2007 cited in Yüksel &Yildirim, 2015). Therefore, in a phenomenological study, participants should have experience with the same phenomenon. Individuals selected to participate in the phenomenological study should have significant and meaningful experiences of the phenomenon being investigated (Cresswell, 2007; Moustakas, 1994 cited in Yüksel &Yildirim, 2015).

The study is about the lived experiences of migrant women during their pregnancy in Germany. For this reason, the inclusion criteria were: being women born and raised up in another country, being pregnant or have shortly experienced pregnancy, speak English or French.

The researcher chose to interview some experts as well. these experts are frequently in contact with immigrant women because of their profession. Therefore, they might know issues related to this group which might help the researcher.

3.6.1 Study location, sampling and recruitment

The study was conducted in Germany southwest region and the participants were coming from the cities Mannheim, Ludwigshafen, Bobenheim, Worms und Aachen. The researcher used a variety of methods to recruit participants: posters hanged in gynaecologist offices, hospitals, midwifes centre, Applied University (Hochschule Worms) website, invitation note sent through WhatsApp groups, and words of mouth.

For a phenomenological study, Creswell (2014) recommend a sample of 3 to 10 participants. In this study, seven (7) participants and a team of three (03) experts were recruited using both purposeful sampling and snowball sampling. The purposeful sampling focus on particular characteristics of a population that are of interest, which will best understand and answer the research questions (Creswell, 2014; Mujere, 2017) thus the researcher can decide whether participants share significant and meaningful experience concerning the phenomenon under the investigation. This sample is not representative for the population, but for researchers pursuing qualitative research designs, it is not a weakness (Mujere, 2017). The second strategy used is the snowball sampling which is a method of expanding the sample by asking one participant to recommend the study to other participants (Miles & Huberman, 1994; Marshall & Rossman 2006 cited in Yüksel & Yildirim, 2015) in the same way, the researcher also asked to friends and relatives to recommend people they know who could fit the requirements for participation.

3.6.2 Sample description

In qualitative research, a high number of participants is not as important as in quantitative research. Creswell (2014) recommends three to ten participants for a phenomenological study. There is another strategy to determine the sample size, it is through the data saturation which means when gathering fresh data no longer sparks new insights or reveals new properties (Charmaz, 2006 cited in Creswell, 2014).

The aim of the researcher was to create as much as possible a heterogeneous sample group which means, having participants from different countries, cultures, educational background, occupation, which would help the researcher to better understand the issues around this particular group. Finally, 7 participants were involved in the study as seen in the table below:

	Name	Country	Age	Education level	Profession	Marital status
1	Sandra	Cameroon	33	Technical training	Self-employed	Married
2	Barbara	Morocco	32	Technical training	Student	Married
3	Julie	Nigeria	31	University degree	Housewife	Married
4	Helene	Yemen	35	University degree	Housewife	Married
5	Nina	Cameroon	29	University degree	Student	Single
6	Denise	Ivory coast	32	University degree	Employed	Married
7	Jade	Cameroon	28	University degree	Employed	Single

Experts (three persons) are working for an organization called CARITAS Verband, in the pregnant women counselling services. The Caritas is the most important Catholic welfare association in Germany. One of their activities is to counsel pregnant women on abortion issues (Schwangerschaftskonfliktberatung).

3.7 Data collection

The data were collected through face-to-face and telephone interviews. It was divided in three phases. The first phase was during the first contact with the participant in order to present the project, to ask for their participation and to fix a date for interview when the participant was filling the requirement conditions. The second phase was the face-to-face interview itself when it was possible or a video phone call with the participant living far away. The third phase was to complete some missing information mostly through a voice phone call.

The interviews were performed according to the participant's preference. It was mostly at the participant's house, one in a park at a relatively quiet morning time. Telephone video calls were used when the participant was living in a region that the interviewer semester ticket did not cover and the ticket was expensive. The researcher performed three telephone calls. The interviews were in English or French mostly but it appears that some participants could not find the appropriate word in English or French but in German. The researcher's German knowledge was good enough to cover this gap.

3.7.1 Interview protocol

The researcher used the protocol according to Creswell (2014). At the beginning the researcher greets and thanks the participant for her participation to the study. Some standard procedures about how the interview are given to the interviewee. The recorder is placed between the interviewer and the interviewee.

The interview begins with an "ice-breaker" in order to relax the atmosphere and help the interviewee to have a more opened attitude. The researcher puts an emphasis on the fact that it is more a discussion about the participant's experience and the questions would be asked according to it.

The ice-breaker is followed by three to five questions and in between questions about some points mentioned by the interviewee for a better understanding or follow up. At the end, a final thank statement acknowledges the time of the interviewee.

3.7.2 Qualitative documents

The documents used for qualitative research may be public documents (e.g., newspapers, minutes of meetings, official reports) or private documents (e.g., personal journals and diaries, letters, e-mails) that can enable the researcher to obtain the language and words of the participant or can represent data to which the participant have given attention (Creswell, 2014). During an interview, a participant related to the researcher a stressful situation that she faced and later on gave to the researcher the link of a journal in which the spoken topic was mentioned.

During the first part of the research process until the data collection process, the researcher had a diary in which she noted some important aspects like learning process, good and bad experiences faced during this period. During the whole data collection, the researcher has learned a lot on how to conduct a qualitative research. The more the researcher was performing interviews, the more she was feeling confident.

The transcriptions of the different interviews represent the third type of qualitative documents used by the researcher.

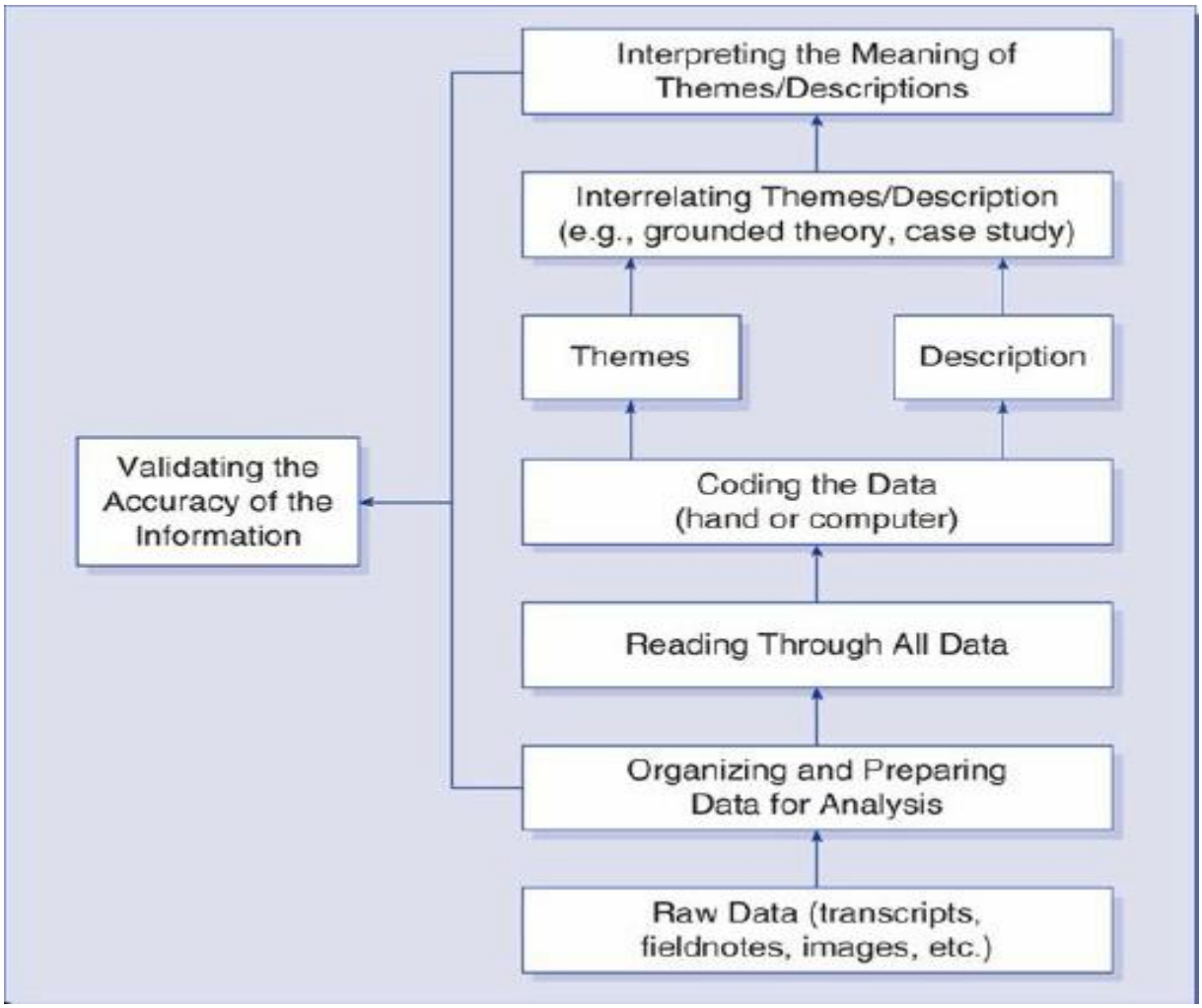
3.8 Data analysis

For this data analysis, the researcher combined the methods of Creswell (2014) and Zhang & Wildemuth (2005). Creswell (2014) considers that the general intent of data analysis is to make sense out of text and image data by segmenting and taking apart the data (like peeling back the layers of an onion) as well as putting it back together. Patton (2002 cited in Zhang & Wildemuth 2005) defines qualitative data analysis as any qualitative data reduction and sense-making effort that takes a volume qualitative material and attempts to identify core consistencies and meanings. Zhang & Wildemuth (2005) go beyond and assert that qualitative content analysis goes beyond merely counting words or extracting objective content from texts to examine meanings, themes and patterns that may be manifest or latent in a particular text but it allows the researchers to understand social reality in a subjective but scientific manner.

Because text and image data are so dense and rich, not all the information can be used in a qualitative research, thus the data analysis need to "winnow" (Guest, Macqueen & Namey, 2012 cited in Creswell 2014), a process of focusing in some of the data and disregarding other aspects of it and aggregate them in small numbers of themes.

Data analysis in qualitative research proceeds hand-in-hand with data collection (interviews) and the write-up of findings. This study will use inductive reasoning, by which the themes and categories emerge from the data through researcher's careful examination and constant comparison (Zhang and Wildemuth, 2005). According to the approaches of qualitative content analysis based on the degree of involvement of inductive reasoning discussed by Hsieh and Shannon (2005), this research will use qualitative content analysis, in which the categories are derived directly and inductively from raw data.

Through this process, the researcher used manual coding because MaxQDA was hard to understand and time consuming. Nevertheless, the researcher could refer to MaxQDA when looking for quotations. It was easy to find out how participants talked about a particular theme. Manual coding was quite a long process but it helped the researcher to be in constant contact with and have a sense of control over the data.



Data analysis in qualitative research (Creswell, 2014)

The following steps helped me to make my qualitative content analysis:

1- Organization and preparation of all data for analysis. This involves transcription of all interviews from participants and experts, sorting and arranging all the documents depending on the sources of information.

2- This first step provides a general sense of the information and an opportunity to reflect on its overall meaning. At this stage, the researcher started to reflect on the general ideas from participants saying and make general notes of the data.

According to Zhang and Wildemuth (2005), this step is to define the unit of analysis, which is the basic unit of text to be classified during the content analysis. The researcher used individual themes as units of analysis. A theme as a coding unit might be expressed by a word, a phrase, a sentence, a paragraph or entire document. I might assign a code to a text of any size as long as it represents a single theme or issue of relevance to my research question.

The researcher obtained 56 units of meaning representing all the aspects that the participants mentioned during the interviews. Those units were classified according to how many times the participants have mentioned it and consequently their importance (Table 1).

3- This step consists of coding all the 56 units of meaning into categories. This involves taking text data gathered during data collection, segmenting sentences (paragraphs) into categories and labelling those categories with a term. In reality, assigning a particular text to a single category can be very difficult. Qualitative content analysis allows you to assign a unit of text to more than one category simultaneously (Tesch, 1990 cited in Creswell 2014). To ensure the consistency of coding, especially when multiple coders are involved, you should develop a coding manual, which usually consists of category names, definitions or rules for assigning codes, and examples (Weber, 1990 cited in Creswell 2014).

The researcher clustered the units that could fit in the same category and through this process 7 main categories were formed (Table 2).

4- After reading many times the interviews, the researcher ended up with 6 main categories and 17 sub categories (Table 3) that mostly represented the "essence" of the lived experiences of the participants.

The interpretation of the meaning of the themes is done in the Result chapter.

The intercoder agreement was achieved through a cross-check by two readers. Each of them was asked to code the texts and had three interviews each. The purpose of the intercoder agreement was to determine if they would code the texts, find the same or similar as the researcher. The emerged themes or codes were almost the same as the researcher. For a good qualitative reliability, Huberman (1994) cited in Creswell (2013), recommends the consistency of the coding be in agreement at least 80% of the time.

3.9 Ethical considerations

Because we deal with participants, the protection of their personal data is an important issue in the qualitative research. The women were informed and agreed that their participation in this study was voluntary and they could withdraw at any time. They agreed that their information would only be used for the Master Thesis purpose and would be kept safely during this process. They were informed that their names will be changed in the report to keep their privacy and ensure ethical consideration.

Table 1: Units of meaning

	Units of meaning	Sandra	Barbara	Julie	Helene	Nina	Denise	Jade	
1	Cultural beliefs and concepts of care	3	2	1	1	3	4	2	16
2	Family (mother) care and support	3	0	0	5	1	3	2	14
3	Role of the husband or partner	1	2	1	1	1	2	3	11
4	Integration in the host society	3	1	1	2	2	1	1	11
5	Social life	1	1	2	3	1	1	2	11
6	Role of the woman	0	0	1	1	5	2	0	9
7	Spiritual beliefs	3	2	0	0	0	0	3	8
8	Fear/uncertainty of the future	1	1	1	0	2	2	0	7
9	Problem solving	2	0	0	0	0	0	5	7
10	Financial insecurity/independency	0	1	1	0	2	2	0	6
11	Discrimination	1	0	0	0	0	0	5	6
12	First pregnancy/experience	1	1	0	0	2	0	1	5
13	Life attitude	3	1	1	0	0	0	0	5

14	Psychologist as last option	1	1	1	0	0	2	0	5
15	Loneliness	1	1	0	3	0	0	0	5
16	Role of health professionals	0	0	0	0	0	1	4	5
17	Self-image	0	0	0	1	0	1	2	4
18	Age and maturity	1	0	1	0	2	0	0	4
19	Self-examination	1	0	0	1	0	1	1	4
20	Marital problems/life	1	0	1	0	1	1	0	4
21	Unplanned pregnancy	1	2	0	0	1	0	0	4
22	Privacy towards family/friends	1	1	1	0	1	0	0	4
23	Access to information/services	1	1	0	0	0	0	2	4
24	German medical services	1	0	0	0	2	1	0	4
25	Baby development	0	0	0	0	1	1	1	3
26	The right place to deliver	0	0	0	0	0	0	3	3
27	Administrative procedures for migrants	0	0	0	0	0	0	3	3
28	Intercultural competence	2	0	0	0	0	0	1	3
29	Nutritional habits	0	0	1	1	0	1	0	3
30	Recreation, distraction	0	0	1	0	1	0	1	3
31	Family centred issues	1	1	1	0	0	0	0	3
32	Comfortable living conditions	1	0	0	0	0	0	1	2
33	Self-confidence	2	0	0	0	0	0	0	2
34	Different experiences/ perception with Nationals	1	0	0	0	0	0	1	2
35	Legal status	0	1	0	0	0	1	0	2

36	Underlying medical issues	0	0	2	0	0	0	0	2
37	Hypersensitivity	0	0	1	1	0	0	0	2
38	Low self-esteem /uselessness	0	0	0	1	1	0	0	2
39	Changed perception of pregnancy	0	0	0	0	1	0	1	2
40	Language barrier	0	0	0	0	2	0	0	2
41	Risks taking at work	0	0	0	0	0	0	2	2
42	Husband centred life/ behaviour	0	0	0	1	1	0	0	2
43	Being abroad increases the risk of AD	1	1	0	0	0	0	0	2
44	System of living	1	0	0	0	0	1	0	2
45	Google search	0	1	0	0	0	0	0	2
46	Parental benefits	0	0	0	0	0	0	1	1
47	Child birth certificate	0	0	0	0	0	0	1	1
48	Workplace ambiance	0	0	0	0	0	0	1	1
49	Delivery process	0	0	0	0	0	1	0	1
50	Cultural appropriation	0	0	0	0	1	0	0	1
51	Hormonal changes	0	0	0	0	1	0	0	1
52	Poor mental health	0	0	1	0	0	0	0	1
53	Person-centred attitude	0	0	1	0	0	0	0	1
54	Student-mother life	0	1	0	0	0	0	0	1
55	Dreams fulfilment	0	1	0	0	0	0	0	1
56	Family expectations and deception	0	1	0	0	0	0	0	1
									210

Table 2: Units association and formation of categories

1	**Different cultural beliefs, perceptions and concepts of care**	• Cultural beliefs and concepts of care • Different perception of pregnancy • Cultural appropriation • Role of the woman
2	**Relationships**	• Family (mother) care and support • Social life • Privacy towards family/friends
3	**Husband/partner care**	• Role of the husband/partner • Marital issues/life • Family centred issues • Husband centred life/behaviour • Age and maturity
4	**Experience of pregnancy and associated feelings**	**Experience of pregnancy** • First-experience • Age and maturity • Unplanned pregnancy • Underlying medical issues • Person-centred attitude • Being abroad increases the risk • Baby development • Delivery process • Dreams fulfilment • Hormonal changes • Poor mental health **Feelings** • Loneliness • Self-image • Self-confidence • Self-esteem/ uselessness Fear of the future

		Hypersensitivity
5	**Integration / life in the host country**	• Integration in the host country • Discrimination • Access to information • The right place to deliver • Different experiences/perception with Nationals (30) • Legal status • Language barrier • Child birth certificate • System of living • Administrative procedures for migrants • Student-mother life • Parental benefits • Financial insecurity • Workplace ambiance • Comfortable living conditions
6	**Coping strategies**	• Positive life attitude • Self-examination • System of living • Nutritional habits • Family centred issues • Spiritual beliefs • Google search • Problem solving • Recreation distraction
7	**Health system**	• Psychologists as last option • Role of professionals • Intercultural competence • German medical services

Table 3: Categories and sub-categories

1	**Expression of feelings and concepts of care for pregnant women**	**a)** Psychological health as taboo **b)** The pregnant woman as a princess
2	**Pregnancy related feelings/emotions**	**a)** Missing mother **b)** Loneliness **c)** Ugly vs beautiful **d)** Fears **e)** Uselessness **f)** Anger
3	**Role of the husband: prince or servant**	
4	**Challenges faced by immigrant pregnant women**	**a)** Difficulties to understand the medical jargon **b)** Special administrative procedures regarding the child's birth certificate **c)** Being treated with less consideration/respect **d)** Facing financial insecurity
5	**Psychologist as last option for counselling**	
6	**Coping strategies**	**a)** Spiritual beliefs **b)** Positive attitude **c)** Social network **d)** Recreational activities **e)** Nutrition

Chapter 4: Results

This study explored the mental health of immigrant pregnant women living in Germany especially their perception and concepts of prevention of antenatal depression. This study revealed the lived experience of immigrant women during their pregnancy, their feelings/emotions, fears, challenges and how the view the role of people around them. My study was guided by a qualitative framework. Phenomenological research method guided my data collection and analysis. This section is a compilation of a deep introspection in pregnant women lived experiences and their "own words".

4.1 Expression of feelings and concepts of care for pregnant women

As the women came in Germany in their adult age, they had the occasion to witness how their relatives were living the pregnancy in their country of origin. For this reason, this category discusses about the different perceptions regarding the expression of feelings and concepts of care for the pregnant woman. It gives a detailed view, on one hand of how psychological issues are perceived within their culture and on the second hand how they perceive the pregnancy itself. The other aspect relates to how the pregnant woman is cared for in their country of origin.

a) Psychological health as taboos

Although the prevalence of perinatal mental disorders is higher in low and middle-income countries, 10-41% compared to 10-15% in high-income countries (Stewart et al. 2003, O'Hara & Swain 1996, Ross & Mclean 2006 cited in Fellmeth et al. 2015; Cooper et al. 1999), many participants are not familiar with the term "antenatal depression". Although they have a higher education, many could not define it. Julie referred to the definition that I gave in my introduction to the interview process. Helene and Nina mentioned that they have heard about antenatal depression but were not really informed about it because it did not capture their interest, they were not concerned by this issue. Nevertheless, they knew about the risk factors according to their personal experiences. For those like Sandra who were more informed about antenatal depression, she had heard and learned about it only in her host country not in her country of origin.

Many migrants do not open themselves or do not discuss about sensitive issues with people they do not know. This behaviour has nothing to do with the place where they live, either their country of origin or their host country, it is their cultural custom (habit). Sandra thinks that it is common habit for many migrants that she encountered; while Nationals will easily and openly

discuss about their feelings, their mood or their psychology, the migrants will close themselves or discuss with people with whom they share some similarities like the same family, culture, origin, or the same background. Julie has a different opinion about the opening herself to others. For her, not expressing her feelings has nothing to do with the relationships with others but on someone's character. She did not inform her family about her pregnancy and the difficulties she faces throughout because she did not want to frighten them. It took her long time to inform her sister-in-law and her best friend who are both living in Germany and with whom she discusses frequently, because she did not want to explain about her condition. Also Barbara did not inform her family about her pregnancy and the difficulties she was facing because she did not want them to be worried, she would feel worse.

Apart from people who do not express their feelings because of their character, in many cultures, psychological issues are considered like a weakness, a shame, a taboo, something people hide or do not discuss openly and for these reasons they have to be kept secret or resolved within the family (Salami et al. 2018; Lubman et al. 2014; Amankwaa 2003).

***"Depression is not a taboo in the German society but for the migrants, it is not something that people talk about frequently. Even now when you talk about psychological problems, it is perceived in African culture like weakness even though it is not always the case.On one hand, I think we should keep our culture but nevertheless when one sees that is not working for her, which is an individual thought, man should seek for more suitable support*" (Sandra)**

Denise and Julie think that psychological health is not considered as an issue that need a medical attention (Lubman et al. 2014; Amankwaa, 2003) rather as a temporary state that will fade after the pregnancy. Mood swing are considered normal due to hormonal variations during the pregnancy period. Nina mentioned that even when women experience more than mood swings, they suffer in silence, do not complain because of their culture.

"People know more about the mood swing during pregnancy. In case women express themselves, it is to very close people not to everybody as it is the case in Europe, to go hospital to discuss about some emotional problems or depression, no no no no. The women try to be strong with the help of their husband or their mother but it is not common for a woman to express her worries and stress. Even if she does, they will tell her that everything will be fine, it is just a temporary situation, many women have passed through it why not you" (Denise).

"I know how to manage myself. I know that is a temporary situation. If it gets worse, then I can ask for an external help. Normally, I am fine it is only during this phase that I have this feeling so I know, it will pass after the pregnancy. I am just counting the days for it to come

to end, asking myself in which situation did I got into and wondering if I will survive this situation or will I die" (Julie).

According to Julie, psychological issues are the matters of wealthy people. People who are rich can have everything they need and for them it will be easier to detect psychological problems. Apart from that, they are the only ones who can pay for the check-ups and treatment. But for the majority of people in country of origin, who are poor, they are fighting for their daily survival. For this reason, they are not interested about psychological problems which would anyway be difficult to detect.

"Most of the times, it is difficult to know if a behaviour is due to poverty or psychological reasons. When you are rich, you can have everything you need as food, money so it will be easy to detect psychological problems. When a woman is pregnant, carrying a baby on her back, she is selling under the sun and the children are crying of hunger, it is difficult to know if it is tension, the stress of the baby, trauma or anything else. The people with money can make check-up but for the majority, the poor people, they only fight for their survival so are not interested in psychological problems" (Julie).

Sandra and Denise are proud to have their African education because it helps them to overcome difficulties, they face in her host country. Although they have inherited a strong culture, Sandra, Denise and Julie think that the women should make a self-examination and seek for help when they realized that their cultural prevention methods did not work (Lubman et al. 2014). Nevertheless, if the woman's attitude does not change after giving birth then a medical attention is proposed.

"*We are brought up with values like courage, perseverance, never give up. So, we always think that man should be strong, never give up, this mentality helps us also to face difficult situations during pregnancy. When the problem is more serious as a medical issue then, counsels, discussions, prayers and search for the causes of this situation are considered*" (Denise).

Another issue mentioned by Sandra is that some women actually recognized that they need help to overcome stressful situations but do not seek help because they are afraid of the others' opinions, of being stigmatized by their community.

Because of the negative connotation attributed to depression, the women deny or they claim not to be concerned nor affected with it. Even though, they have episodes of sadness, loneliness, anxiousness, they did not consider it as a problem needing a medical attention rather than

something normal which is related to their actual state, the pregnancy. Julie considers her anger and bad mood as temporary emotional states that will fade of after her pregnancy.

On the other hand, the difference in perception is also about the expectations of the women regarding pregnancy. As women have witnessed their relatives during the pregnancy period, they had an idea of what the pregnancy is. But what they did not know or consider is that, the outsider and insider views of the same situation are different. As outsiders, they had only experienced a part of the whole situation but now that they face it themselves as insiders, the reality is different.

"*While the other pregnant women that I knew were normal, without complaints. It is the way I was also expecting my pregnancy to be, but when I got pregnant, it was the opposite and a shock. Sometimes, I was crying because I was feeling so bad, vomiting blood was stressful. I could not eat, my daily meal was one yoghurt Activia, if I did not vomit. I was vomiting even water" (Jade).*

"*I have sisters that I assisted during their pregnancy…. I was really stressed because I was asking myself if it is normal for somebody to suffer this way because she wants to give birth; I was really considering it like suffering. I was vomiting and feeling weak" (Nina).*

b) The pregnant woman as a princess

In their respective countries of origin, the concept of care of the pregnant woman is mainly based on the physical aspect. The woman during this phase is considered like a princess, says Barbara. She eats good food, receives care from everybody and can ask for everything and no matter if it is difficult or not, she will get it. In the Yemenite culture, said Helene, there is a special concept called "Eyafa" meaning swinging of hormones during the first trimester of pregnancy. During this period more care is provided to the pregnant woman to help her to deal with her discomfort.

I think people in Yemen understand better the situation than here…"Eyafa" swinging of hormones during pregnancy, is well known in Yemen so the people understand better that during the first 3 months, women need more care because they are not feeling well… they are not aware of psychological discomfort during pregnancy. The assistance is more for cooking, pain release" (Helene).

The women connect the psychological health to the system of living and the presence or absence of family members. The more the people who are surrounding the pregnant woman the better is her emotional state. For Sandra, migrant's life is not easy because not having the family to

care and support her during the pregnancy as it would have been in her country of origin, makes things even more difficult. Denise and Barbara add that people are never alone in Africa, no matter the feelings the pregnant woman can discuss about it with people around her as there is always an attentive ear for the one in need.

"The life as a migrant is not easy and not having the family nearby make things even more difficult and can result in depression because we cannot receive the same care and support from our family during the pregnancy as in Africa… Here, in Germany, you have to deal with the challenges by yourself without having a daily support" (Sandra).

4.2 Pregnancy related emotions

This category describes how the women live their pregnancy; what do they feel during this period of transition. Missing mother care, loneliness, feeling ugly or beautiful, high or low self-esteem, fears and anger are emotions that the women experience differently according to how much they are surrounded and cared for, their relationships with people around them, how much they value themselves and their fears.

a) Missing mother's care

During the pregnancy, being surrounded with family members is important for the physical and emotional wellbeing of the pregnant woman, but the most important person is the mother.

Helene said that no matter how caring her husband is, he cannot replace her mother. She misses not being able to go to her mother like her three sisters during their pregnancies, to receive care and support. Nina has the opportunity to discuss often with her mother through phone calls but she thinks it would have been better if her mother was close to her so that she could receive directly advices on how to deal with a present situation. Denise calls her mother whenever she was stressed or have fears, to ask for her advices.

I did not have this experience in my country of origin but I think, it would have been better. I feel that I do not benefit from the same support as if I was in Africa. There, you have your family particularly your mother… I chat with my mother but it is not the same as if she was next to me. I do not get the advice that I could have directly when I face a particular situation. Like when I feel bad and do not know how to deal with, someone more experienced would have advised on how to get rid of the pain or discomfort. It is true that I benefit from medical monitoring but I lack this familial affection and support" (Nina).

Jade lost her mother many years ago. It happened that she cries because she thought that things would have been better if her mother was still alive.

"I think if my mother were still alive, she would have been my confident. I wouldn't have hesitated to tell her how I feel…The fact that my mother is no more alive was also making me cry because I was thinking that maybe things could have been different if I could talk to her and gain some comfort…" (Jade).

Nevertheless, she has good relationships with her mother-in-law from whom she received advices on how to deal with some health issues.

"I had an anaemia and was feeling very weak. My gynaecologist advised to eat a lot of meat but I do not tolerate red meat nor chicken not even at sight, I was not eating at all. The gynaecologist prescribed me tablets. When I explained the situation to my mother-in-law, she advised to eat Bette to solve this issue" (Jade).

b) Loneliness

Loneliness is a common feeling for migrants because they have left their families and even more pregnant women because they would have like to experience this transition phase surrounded with the love and care of their families.

The women experienced loneliness in different ways. Barbara was lonely; her husband was working so she was most of the time alone at home. She had no one with whom to discuss about her situation. Actually, she knew people but what she needed was advices from someone who had faced the same situation to guide her through or someone who could inform her about how to do when you are a student and pregnant in a host country. She said that the people she knew had either no children or were not migrant and for this reason, could not help her. Apart from that, she did not inform her family about her pregnancy because she did not want them to be worried which would make her feel worse.

Helene was feeling alone not only because she was far from her family and especially her mother but also her husband was mostly absent. Her mother told her **"*wherever your husband is, your nation/ your country is" it means that no matter where you are, what matters is to be with your husband, your husband is enough*"** but unfortunately, Helene's husband was a consultant and was travelling a lot. He was going on Monday and was coming back on Thursday, which means that she was twice alone missing important people during this transition period. While some people will try to create new relationships, Helene did the opposite, she was withdraw herself from people and activities.

***My problem is that my family is not here and my husband too. He is absent because he works as a consultant for a company and has to travel a lot. He spends the whole week abroad in consultancy and comes back home only on Thursday evening. I was feeling stressed because I was alone… Sometimes, I don't want to see people because they will see that I am tired, they will feel sorry for me and I don't like this feeling. I cry immediately when I see that somebody is feeling sorry for me… I stopped some of my activities like German courses not because I was tired but I did not like the attitude of the lecturer who was only talking and dealing with the front desk students and did not care about the rest of the class. She was not normal. I was irritated and could not cope with so I decided to stop the course*" (Helene).**

Except from Sandra who was living with her elder sister and received care and support during her first pregnancy and then, for her second pregnancy, had the chance to have her mother by her side, the other pregnant women were surrounded with friends, who were already mothers or not, from whom they could receive some care and support, and thus did not feel lonely.
Sandra pointed out that being surrounded with people does not mean not being lonely but rather, it depends on the relationship that the pregnant woman has with these persons. It is not the number but having someone with whom the woman feels free and comfortable to discuss about sensible, private issues. Someone that she trusts and who will not report or tell to someone else. Denise had her husband, her sister and her friends who were often around her. Nevertheless, she felt alone because they were not providing to her the help that she really wanted the timely manner. She reported that she had to everything by herself like cleaning, cooking and others. She already had the emotional care but actually missed the physical support.

c) Ugly versus beautiful

The pregnancy is a state of transition to motherhood. It involves a lot of changes among the physical aspect which is the most visible. Depending on how a woman feels about her body, her social network will be affected. The more a woman likes her body the more she is open to others and vice versa.
Helene did not like her body appearance, she was feeling ugly and for this reason, was always wearing large sized clothes to hide her belly. Although she said that she likes to see other women's belly, she was not feeling comfortable with her own. She mentioned that her friend advised her to wear tight dresses but she could not.
My physical appearance was another problem. You don't look good when you are pregnant. I don't know if all women experience that but I see myself ugly. My friend used to tell me

that I have to wear tight dresses because it is nice to see pregnant women belly but I can't do it… I wear always very large sized dresses. I like to see pregnant women belly but not mine" (Helene).

On the contrary, Jade was happy and satisfied with her body. During the first five months of her pregnancy, Jade experienced anaemia, hematemesis (vomiting blood) and loss of appetite; as a result she lost ten kilos. She is normally a heavy person and has tried to lose weight without success. Even though, this experience has been difficult, she had the opportunity to lose this extra weight and felt good in her new shapes.

I feel good since the pregnancy, I like my body. I am feeling light and I like it. People who know me realised that I lost weight but it was not as bad as I was still wearing size 38… normally I have weight and during the first months I lost to much weight, ten kilos so it was fine for me… Many people realise it when I was already in maternity leave. My belly was not big" (Jade).

For Denise, the physical transformation was not at all a problem. She did not bother about the proportions of her belly but rather about her wardrobe that would have to be renewed. She considered this transformation as a positive experience and a sign of maturity, moving from the status of a young woman to a greater status, mother-to-be.

"***It has been a positive transformation, I thought I have moved from the status of young woman to a greater status. It was good without any difficulties. I have no problem with physical change, I do not bother about it, if my belly stays big or not. Apart from the fact that it implies a new wardrobe, I don't have any other problem" (Denise).***

d) Fears and worries

The women expressed their fears and worries in different ways. As their first experience, Barbara and Nina, who were students, had to interrupt their studies during the first period of their pregnancy. They were not feeling good, experiencing often discomfort and vomiting and were afraid that it happens on the street or in classroom during the lectures. Related to this discomfort was the fear that the baby does not develop properly because the baby might not receive all the nutrients needed.

For Jade who was employed, she feared that informing her employer about her pregnancy would negatively impact her work. She was forcing herself to go to work even when she was not feeling good and travelling for hours to provide client consultation.

"I was always trying my best to go even when I was not feeling good because I did not want them to say that I am pregnant so I take sick leaves… I decided to inform about my pregnancy after a journey to Austria, I went there alone and the travel was quite long and driving starts to be very exhausting for me and I was feeling dizzy… Since that moment, the ambiance was strange and cold. I could not get any work proposal only when no one else was available. After revealing my pregnancy, I had only one more opportunity to work outside, to travel until I enter in maternal leave. I discussed with my boss and explained that I am pregnant but not sick so if there is something to do, he can trust me I can still do, I do not have any problem. My pregnancy is going well, I do not have a particular problem, and I can work. He answered me that he understood but. I asked many times for something to do but the answer was always the same that when there will be something to do, they will give me" (Jade).

Jade was also worried not to find an apartment before she gives birth. She was living with her partner in a student dormitory where they shared kitchen and toilets with other people and did not imagine herself with a baby in these conditions.

Apart from the above-mentioned fears and worries, the location to give birth not only the hospital but also the city/the country were important for Jade. She was looking for hospitals where the migrants were well treated during and after delivery. And also, as a Cameroonian, she was looking for a city or a country where she would be able to establish the birth certificate of her child without special administrative procedures because she needed that document as soon as possible for her Insurance scheme and for her work.

Denise expressed her fear of the deliver process; whether she would live or die and to give birth to sick or premature child.

*"**The only stress that I have is the fear to give birth to a sick or premature child because the child is the womb and we don't know how he looks like. The medicine here is advanced but it also has limits so nobody could 100% sure that the child will be healthy or have some malformations. It thinks is a fear for all mothers. During the delivery, life or death can occur only God knows so one might ask herself if she is going to overcome it. I am asking to myself, Will I come back with the child or not*" (Denise).**

e) Uselessness

Nina and Helene complained of feeling useless during their pregnancy for different reasons. According to Nina, when a woman is at home, her role is to take care for the house (cleaning, cooking, …) when her husband or partner is at work. Because of her physical discomfort, she could not handle these tasks and for this reason, Nina was feeling useless not being able to contribute neither financially nor practically.

On the other side, Helene felt useless because due to her pregnancy she has limited activities and could not do anything for herself, that would have provided her joy and happiness.

***"I had the opportunity to teach photography and I enjoyed it because I felt being myself once again not only a pregnant and useless woman. I wish to do again something for myself once the child grows. The fact that I am not doing anything for myself makes me feel bad*" (Helene).**

f) Anger

The anger is a feeling exclusively expressed by Julie from the first day of her pregnancy. Julie's anger was particularly directed to her husband. She thought that the pregnancy is the result of two persons' actions and so there is no reasons that only one has to suffer from the discomfort related to the pregnancy. Although she said that her husband was doing everything possible, nothing could please her. She wanted him to feel what she was experiencing.

"***The person suffering the most from my bad mood was my husband because as an adult, he has to understand and accept all even the worst from me. My husband was right, he was doing all he could for me, I was just not satisfied, I did not appreciate at that moment of anything coming from him. I cannot even explain how I want things to be done… This burden has to be for both of us not only one person to suffer from it. The other person has then to understand and do all possible even if it is 300% for him to experience the same thing as you. If I am annoyed, I have to do something to annoy him also. For the other people, they are not concerned about this situation so I am fine with them" (Julie).***

4.3 The role of the husband or partner: prince or servant

In a foreign country, the husband or partner is the closest person to the pregnant woman. This category discusses about the women's culturally specific expectations of care during the pregnancy. What kind of care they would have like to receive, how the women perceive the role their husband or partner and what they expect from them.

Sandra has the luck to have her family members: her sister during her first pregnancy and her mother during the second one. For her, regarding the questions on pregnancy, her husband is a great support but not in first line.

"***I have my sister who is a great support if I need advice in any situation, she is the first person that I call. When she gives me her opinion, I weigh the pros and cons and I take my decision. My husband is also there for daily support" (Sandra).***

For Jade, Denise, Nina and Barbara, their husband were the first line of support and they were grateful for having good and supportive husbands. Jade could not imagine what this experience would have been without her partner. She even thought that she would have been admitted to a psychiatric unit because she had a very difficult pregnancy during the first trimester and would not have manage without her partner.

"If I had a partner who did not accept the responsibility of my pregnancy, I do not know what would have happen. It was already difficult even when together that I do not imagine living that alone. The fact that he was there was a great comfort. I used to tell my friends that if I was alone, I would have been hospitalized in a psychiatric institute because it was very difficult at the beginning" (Jade).

Denise clearly discussed and explained to her husband the current situation and her expectations. They did not have family members by their sides and she was living her first experience of pregnancy. For these reasons, she needed his help. Luckily, she has a partner who is understanding and did his best to support her.

"I did not have so many difficulties during my first pregnancy because my husband was very understanding and helped me a lot. I told him that I needed his help because it was the first experience and we don't have family" (Denise).

Even that was not enough for Denise because she had to do the most of domestic work as well. ***"In this situation, you have to do everything by yourself cleaning, cooking and other. No matter how you feel, you have to do it because no one will help you. The husband just makes the little he can to support but the big is yours" (Denise).***

Nina received the support of her partner but it was not an easy process. Although they were both living their first experience, she thought her partner was not mature enough and for this reason, was not acting properly. In order to protect her relationship, she preferred not to disclose some private information to her elder sisters and instead, explain nicely to her partner, hide things that can create his discomfort and make concessions. She thought it was her role as a woman if she wanted things to get better.

"It is a bit complicated but I think for example you know that your partner is violent or that when he faces some situations, he gets easily angry, you should know how to react. The beginning of the pregnancy is not always easy, if the partner is not strong or prepared enough, he might get angry so to avoid this situation, you should hide things that might create his discomfort. The maturity of the partner also has an impact because in the first pregnancy, everything is new to both of you and you don't know how to deal with. I discuss a lot with my elder sisters about the topics related to pregnancy because it is my first experience but not so deeply about everything, I am facing because I would like to protect my relationship. Sometimes, the partner can react in a certain manner because he does not know but if you want to thing to get better, it is your role as a woman to make concession agreement or explain to your partner" (Nina).

For Barbara, her husband was her first and only support. During the difficult times, he was comforting and encouraging her.

"I have my husband to exchange and he comforts me. My husband (also a student) advised to continue the studies while waiting for the baby to come but I cannot" (Barbara).

Helene's experience is different from the other women. When she was leaving her country, her mother told her that no matter where she is, her husband is enough. Unfortunately, during her first pregnancy, she was mostly alone as her husband was travelling for clients' consultancy. In addition to that, when he was there, he did not understand anything about what she was experiencing and moreover, she had to take care of him.

"My mother used to say:" wherever your husband is, your nation/ your country is" it means that no matter where you are, what matters is to be with your husband, your husband is enough"…Here, you are with your husband and he does not understand what you go

through especially during the first 3 months, only a woman will. My husband tells that only Yemenite or Arab women have this discomfort during pregnancy. Here, a woman has to cook for her husband even though she feels discomfort due to the smell of the food or any other smell. Regarding the psychology, only talking to somebody who can understand can provide a relief but when your husband does not understand you, it makes it worse" (Helene).

4.4 Challenges faced by pregnant migrant women

Dealing with daily challenges as a migrant is already stressful. Adding to it the pregnancy increases the stress. This category relates to the difficulties the pregnant women face in their everyday lives regarding particularly the difficulty to understand the medical jargon, specific administrative procedures regarding the child's birth certificate, being treated with less consideration/respect and facing financial insecurity.

a) Difficulties to understand the medical jargon

In any form of communication, both the sender and the receiver should use the same code. In health care it is even more important because it can result in misunderstandings and discomfort. Nina pointed out that although her German language is good, the communication with her doctor/gynaecologist was difficult. They did not understand each other. She did not understand the medical jargon that the doctor used and she felt like the doctor did not understand her. As a result, she had to find other ways to get the message as using Internet searches.

"I will not consider it like stress but I would like to mention it, the consultation, understanding the medical language in a foreign language. Certainly, I speak German but the medical jargon during pregnancy is not easy to understand. The doctor tells you something but you do not really understand, you say something but you are sure that the doctor did not understand it. This is stressful and consequently you have to make by yourself a lot of research. The language might be a problem especially when it concerns a domain and specific words are used. Even when you speak fluently the language, there are always words that you do not understand because they are technical words" (Nina).

Nina thinks it would be better for someone to discuss health issues in the language that s/he feels more comfortable with. Nina speaks fluently French and had the opportunity to be consulted by a doctor who could express herself in French. She felt so good because she could benefit from advices and ask her questions.

"It would have been wonderful to express oneself in a well-known language. I have been consulted in my workplace by a Doctor assistant in French, which I speak the best and I felt very good because she explained to me a lot of things" (Nina).

Julie encountered language difficulties during consultations. For these reasons, she was always going to the consultation with her husband as his German proficiency was better than hers, so that he could explain what she did not understand.

b) Special administrative procedures regarding the child's birth certificate

A birth certificate is a document proving the birth of a child and is necessary for the health insurance scheme and for the employer so that the employed parent can receive a salary during the maternity leave and other related benefits.

In some regions of Germany, there are restrictive administrative conditions for Cameroonians and it is the reason why Jade had to find the best way to avoid this situation. She got this information from a close friend whose child at one year old, did not have a birth certificate. According to the immigration office, there must be a verification of the parents' birth certificates. A procedure which can last three to six months and cost for both parents, a lot of money.

"I went to the immigration office to know which documents I need to provide to establish my baby's birth certificate, they answered me that as a Cameroonian, they will have to verify my own birth certificate and it can take three to six months for the procedure, which costs each 365 euros. That was already too much money to spend while we are expecting the baby to come" (Jade).

For Jade, it was a shock because she had already planned to give birth in a hospital in Frankenthal, which receive the most positive comments regarding the treatment of migrants during and after delivery. For this reason, she decided to travel to another country, where she has relatives and where she could without so many difficulties, have a child birth certificate.

"It has been a shock because, I have already planned after all investigations to give birth in Frankenthal and I am delivering soon… I was so stressed that I decided to go to give birth in France where my partner's aunt is living and at least there, I know, I can get the birth certificate of my child" (Jade).

It was not the end of her stress. Later, she learned that, as she has applied for German citizenship, by giving birth in another country, her child would not benefit from any advantages

in Germany like child allowance. This pushed her to find another region in Germany where she could deliver and get her child birth certificate within a short period of time.
Jade pointed out that it is because she is a migrant that she has passed through all this stress. ***"The fact that I am a foreigner had a negative impact; at the last stage of my pregnancy, I was under so much stress. If I were a German, I would have given birth at any place but because you are a foreigner, you do not feel comfortable but you have to overcome it" (Jade).***

c) Being treated with less consideration/respect

Being treated with less consideration and/or respect was exclusively by Jade who mentioned situations where she personally felt treated differently and with less consideration and respect in her workplace, by house owners and by her gynaecologist.

Jade said that as soon as she informed about her pregnancy, she had to perform more office work and the ambiance at the workplace was not nice. At the point that she felt guilty of being pregnant while it was a good thing. Apart from two colleagues, the rest did not congratulate nor give concern about her. The difference in her colleagues' behaviour was more obvious as another colleague gave birth before her. All the colleagues congratulate her and contribute to offer her a present. She was disappointed that only two among all contributed for her.
"I had the feeling that my pregnancy was bad news so I felt bad, guilty of something even though it was a good thing. Nobody congratulated me so I was waiting with impatience for my maternity leave... Only two colleagues were showing concern and asked sometimes how I was feeling, if everything was going well… Before me, another colleague, a white, gave birth, they were so happy that we collected some money and congratulate the person. I waited until I go to maternity leave to see. Actually, the collect is not mandatory, people give what they want. I understood that my case was embarrassing because when you give some money you sign and when I received my collect only two people have contributed. I do not know how to interpret this behaviour but I think it is because I am a migrant" (Jade).

Jade pointed out that the pregnancy has been a handicap for her while she was looking for a house. She said that although she was employed, the house owners did not want to rent their houses because during the maternity she would be depending on the social services and thus it would be difficult for them to receive their monthly rent.
"It was difficult as when people see a pregnant woman, they say that they do not want someone who is going to depend from the social services. I used to answer that I am working

but they replied that I am going to maternity leave and I will depend on social services and they are not sure that I will be able to pay the rent. I had as proof my payslip but it was not enough. I used even to lie that I will go back to work four months after delivery so that the person understands that it is only for a short period of time. The pregnancy has been a handicap to find a new house" (Jade).

At her gynaecologist office, Jade encountered twice, negative behaviours towards her. As she went to her gynaecologist office without appointment because she was not feeling the baby's movements and was afraid of miscarriage. She was shocked and felt devaluated when they asked her if she knows what a phone is or if she has one.

"For a first pregnancy, you can panic when you don't feel the baby's movements. For this reason, I went twice to the gynaecologist. I called first to ask for appointment but the secretary did not answer so I went directly there. When I reached the gynaecologist office, they asked me "don't you have a phone? Do you know what a phone is?" I was a bit chocked, I thought it was devaluating me because I am not sure they would have answered the same way to a German woman" (Jade).

d) Facing financial insecurity

The problem of finances was encountered by the students, Barbara and Nina. According to the Immigration Law paragraph 16 which concerns the students, they cannot receive any financial help from the Government.

For Barbara, it was one of the most important sources of stress. Being pregnant was a good news but it was not the right moment. As students, her husband and she could have part time jobs which was just enough for their needs; having a child means more expenses. She could not work anymore because of the pregnancy which has reduced their income. Receiving financial support was the only way to get a relief but unfortunately, she did not fill the requirements because she was a student.

"I like the children but it is not the appropriate time. I am happy when during the ultrasound, I can see the baby but at the same time, I am stressed… I am stressed about the financial situation… I made a lot of research on Internet to know how to get some financial help, German laws for internationals, how to I get any form of help, any support of assistance for mothers. Through these researches, I read that women who deliver in Germany and their baby receive some financial help. I went to ask and apply to the service in charge but

unfortunately, they told me that as a student with temporary residence permit (paragraph 16) I was not filling the conditions to receive this help. This has increased my stress." (Barbara)

For Nina, the financial insecurity was at another level. Her partner was employed so receiving enough money for their expenses. Her problem is that before her pregnancy she was working and could satisfy her needs. Now, with the pregnancy, she finds herself depending on everybody, her partner and her family. Being financially independent had a great value for her, being now dependent at the point that she hears sometimes that she asks too much, hurts her. Although she knew from friends that she could get some financial help, she thought it was better to accept and deal with her partner than depending from social assistance.

"Another stress was my financial situation; before I was financially independent but now I depend on everybody, I cannot work anymore as I was doing and sometimes it might the point that someone tells you that it is too much. Before you were doing it alone because you had your money but now it is no more possible, that might hurt and stress you… For those with financial difficulties, there are Diakonie and Caritas granting help. I have some friends who benefit from financial help because both partners were students and during the pregnancy, the woman could not work anymore…You have to tolerate because you depend on him if not you might end up being obliged to ask for social help." (Nina).

4.5 Psychologists as last option for counselling

Health practitioners are very important persons during pregnancy and for this reason, their relationship with the pregnant women have a great impact. This category discusses how the women perceive their care during their pregnancy and how they perceive psychological counselling.

The women were very satisfied with the German's health system regarding the care for the pregnant women. For Sandra, Denise and Nina, the pregnant women receive all the support and care they need during their pregnancy.

"We can congratulate the German health system which allows the pregnant women to receive good care and follow-up… The health insurance allows you many benefits: having a Gynaecologist who informs you about your health and the baby's health. As the pregnancy progresses, you can have a Midwife paid by the health insurance scheme who takes over the Gynaecologist after the delivery" (Denise).

"You have the possibility to have a midwife who will assist you at home. There are psychologists, family counsellors for those in need, there are many institutions. During consultation, one can express her difficulties" (Nina).

Nevertheless, none of them would have consulted a psychologist for different reasons.

Sandra would accept psychological counselling only from someone who shares the same culture or the same background. She thinks that: first, migrants' live difficulties that nationals cannot understand; second, they already have their own problems and cannot deal with her own; third, she values more the advices from her experienced mother than from someone who have learned through books.

"I think they have their own problems even if it is their work. We live in a society where we are from different race, culture, background, our daily situation is different and for these reasons, I fell they cannot understand me. I think they have studied in this field but my mother's advices have more value. Everything about counselling, either psychological or marital, I am not fan, it will the last thing to come in my mind… I don't know, maybe if it was in Africa that a psychologist counsels me, I would take it differently than if it is here because each one has his way of dealing with issues. When I see what we, migrants are going through and I listen to my European friends, I just shake my head. That's why I think they cannot have the appropriate solution to my problems and so I deal with it in another way. It is not really that I have my family but when I weigh both, I prefer to call my mother which will give one or two tricks to solve an issue than sitting for hours to discuss with a psychologist who learned through books" (Sandra).

Even though Barbara and Helene, recognized that they may have faced a prenatal depression, they would not have accepted any psychological consultation. What Barbara wanted was to be guided by someone who have faced the same situation or who knew about it. Sitting and discussing for hours with a psychologist would not solve anything. For Helene, it was normal to cry due to the hormonal changes.

"I would like to receive advice from someone who already passed through the situation. I want someone to reassure me that everything will be all right, someone to guide me… I suffered from depression but I do not need to discuss my problems with anybody (psychiatrist or health counsellor) but I needed solutions to my problems" (Barbara).

For Denise, it is only in Europe that people go to hospital to discuss about their emotional state. Even if she is living in Europe, she still keeps her cultural belief that sensitive issues are better discussed within the family or with close people and not with strangers.

"In case women express themselves, it is to very close people not to everybody. When I am stressed, I talks to my husband or my parents in Africa. When I have some fears, I call my mother to ask how to do" (Denise).

4.6 Coping strategies

Good coping strategies are important to deal with stressful situations. According to the situation women have developed strategies that helped them to manage this transition period.

a) Spiritual beliefs

Believing in God was the most common coping strategy among the interviewed immigrant pregnant women. For Sandra and Barbara, children are a gift from God. He cannot give you a weight that you cannot carry. Sandra added that no matter how difficult a situation can be, the patience is the key. Barbara said that He will give a solution to the problem on the appropriate time.

"The advice I can give is to enjoy the pregnancy, it is a gift from God not all women have this opportunity. Some women would give everything to have a child… I think God cannot give you a weight that you cannot carry, so there is always a solution, be patient and it will come. The patience is very important and the rest comes from God and the nature". (Sandra)

"I have Faith in God. I believe he knows everything and no matter what happens, we should continue to live. God makes things to come on the appropriate time. We have to live the present and not to think too much about the future because God will provide… In our culture, we always say that God will provide and that children bring good things in life". (Barbara)

Denise prays whenever she feels stressed about any situation because she thinks God has the last word on every situation.

b) Positive attitude

Sandra has developed a "sport spirit" as she calls it, which helps her to deal with every situation. She considers all situations as temporary and looks for ways to deal with them. She does not withdraw nor cry by asking "Why me" but she looks forward for solutions. She thinks there is no reasons to worry about thinks that you cannot change or do not depend on you.

"I have a sport spirit; when I face a situation, I just do my best to get the better results and move on. I keep this spirit in order to avoid excess stress. All situations in someone's life are temporary, it is the way I see things. Even the pregnancy, I do not see it like a stressful

situation but rather like a temporary situation to deal with… there are situations that you cannot change nor influence, you have to find solutions and move on with your life. If you keep thinking about the "why me", you will get depressed. I always look for solutions instead of thinking about the "why ", I always look forward, find solutions and move on" (Sandra).

Even though Sandra believes in God, she thinks that we have to find solutions ourselves because no one can find the ideal solution to your problem except yourself.

"I develop this character or spirit because no one will come from above to help you and here in Europe it is even more difficult to find someone who will support you so you have to find solutions by yourself. People may guide you but nobody will give the ideal solution to your problem except yourself" (Sandra).

Nina developed positive attitudes that helped to deal better with the others. She thought that she had to be strong in order to manage her partner's emotions.

"With the time, I develop self-attitudes to strengthen myself and to understand others. Sometimes, you get angry because your partner said something and he gets angry too, consequently, it brings you further than it was supposed to" (Nina).

c) Social network

Being surrounded with people (family and/or friends) with whom we can discuss and share our experiences and feelings have a great impact on mental health.

Apart from Sandra who could directly discuss with her sister and her mother (respectively during first and second pregnancy) and received from them direct support; Julie, Denise, Nina and Jade were either receiving advice and support from distance (phone call) or from very close friends.

"I had my sister near to me and she supported me since the first day. For my second pregnancy, neither; everything went well during the whole pregnancy and my mother came from Africa to help me, my husband and my sister were also there. Even though, my sister was no more living in Germany but in Switzerland, she took some time to come to assist me. I do not have real friends. I have my sister who is a great support if I need advice in any situation, she is the first person that I call" (Sandra).

Nina called often to receive advice and support from her sisters and her mother. As she could not deal with the housework, she could receive some advice from her mother on how she was handling similar situations.

"I discuss a lot with my elder sisters about the topics related to pregnancy because it is my first experience. My mother told that when she was pregnant, she used to cook in many small bits, not straight away. She was starting and when feeling tired, she was going to rest and continue later because the food has to be ready when her husband and her children will come home" (Nina).

Julie, Denise and Jade Julie benefit of the support from very good friends.

"I also benefit from the support from my Ivorian friends who living in different cities in Germany. With the help of my sister too, I managed this situation. I even ask to some friends in France to find it for me. If I cannot find something (referring to traditional food) here, I ask to my friend to send it to me and luckily, they find it easily in other cities or in France. When I have some fears, I call my mother to ask how to do" (Denise).

"I have also very three good friends like sisters to me; we know each other since in Cameroon. Two of them have already passed through this situation so I do not hesitate to tell them about my feelings. It is difficult to find people who keep your privacy (do not report to others what you confess to them). They helped me a lot, when I was feeling something, I explained to them and they reassure me that it is normal; they also felt that at some point of their pregnancy. Having people with whom you can discuss freely, helps a lot" (Jade).

d) Recreational activities

As recreational activities, Nina likes to walk, uses social media to change her mind, play games or listen to music. While Julie was feeling relaxed when watching movies, listening to music or walking to get some fresh air.

e) Nutrition

For Denise and Julie, eating special traditional foods made them feel good. When they could not find it in the city where they were living, they were asking their friends in other cities or even countries to provide it.

"There is something called "kaolin" that I really like to eat but it is difficult to find it. If I cannot find something here, I ask to my friend to send it to me and luckily they find it easily in other cities or in France" (Denise).

"I also lack of nutrients; I am not eating enough. In Nigeria, I could get anything I wanted. Here, there is only German food. The fruits are different and even when you find the same fruits, the taste is different. During pregnancy, there are some food that I have hunger for

but I cannot get them here. I cannot find the spices here. Some fermented foods that I like, are not here. The alternative that I can find here does not please me. Eating something I like also help to have good mood. There are a lot of sweet food which I don't like, during pregnancy, I prefer sour fermented foods. As I cannot find, my friend gave me the little she had but it quickly finished. Even the vegetables that I like, I could not find them. I was hungry but did not know what to eat" (Julie).

Chapter 5: Discussion

5.1 Discussion of the method

To explore the lived experiences of immigrant pregnant women, the researcher chose the constructivism approach. This approach uses subjective meanings to understand participants' lived experiences. The open-ended questions helped the researcher to understand how the immigrant pregnant women live their pregnancy in Germany and particularly how they feel and describe their mental health during this period.

The participants were recruited using both purposeful sampling and snowball sampling. The purposeful sampling focusses on particular characteristics of a population that are of interest, which will serve for best understanding and answering the research questions (Creswell, 2014; Mujere, 2017). The second strategy used is the snowball sampling which is a method of expanding the sample by asking one participant to recommend the study to other participants (Miles & Huberman, 1994; Marshall & Rossman 2006 cited in Yüksel & Yildirim, 2015). Furthermore, the participants are from five different countries, have various educational background, marital status and professions.

The researcher used reflexivity to understand how her positions and interests could affect the different stages of the study. Being an outsider has not been an easy role as the researcher had sometimes the same cultural background, the language and sometimes the same purpose of residence as many women. Nevertheless, the researcher did her best to keep her role.
The interviews were cross-checked by two readers. Each of them was asked to code the texts and had three interviews each. The purpose of the intercoder agreement was to determine if they would code the texts, find the same or similar as the researcher. The emerged themes or

codes were almost the same as the researcher. For a good qualitative reliability, Huberman (1994) cited in Creswell (2013), recommends the consistency of the coding be in agreement at least 80% of the time.

This study has some limitations. The researcher encountered participants who did not open themselves easily regarding sensitive issues like the depression. The qualitative method recommends to ask few questions (or just guiding questions) and let the participant to express herself. The researcher had to ask more questions to the participants to get a deep understanding of their experiences.

The researcher's target group were immigrant women who were not born in Germany and were living in the country for studies, work or family reunification purposes. She ended up having more women from Africa and particularly from Cameroon which might affect the generalizability of this research.

Although the researcher avoided to choose as participants the people that she knew, she had the feeling that the women with the same cultural background as hers, did not open themselves completely and selected the answers that would show a good image. Having participants from different countries and cultures would have given a richer discussion.

5.2 Discussion of the results

The objective of this study was to explore the lived experience of immigrant women during their pregnancy. To the question concerning their mental or emotional health during this period of transition, the first reaction is the comparison between their country of origin and their host country regarding the psychological health, the expression of feelings and the care for pregnant women.

Although they live now in Germany, their perception of psychological health, their help-seeking behaviour and their access to mental health services are still influenced by their culture of origin. These findings are consistent with the findings of O'Mahony & Donnelly (2007) which state that culture is a strong determinant on how immigrant women would access mental health service and respond to mental health problem. The women think psychological issues have a negative connotation and are considered like a weakness, a shame, a taboo, something people hide or do not discuss openly (Salami et al, 2018; Lubman et al, 2014; Amankwaa, 2003; O'Mahony & Donnelly, 2007) and for these reasons, they deny it and are reluctant to ask for help. For those who acknowledge that they might be suffering from depression, they are hesitant

to ask for help because they are afraid of been stigmatized by their community. This is consistent with O'Mahony & Donnelly (2007) which found that in some situations the immigrant woman would isolate herself because of fears of community backlash. It was noted that even when mental health services were available for these women, the stigma and shunning from family and community exerted stronger influence over the women's mental health care behaviour. Thus, the lack of community support and high stigma regarding mental health might be other barriers to seeking mental health care services for some immigrant women.

The study revealed that immigrant women are not opened to discuss sensitive issues like mental or emotional health with people they do not know (Gardner et al, 2014). When they face a stressful situation, they look for solutions within their families. In their study, O'Mahony & Donnelly (2007) found that counselling or "talk therapy" can be viewed as intrusive and might not be an acceptable treatment modality for some immigrant women. Talking to someone about a mental health problem outside the family could be seen as a dishonourable behaviour. Thus, adopting Western biomedicine mental health care approaches is a cultural leap that is difficult for some immigrant women to make. These women would prefer to visit psychologists as their last option, when they could not find any other solutions or they have tried but nothing worked. Among the reasons for not consulting a psychologist are the difference of culture but also the lack of trust in the way they would deal with their situation but they rather prefer their family and traditional solutions (O'Mahony & Donnelly, 2007) most of the women do not consider their symptoms as an illness that needs medical attention (Gardner et al, 2014) but rather as a situation that will fade with the pregnancy.

The women mentioned that although a psychologist is their last option, they would accept to visit one who shares the same culture or has some knowledge about their culture of origin. The women just want someone who understands their culture and point of view (O'Mahony & Donnelly 2007; Ny et al, 2007; Lundberg & Gerezgiher, 2008). The level of cultural understanding by the health care provider was seen as an important factor in providing appropriate and quality mental health care. Thus, viewing immigrant women in a holistic manner would contribute to the health care provider's understanding of the social cultural context experienced by these women. (O'Mahony & Donnelly, 2007)

In their study, Sharapova & Goguikian Ratclif (2018) found that the attachment to heritage culture plays a role in the development of antenatal depression because the motherhood occurred far from their families and cultural framework and thus far from the usual intergenerational transmission of and guidance practices. In my study, the women who were

attached to their culture and did not have family members or relatives in Germany were longing more for lost familial ties and presented more depressive symptoms than the ones who have family members in Germany. Koneru et al (2007) suggest that the migrant mothers should adopt a bicultural identity which mix both their culture of origin and the host culture during the acculturation phase. Bina (2008) cited in Sharapova & Goguikian Ratcliff (2018) concluded that the maintenance of cultural traditions in the host country could be at the same time a risk factor and a protective factor against depressive symptoms; therefore, the role of attachment to the heritage culture varies among individuals and contexts.

The women mentioned the difference in the concept of care for the pregnant woman. The women connect the psychological health to the system of living. The more the people around the pregnant woman, who is considered like a princess, the better is her emotional health. In their study, Hyman and Dussault (2000) found that the women who were in close proximity with other members of their ethnic community were experiencing less psychosocial concerns because they were feeling secured in their social networks. Nevertheless, Sandra and Julie mentioned that been surrounded with people is not enough but it depends on the relationships the pregnant woman has with them; if she feels comfortable to discuss sensitive issues and been understood, it is also important.

The women mentioned about the risk factors according to their respective experiences and were feeling at risks due to their migration background. They consider not to be able to receive care from their mother as difficult. Their general wellbeing during the pregnancy would be better if they could benefit from the physical presence of their mothers (Ny et al. 2007; Fair et al. 2020). Discussing and receiving advice from the phone do not have the same impact as direct contact with the person. Nevertheless, Barbara and Julie did not inform their mothers of their pregnancy because informing their mothers would mean discussing about diverse issues including the difficulties they were facing. For these reasons, they prefer not to inform and thus avoid their mothers to worry about them.

Loneliness is mostly expressed by the women who, apart from their husband with whom they can discuss, they have nobody else (no family, no friends) in their host country (Nahas et al, 1999). Many studies show the importance of family and social support from friends during the pregnancy. While many people will look for ways to create more relationships as they are lacking their families, Barbara and Helene close themselves for one reason or another. Barbara does not know anyone who is facing or has faced the same situation to advise her. Helene feels worse when people have empathy for her. Their behaviour is contradictory with others studies

(Gardner et al, 2014; Callister et al, 2011; Ahmed et al, 2008; Grewal et al, 2008; Thornton et al, 2006; Nahas et al, 1999) in which women open themselves and found support from family, friends or community, as did the other migrant pregnant women of the study.

There are different opinions regarding the body image of pregnant women during their pregnancy. While some studies (Clark & Ogden, 1999; Loth et al. 2011, cited in Meireles et al., 2014) founded that pregnant women were less dissatisfied with their body image than non-pregnant women, other studies (Kendall et al. 2001) showed that pregnant women like less their body compared to non-pregnant women. In this study, apart from Helene, most of the women are satisfied or do not give particular attention to their body image. According to Silveira et al. (2015), social support is a potential confounder that many studies did not consider; it has an impact on body image dissatisfaction and depression during pregnancy.

Helene who did not like her body image remained closed to herself, withdraw from many activities, and had less self-esteem. This finding corroborates the findings of Karmierczak & Goodwin (2011) found that good body image was positively associated with self-esteem.

The women mentioned that although their language knowledge was good, they could not understand the medical jargon (Balaam et al, 2013) which had negatively impacted their communication as they did not understand the doctor. Being consulted by a health practitioner who was speaking the same language (Illiadi, 2008) make them feeling better, more understood and they could ask more questions. In contrary, Ny et al (2007) found that understanding the woman's native language or her culture was not vital to develop a good relationship with the midwife. Instead the immigrant woman developed trust in the midwife based on the knowledge and the empathy the midwife imparted.

The women felt devaluated and discriminated by their health carers (Straus et al. 2009; Robertson, 2015; Lephard & Haith-Cooper, 2016). They would have liked to visit their health carer when they were feeling stressed or in need even without appointment (Becky &White 2010). O'Mahony & Donnelly (2007) state that this behaviour was unintentional but due to different styles of communication which might be perceived as discrimination. Immigrant women may perceive communication differences as discriminatory because the health care provider's style could be very confrontational. This created a lack of connection and poor relationship with Health professionals (Fair et al. 2020) which push them to ask advises from friends and family when facing stressful situations and not willing to visit the same professional for their further pregnancies.

For many immigrant pregnant women, their husband is the closest person and sometimes the only support that they have. For this reason, his behaviour has a huge impact on their mental health. When this one is caring and when they feel understood by him, they are also mentally or psychologically good. As in my study, Ny et al (2007) found that women saw their male partners as supporters, someone to pave the way for them during pregnancy and delivery.

It was identified that spirituality was very much a part of the immigrant women's culture and way of life. For some immigrant women, utilizing these practices was a normal and accepted way to manage their health concerns. Spiritual and religious practices such as daily prayer and attending church were seen as sources of strength, comfort, and part of the context of their health practices (Nahas et al, 1999; Meadows et al, 2001; Gardner et al, 2014; Shafiei et al, 2015). The women were most of the time referring to God as the One who can solve any difficult situation, who has the last Word and who blesses mothers and their babies. Although their spiritual belief helped them to cope with their stressful, it was not perceived as a barrier to seek mental health care (O'Mahony & Donnelly, 2007). They women were willing to seek help if the symptoms did not fade over a certain time.

Chapter 6: Conclusion and recommendations

The research aimed at exploring and gaining an understanding on mental health of immigrant pregnant women in Germany, focussing on prenatal depression. The study revealed that the women considered psychological problems not only a taboo but also as a disease of wealthy people. The women were not interested with their mental health but rather how to deal and manage their daily struggles. The interviewed immigrant pregnant women are at risk of antenatal depression for a variety of reasons: they expressed loneliness and useless, missing family support and care especially from their mothers, facing financial insecurity and discrimination. Because they are far away from their families, the women cannot benefit from the special treatment "as a princess" as it would have been in their country of origin. Instead the women mentioned feeling like servants as they have to still care for their husband and family although they are not feeling good. Most of them did not pay a particular attention to their physical appearance and the one who found herself ugly tended to reduce her social contact and thus expressed feeling lonely.

For most of the women, their spiritual belief was the most important protective factor as the women considered God as their source of strength, the One who can solve all the difficult situations and the One who has blessed their family with a child. Their husband or partner and social support represented their other protective factors during this transition to motherhood.

Due to the attachment to their culture of origin, the women thought that only a health professional who has some knowledge of their culture and conditions could provide effective counselling. In the same way, their social support was mostly people from the same origin because the others (not from the same culture) could not understand their reality. Regarding their needs, the women want to be treated with more respect and consideration by their health practitioners and in their daily interactions in the society.

As the women's cultural attachment and beliefs about mental health can prevent them from opening themselves and seek for help, it would be recommended that the health practitioners (Gynaecologists and midwifes) develop more cultural approach to better access immigrant women mental health. A screening would be a preventive measure and therefore, help to reduce all the effects due to perinatal depression. Due to the fact that the immigrant women were not aware of depression in their country of origin and that their living conditions and their realities are not the same as the non-migrant pregnant women, a more culturally screening tool would be more appropriate to detect their mental health status. Assessing immigrant pregnant women mental health should be an integrative part of the antenatal care. Because they are considered

as protective factors, the husbands or partners should be more integrated in the mental aspect of the antenatal care, as it is already done during the preparation to birth classes. The women are in general satisfied with the care they receive in Germany during their pregnancy. The services offered to immigrant pregnant women are mostly consistent with the WHO guidelines. Regarding the administrative regulations, the immigrant women should be informed through various ways and the information should be given in different languages in order to avoid induced stress.

Further researches are needed to address and deal with mental health issues in population with migration background in Germany, particularly during the prenatal phase. Performing the studies in other languages might be challenging but it could help to include more immigrants and thus have a better representation of the population. To enrich the results of this study on the mental health of immigrant pregnant women, a larger study is recommended.

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Appendix

Appendix 1: **Flyer - Search for participants and invitation to interview**

Is Pregnancy always happy?

How do you live your pregnancy in a foreign country?

If you:

- are a pregnant woman
- are born and raised in another country
- speak English or French

You are kindly invited

I am Germaine, Master in Public Health student. I am currently writing my Master thesis on the **Health of immigrant women during pregnancy**. For this purpose, I would like to invite pregnant women to a focus group discussion or an interview in order to hear about their experiences as being pregnant in a foreign country, how they live this transition, learn about their daily stresses during the pregnancy period, the ways of dealing with and what are their needs during this period. I would kindly appreciate your participation to this research.

If you are interested, contact me: Phone number: **0176 87 446764**

Email: **mph.research18@gmail.com**

Appendix 2: **Invitation letter to participate in an interview or focus group discussion on Prenatal Depression in Migrant Women living in Germany**

Dear Mrs/Ms**,**

my name is Germaine Marie NGO HANNA, Master in Public Health student at the Hamburg University of Applied Sciences. For the completion of my Master program, I am conducting a research on Prenatal Depression in migrant women and I would like you to participate.

I am interested in researching how migrant women experience life during pregnancy. During the interview, I will ask you questions about how your experience of motherhood during the prenatal period. *What do you know prenatal depression, your experience, how to deal with it and how women can prevent it?*

Depending on the availability of the participant, there will be in-depth interviews or focus group discussion.

The in-depth interview will be a face-to-face or phone call interview taking place at the participant convenience time and place. It will lasts 45 minutes to an hour.

The focus group (small discussion group) will take place on an arranged date and place and lasts between one and half to two hours.

I will collect some personal information as your age, country of origin, educational background, marital status, number of children. You will be attributed false names for this purpose. All the given information will be kept private and confidential. This is an academic research and your details will not be used for any other purposes. The interview will be audio-recorded so that I do not miss any detail on what will be discussed.

There are no right or wrong answers, only your thoughts matter. Your participation to this research is voluntary so you may also decide to withdraw at any point of time during the process or not answer some questions that you don't want. The participant consent form will be given to you prior to the discussion.

I will be glad to answer any questions you may have regarding the study. Feel free to contact me at this email ***mph.research18@mail.com*** or through this phone number: ***0176 87446764*** if you want to have more information about the research.

Your participation in this research will be of great importance and help us to learn about the migrant women's perceptions on prenatal depression and ideas to deal with and prevent it. This knowledge, we hope will improve support and services provided to migrant pregnant women in Germany.

Thank you for your precious time and the consideration of my study.

Sincere Greetings,

Germaine Marie NGO HANNA
Master in Public Health Student

Appendix 3: **Participant information sheet**

You are invited to take part in a research study regarding the knowledge and practice of antenatal depression in Germany. The researcher is inviting pregnant Immigrant Women who were born and raised up in another country and migrated in Germany as adults for any reasons. This letter of consent is entailed to give you the necessary information that you need before deciding whether or not to take part in the research study.
The study is conducted by the researcher Germaine Marie NGO HANNA, Master student at the Hamburg University of Applied Sciences for the completion of her Master Degree in Public Health.

Study title: *Immigrant Pregnant Women's Mental Health in Germany: Perceptions and Concepts of prevention of Antenatal Depression- a qualitative study*

Aims/objectives of the study:

i. understanding immigrant women knowledge about depression during the pregnancy period
ii. what are their personal experiences as living in a foreign country
iii. learning about how they deal with and would prevent it

Procedure:

You will be asked to complete a demographic questionnaire including questions as your age, country of origin, marital status, income and level of education. The questionnaire will include questions related to your migration status as number of year in the country, actual residence status, family relationships. The last part will be an interview including questions as:
How do you define prenatal depression?
What do you consider as stressful situation needing an external help (that you cannot cope alone)?
Do you feel endangered of prenatal depression and how do you deal with it?

Disclaimer

Your participation to this study is voluntary. It is your free will to take part or not. There will be no consequences of any sort if you decide not to participate. You are also free to stop at any point of time. If you decide to withdraw from the study, your data will be destroyed. However, if you decide to withdraw 3 months after the interview, it may not be possible for the researcher

to remove/destroy the information you have provided as it may already be included and analysed as a part of the research as a whole.

Risks, discomfort or distress during the interview

There is a little threat of risk that you may experience in the course of the study. This may arise because we will be discussing about issues that could cause distress or discomfort. In this case, we could stop partially or completely the interview if you are no able to proceed.

Benefits in participating to the study

We hope this study will help to understand how migrant women perceive prenatal depression, how they deal with stressful situations during pregnancy period and what can be done to prevent migrant maternal depression. It may also help the health professionals to understand what type of support to provide to migrant women during the pregnancy.

Remuneration

There will be no financial remuneration for participating in the study.

Data confidentiality

The researcher will follow ethical and legal practice. All the given information will be kept in confidence. Your personal data will be used only for the purpose of the study and if there is a need to contact you. Otherwise, false names will be assigned to you during the information processing and any publication, so that no one could recognize you. If you decide to withdraw from the study, your data will be removed as well.

The interview data, audio recordings and printed documents will be kept locked in a secure location.

Appendix 4: **Participant Consent Form**

Title of the study:

Immigrant Pregnant Women's Mental Health in Germany: Perceptions and Concepts of prevention of Antenatal Depression- a qualitative study

I have read the information leaflet relating to the above program of research in which I have been asked to participate. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data.

I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.

Having given the consent, I understand that I have the right to withdraw from the study at any time up to 3 months after the interview date, without disadvantage to myself.

Participant's name:

---------- Signature

Researcher's name:

---------- Signature

Date: _____

Appendix 5: **Questionnaire to participants**

Demographic

Name: _____

Telephone number and e-mail:_____

Age: How old are you? _____

Country of origin: _____

Education: what is the highest degree or level of school you have completed?

High school graduate ☐ technical/vocational training ☐ University degree ☐ other ☐

Household

Marital status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Current relationship with baby's father? Yes ☐ No ☐

How satisfied are you with the relationship? Very ☐ somewhat ☐ not satisfied ☐

Housing: where do you live? own ☐ rent ☐ parents ☐ room & board ☐ other ☐

Number of adults in household_____ Number of children under 18_____

Adequate/suitable yes ☐ no ☐ Plan to move: yes ☐ no ☐

Employment status

Employed for wages ☐ Self-employed ☐ Housewife ☐ Student ☐ other ☐

Your family income: (√ one only)

Social assistance ☐

Less than 12,000/yr ☐

12,000 - 24,000/yr ☐

24,000 - 50,000/yr ☐

More than 50,000/yr ☐

Other financial support

Are you getting? Employment Supplement ☐ Bank funding ☐ Student loan ☐

Familial support ☐ Partner support ☐

Do you have any financial concerns: Yes ☐ No ☐

Present pregnancy

Do you use birth control? Yes ☐ No ☐

Did you plan this pregnancy? Yes ☐ No ☐

How do you feel about the pregnancy? Happy ☐ Scared ☐ Overwhelmed ☐ Not happy ☐

How does your partner and/or family feel about the pregnancy? Happy ☐ Unsure ☐ Overwhelmed ☐ Not happy ☐

How would you rate your overall health today?

Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

Do you plan to breastfeed? Yes ☐ No ☐ Undecided ☐

Are you interested in Prenatal Classes? Yes ☐ No ☐ Undecided ☐

Migration status

1. Since how long are you in Germany?

   Less than 2years ☐ 2 to 5years ☐ 5 to 10years ☐ more than 10years ☐
2. Do you speak German language? Yes ☐ No ☐
3. Do you feel integrated in the German society? Yes ☐ No ☐
4. If yes, how? ___
5. When did you visit your home country for the last time? _____
6. Do you have family or relatives living in Germany or in Europe? Yes ☐ No ☐
7. Do you visit each other regularly?
8. Is it possible to have assistance and help from members of your family during and after your pregnancy? Or when you need some advice?

Prenatal depression, care and prevention

1. Can you tell me anything about prenatal or antepartum depression?
   - What could cause it?
2. Some studies have shown a relation between stress and depression. What kind of situations stress you and how do you deal with it?
   - Where or to whom do you turn to?
3. What do you think about maternal depression prevention?
   - What is your experience as being pregnant in a foreign country?
   - How can migrant women prevent from developing or deal with prenatal depression?
4. How do pregnant women discuss about their feelings in your country of origin?
   - with whom?

5. What do you think about a particular attention/emotional support from health practitioners to migrant women during the prenatal period?
    - what kind of support would you expect?
6. Tell me about yourself in regard to prenatal depression?
    - What makes you feel endangered or not?
    - How do you deal with it?

Appendix 6: **Questionnaire for experts**

1. Seit wann bietet die Caritas schwangeren Frauen Hilfe an?
2. Woher wissen die Menschen von den Caritas-Angeboten?
3. Wie hoch ist der Prozentsatz der Einwanderer (nicht Deutschen), die von Ihren Dienstleistungen profitieren?
4. Was sind ihre Nationalitäten? Alter, Status, Beruf?
5. Welche Problemen haben diese Frauen?
6. Welche Art von Unterstützung bietet die Caritas?
7. Ist die gleiche Unterstützung für alle oder es gibt einige Besonderheiten (Studenten, Flüchtlinge, alleinerziehende Mütter)?

Appendix 7: Child does not get a birth certificate

m.westfalen-blatt.de/OWL/Kreis-Paderborn/Paderborn/3914378-Standesamt-bezweifelt-Identitaet-des-inzwischen-deutschen-Vaters-Kind-bekommt-keine-Geburtsurkunde

Menü Suche Anzeigen Unternehmen Verlag Karriere WB-Welt Abo Portale

Dienstag, 13.08.2019, 05:00 Uhr aktualisiert: 13.08.2019, 07:06 Uhr

Standesamt bezweifelt Identität des inzwischen deutschen Vaters

Kind bekommt keine Geburtsurkunde

Seit Januar vergangenen Jahres wartet eine Studentin aus Paderborn darauf, dass das Standesamt ihr die Geburtsurkunde für ihr Baby ausstellt. Doch die Behörde zweifelt daran, dass die Geburtsurkunde des Kindesvaters echt ist. Foto: imago

Paderborn (WB). Seit mehr als eineinhalb Jahren verweigert das Standesamt Paderborn einem Kind die Geburtsurkunde. Der Vater spricht von Behördenwillkür. Von Christian Althoff

Christian Nkombou (34) stammt aus Kamerun. Er ist Psychiater und arbeitet am Knappschaftskrankenhaus Lütgendortmund in Dortmund. Seit 13 Jahren lebt er in Deutschland, vor acht Jahren wurde er eingebürgert. »Seitdem bin ich Deutscher«, sagt der Arzt und zeigt seinen Personalausweis. »Ich musste meinen kamerunischen Pass abgeben und gelte da jetzt als Ausländer. Ohne Visum kann ich nicht mehr dorthin.«

https://m.westfalen-blatt.de/OWL/Kreis-Paderborn/Paderborn/3914378-Standesamt-bezweifelt-Identitaet-des-inzwischen-deutschen-Vaters-Kind-bekommt-keine-Geburtsurkunde

Appendix 8: **Researcher's diary**

Even if the participant's story is very similar to mine, it was not my intention at the beginning of this research.

I have always been interested in women's health and health promotion. In the process of finding my research topic, I searched for the women health issues. In the list of eight most frequently illnesses posing considerable health risks: heart disease, breast cancer, ovarian and cervical cancer, gynecological health, pregnancy issues, autoimmune diseases, depression and anxiety, health technology for women; I was interested with three: Heart disease, pregnancy issues and depression and anxiety. Within the three, I decided to join pregnancy issues and depression.

During my study program, I did an assignment on postpartum depression, "Can family support reduce the incidence of postpartum depression?". My thought was that women in developing countries have a lower prevalence to PPD compared to women in developed countries, because I thought the family environment (extended vs nuclear) family organization respectively in developing and developed countries has an impact on how women experience postpartum period. The literature shows that depression is higher in developing countries compared to developed countries. The family support is protective factor but many other factors impact on the incidence of postpartum depression.

I got interested to learn more about it but in another way. As there are many studies on postpartum depression, why shouldn't I investigate about something new or not as common as antenatal depression and learn how immigrant women who have lost an important protective factor as family support, live their pregnancy in a foreign country? Are they more susceptible to develop depression? It is after all this brain storming that I realized that it was part of my story and that increased even more my interest for this topic.

My target was immigrant pregnant women who were not born in Germany and was living in the country for studies, work or family reunification purposes. I ended up having more women from Africa and particularly from Cameroon. In this situation, it is not very easy to stay as an outsider because the researcher and the participants share culture, the language and sometimes the same purpose of residence.

Through this experience, I improved my interview techniques.

Interviewing is not only a process of standing in front of people and ask them questions about your topic of interest. Before engaging in this process, the researcher must learn qualitative methods and how to perform it in order to gain the maximum or what you need from the participants.

I did the first draft of my study questionnaire trying to pick some questions from other studies similar to mine but I realized that they were not appropriate as the studies that I found where mainly about the prevalence and risks factors for developing perinatal depression while my study is about the women perception of perinatal depression. I, then tried to develop questions. I was just writing what was coming out of my mind and ended up with 16 questions.

With these 16 questions, I did my pilot study. During the first interview that I made, I was a bit stressed because it was my first real experience and I was wondering if I will get interesting answers from my questions. Over the course, I was feeling less stressed but I could not follow the questions as I stated on the paper. I realized, first that 16 questions were too much and I had to just pick the ones that I taught to be the most important. My second remark was that I was distracted when trying to choose or modify the questions and I was missing my active listening.

After this first interview, I decided to use my questionnaire as it was so that I could stay focused. At the end, I was happy, I did it. It was the beginning of a long journey and I was excited.

The second interview was completely different because the participant did not want to be recorded, so I had to write everything. This has changed the course of the interview and made it more difficult. I tried to convince my participant but she insisted, I was the one in need so I had to manage. Writing while somebody is talking require a training and I was not equipped with the necessary tools for this process. I had to try my best.

As I decided after the first interview to keep my questions so that I could be more focused, I did it. During the process, we both (the participant and I) realized that there were questions so similar one to the other that there was no more need to answer. I felt embarrassed due to the situation because I felt incomplete, I needed to improve my questionnaire.

It is during the report of my interviews to my supervisor that I realized that I did not send her the questionnaire, so she had no idea about it. I the send it and she made some remarks and gave me advices:

- I had to read how to formulate questions for a qualitative research

- There were too many questions, I had to reduce them by half
- Many questions were identical, I had to combine them

I followed her advices and revised my questionnaire. I end up with 8 questions instead of 16. We had a meeting and worked a bit more on the questionnaire, and I had to send her the revised version. What a shock when she told me that this version was worse than the previous one apart from the number of questions. She sent me back to read and learn how to formulate questionnaire. It was a bad news, as I thought I did my best and was quite happy about it.

As I am keen to learn, I went back to research about qualitative research questionnaire. I realized that by trying to improve, I worsened it, I removed the most important aspect of the questions, the open-ended form and replace it with the "Yes or No" which was completely denaturing it. How difficult and complex can be the learning process! But to know, we have to pass through different stages. At the end I learned.

I did not want to be super excited this time, I revised the questionnaire taking into account all aspects and sent it to my supervisor. How happy was I when she told me that this version was very good, made very few remarks on it and agreed that I should start the interviews. I was so happy and did not hesitate to let her know about it. I have learned.

For the 3rd interview, I was a bit anxious but tried to keep calm and professional. I present myself and my project to the participant and explain her what I expect from her. I told her that my purpose is more to listen to her story and experience, I will just be guiding her by asking sometimes a question.

The interview went quite well, I was happy. I felt a big improvement compared to the previous interviews: I was focused, I could listen to her and ask questions according to what she was mentioning, I was using my guiding questions but was not sticking to it but letting the participant bring new themes and issues. I had to rephrase some questions to fit the situation.

I know there is always room for improvement, this interview was good but I want the next to be better and will reflect on it.

The more I was interviewing the participants, the more I was improving. I was no more feeling stressed when preparing for, it took me less and less time, I was feeling confident during the process and more able to listen and react and more important to formulate questions according to the participant's story.

During this whole interview process, I felt sometimes discouraged and disappointed because I had the feeling that the participants were not really giving me what I was expecting. Pregnant immigrant women face difficulties during this time, they talk about it during informal sessions but when I expected them to tell me their story, it seems like they did not have problems anymore. The reality is that I have to do only with what I have and not create my own stories according to what I know.

My wish was to perform a focus group, invite many women to discuss and exchange opinions about the topic. During this exchange, women can bring out more issues that they would not have thought about during an individual interview. I real wanted to do this focus group because my supervisor and a friend who had the opportunity to perform it for her research told me that it was a very good way to collect interesting data. After few months trying to gather women, I had an experience that completely discourage me and at the same time, I learned from it.

As I got most of my participants through "snowball strategy", I had a great opportunity to perform a focus group. I had eleven potential participants to whom my project have already presented, I just to contact them myself and explain more about the topic, the interview and their participation. I used many ways, e-mails, telephone calls, WhatsApp messages. At the first attempts, seven answered, within them three told me they were not willing because of time constraints, two could not because of family problems and location. Within the last two, one gave birth before the date and was no more willing and the last, could not make an interview but was willing to answer the questions in written form. I was so disappointed; I was so close to realize something whished and planned for so long, I had at a moment in time eleven potential participants and at another point of time, nothing. It took some time to accept it but I had to move on.

Because I was looking for the perfect story and mostly because I was trying to find a way to make a focus group, I kept on extending the period of data collection.

Through this experience, I have learned about qualitative research, different types of interviews and how to perform. Another important aspect, I learned to set a period of time for every part of the research process, never underestimate what you have but try to bring out the best of it; In each experience, there is something to gain even in the hard or difficult ones.

This process has not been an easy one for me because I have the same origin as many of my participants. In the African culture, people do not open themselves easily, especially when it

regards private issues. It might be the reason why, my interviews were short. My goal was to guide the questionnaire and let the person express herself but unfortunately as they are not used to open themselves to strangers, they did not have much to share with me even though we have the same origin or were retaining some important aspects of their private life.

Appendix 9: **Participants interviews**

Transcription Interview 1

Interviewer: the researcher

Interviewee: [redacted]

Date: 28/02/2020

Q1: Have you ever hear about prenatal depression?

A1: Yes, it is not a new term for me, it is not a taboo in the German society but for the migrants, it is not something that people talk about frequently.

Q2: What can be the causes, according to you?

A2: I think the causes can be first of all, that we are immigrants meaning that we are not living with our families. The life as a migrant is not easy and not having the family nearby make things even more difficult and can result in depression because we cannot receive the same care and support from our family during the pregnancy as in Africa. Here, in Germany, you have to deal with the challenges by yourself without having a daily support. You can benefit from administrative support, from different departments taking care of pregnant women but the human warmth is lacking. If it is your first child, it will be difficult for you to cope and can result in depression because of the fear of the future.

Q3: Regarding you personally, did you experience such in one of your pregnancies?

A3: No, for my first pregnancy, I did no live it for long as I discovered that I was pregnant at the 6th month so I did not have time to think about it and at that time, I had my sister near to me and she supported me since the first day, so I did not experienced it. For my second pregnancy, neither; everything went well during the whole pregnancy and my mother came from Africa to help me, my husband and my sister were also there. Even though, my sister was no more living in Germany but in Switzerland, she took some time to come to assist me. For this pregnancy, the 3rd one, I am not afraid, I have learned already with the previous ones what I can do, the preventive methods to avoid it.

Researcher: it is very important to have people who can assist you during these periods. For many women, it is not only about family assistance but also how to adapt to their new

environment. This might not be your case as you are here since a long time and you are used to this system.

Interviewee: the fact that immigrants in a new country always want to stay with those with whom they share the same culture and do not integrate the host culture make their life more difficult. Being with people with whom you identify yourself is good but in difficult situations, you may have the same thoughts and sometimes, it does not help. Discussing and exchanging with Nationals, changing your environment is certainly not the same but it helps to see things in another way and when you face a situation in which you don't know from where to start, this collaboration can be very helpful. This phenomenon is not only common to Africans but also Turks and Arabs. I just hope it will change soon.

Q4: which kind of stressful situations did you face during your pregnancy?

A4: Finding a new house has been very stressful, where I am living is already small and I was wandering if I will be able to find one. It was just a temporary situation. I have a sport spirit; when I face a situation I just do my best to get the better results and move on. I keep this spirit in order to avoid excess stress. All situations in someone's life are temporary, it is the way I see things. Even the pregnancy, I do not see it like a stressful situation but rather like a temporary situation to deal with. The situation might be different for a woman who is expecting her first child. I already know what to expect but she will not. It also depends on her age and her situation.

Q5: What is you secret to keep your sport and positive spirit?

A5: My secret "Laughter…."there are situations that you cannot change nor influence, you have to find solutions and move on with your life. If you keep thinking about the "why me", you will get depressed. I always look for solutions instead of thinking about the "why ", I always look forward, find solutions and move on. I develop this character or spirit because no one will come from above to help you and here in Europe it is even more difficult to find someone who will support you so you have to find solutions by yourself. People may guide you but nobody will give the ideal solution to your problem except yourself.

Q6: When you face a difficult or stressful situation, apart from finding answers by yourself, do you sometimes turn to someone for advice?

A6: I do not have real friends. I have my sister who is a great support if I need advice in any situation, she is the first person that I call. When she gives me her opinion, I weigh the pros and

cons and I take my decision. My husband is also there for daily support. I think an outsider is never the ideal person to find solutions to your problems, s/he has her/his own problems to deal with. Here in Europe, people pretend more to be so to avoid my private life to be exposed outside, I prefer to deal with it at home.

Q7: Regarding professional assistance, did you ever think about?

A7: No, laughter… I think they have their own problems even if it is their work. We live in a society where we are from different race, culture, background, our daily situation is different and for these reasons, I fell they cannot understand me. I think they have studied in this field but my mother's advice have more value. Everything about counselling, either psychological or marital, I am not fan, it will the last thing to come in my mind.

Researcher: In your case, your family is very near and present so it is enough for you. Many do not have this chance and cannot find solutions to their worries that is the reason why they are depressed.

Interviewee: Because I am here since a long time, I know both cultures and I am proud to have lived the first part of my life in Africa and when I came here my sister has made all efforts so that I should not lose my culture. I don't know, maybe if it was in Africa that a psychologist counsels me, I would take it differently than if it is here because each one has his way of dealing with issues. When I see what we, migrants are going through and I listen to my European friends, I just shake my head. That's why I think they cannot have the appropriate solution to my problems and so I deal with it in another way. It is not really that I have my family but when I weigh both, I prefer to call my mother which will give one or two tricks to solve an issue than sitting for hours to discuss with a psychologist who learned through books. Nevertheless, I know that some people do not have a strong character like mine and who need this assistance. Because this lack of family support and atmosphere, it is not also all the African parents who deal or react the same way, rituals. Concerning the pre and post-partum periods rituals, they differ from one culture to the other. Your belief in what you hear and do have also an impact.

Q8: Do you think it is common to discuss about psychological issues during pregnancy in your country of origin?

A8: No, it is not common, even now when you talk about psychological problems, it is perceived in African culture like weakness even though it is not always the case. Concerning pregnancy, there are cultural ways to prevent post-partum depression, I know what to take to

avoid depression. I don't know about other cultures but I used these preventive methods after my previous deliveries and it worked so I will do the same for this and hope for a positive effect.

Q9: Do you think it would be important for migrants to benefit for psychological assistance or do you think we should keep our culture?

A9: on one hand, I think we should keep our culture but nevertheless when one sees that is not working for her, which is an individual thought, man should seek for more suitable support. I know women who had depression due to miscarriage, marital problems. The problem is first to acknowledge that you are in need. We are so much afraid of what they others will think and say about that we do not seek for help. Another cause of illness is the loneliness even when you are married, it is not all woman who share everything with her companion. Some men do not understand the situations their wife go through during and after pregnancy, for example that a woman might 6 months to accept her body again. This creates a situation in which you have opposite thoughts which can create depression. The couple situation and their respective education has also an impact.

If I realize that all the preventive methods that I used are not working, I know where to find professional help.

Q10: Which advice can you give to other women to avoid depression?

A10: Laugh….The advice I can give is to enjoy the pregnancy, it is a gift from God not all women have this opportunity. Some women would give everything to have a child. I know it because I passed through many miscarriages so I know what I am talking about. I think God cannot give you a weight that you cannot carry, so there is always a solution, be patient and it will come. The patience is very important and the rest comes from God and the nature. Health is another gift that all do not have so when you have a consultation and everything is fine for you and the child, you should not worry.

Transcription Interview 2

Interviewer: the researcher

Interviewee: [redacted]

Date and time: 30/02/2020 at 11am

Q: what do you consider as stressful situations?

A: At the beginning, everything was stressful. I asked myself many questions. As a student, to become mother I was wondering how I would live. I had many plans for my life and now how will I manage to deal with? Will I be able to fulfill my dreams?

I made a lot of research on Internet to know how to get some financial help, German laws for internationals, how to I get any form of help, any support of assistance for mothers. Through these researches, I read that women who deliver in Germany and their baby receive some financial help. I went to ask and apply to the service in charge but unfortunately, they told me that as a student with temporary residence permit (paragraph 16) I was not filling the conditions to receive this help. This has increased my stress.

I am stressed about the financial situation but also as a student, my visa depends on my studies which means if I am not studying I cannot extend my residence permit. Because of the pregnancy I find myself with no job so no money, no studies so no visa.

My husband (also a student) advised to continue the studies while waiting for the baby to come but I cannot.

My family back home expect that after my studies, I will get a job and then earn money. This is another part of the stress.

I like the children but it is not the appropriate time. I am happy when during the ultrasound, I can see the baby but at the same time, I am stressed.

Physically, I am not well, not sleeping, not eating and vomiting.

Q: when do you think you need an external help?

A: I would like to receive advice from someone who already passed through the situation. I want someone to reassure me that everything will be all right. Someone to guide me but I am alone because my husband has to work.

As expecting a first baby, any mother need some help and advices for example on how to get a place in a kinder garden.

Q: how do you deal with stressful situations and where do you seek for help?

A: I am alone, no one to discuss, no one to talk to. All I can do I to make Google searches. I do not explain my situation to my family because they will be more worried.

Q: Do you think prenatal depression can be prevented and how can women care for and protect themselves against prenatal depression?

A: prenatal depression can be prevented when someone has everything. I had a friend who has planned her pregnancy, she was also preparing to return home (in country of origin) so she was happy, has no more reasons to stress about visa renewal or studies and consequently he was showing her belly, was excited.

I have Faith in God. I believe he knows everything and no matter what happens, we should continue to live. God makes things to come on the appropriate time. We have to live the present and not to think too much about the future because God will provide.

Q: Is it common to discuss about psychological issues in your country of origin? How and to whom?

A: it is not common to discuss such issues. In my country, Morocco, a pregnant woman is like a princess, she eats good food, receives care from every body and can ask anything she wants even if it is difficult, she will get it. So there, prenatal depression is not a common issue.

Prenatal depression can occur maybe if the woman is not married.

There might be difficulties after birth like pain but not psychologic.

In our culture, we always say that God will provide and that children bring good things in life.

With the family's help, many problems are solved.

In Germany, depression is common because there is a lack of social contact.

Q: What are the barriers and challenges to access mental health services or any other kinds of services?

A: Some people do not like to beg. I need help but no one has a baby around me (chef or friend) so I suppose that they cannot help because they do not have any experience. I am open to receive help. Migrants do not have access to services not because they do not want but they do not

know where to get help. For example: the people that I met (at school, at the German lessons, my neighbors) are in majority foreigners. I won't go out and just meet people on the street and tell them my stories or ask for friendships.

Q: Do you see yourself as endangered? What do you do about it?

A: I suffered from depression but I do not need to discuss my problems with anybody (psychiatrist or health counsellor) but I needed solutions to my problems. I have my husband to exchange and he comforts me.

I needed to know that I am secured regarding my visa and residence permit because without a valid visa I will be have to leave the country. Discussing or psychological counselling won't solve any of these issues.

Q: What do you think; do migrants need prevention against prenatal depression?

A: Yes, the health of a pregnant woman is very important; she needs to eat well but also a lot of family care to avoid further health situations.

Interview participant 3

Interviewer: the researcher

Interviewee: [redacted]

Date: 08/03/2020

Q1: **What comes in your mind when I tell "prenatal depression"?**

A1: Prenatal depression refers to the difficulties and challenges that I face during pregnancy. At the initial stage, it was not always easy for me; from the sixth week, I faced a lot of challenges. I was moody, not feeling happy, everything put me in a bad mood, I wanted to stay on my own. No matter what someone could do, it did not please me. I had fever, vomiting, loss of appetite, I was very sensitive to smell no matter how far it comes from.

Researcher: at the beginning of the pregnancy, most women face these experience. The body has to adapt to something new, the hormones variation can cause this discomfort.

Q2: **You said that nothing could please you and you wanted to stay alone, why?**

A2: I was not happy, anything someone could do was provoking. I was feeling the pain, I was not comfortable. I was sleeping only on one side (position). If I did not had a good sleep and someone comes to discuss anything in the morning, I did not have any interest on his/her issues. I was the one to introduce a discussion when I was feeling the need but someone else wanted to discuss, the person could not know if it is the appropriate time for that.

Q3: **How did you cope as you are living with other people who may not know what you are feeling at a certain time?**

A3: I feel bad when I see familiar people especially my husband. I have the feeling that he should understand me and accept whatever I do. When it was not the case, I was feeling more annoyed. When I was meeting other people, going out, I was doing more efforts to hide my feelings, I enjoyed going out. As soon as I am at home, I start to feel bad again. Even with my children, I was feeling bad but I was trying as much as possible as a mother to hide my feelings. I know that if I don't do something for them, they can't get it from someone else so I had to. The person suffering the most from my bad mood was my husband because as an adult, she has to understand and accept all even the worst from me.

Q4: how many children do you have? Is this behavior common during all your pregnancies?

A4: I have four children. When I was pregnant for the first time, it was so bad. I was very sensitive to smell, I had loss of appetite, feeling sick. As the pregnancy was going, I started over eating. I did not feel so bad maybe because I was still young (21 years), I don't know. For the second too, it was almost the same, maybe it is because for these two, I was not with my husband. I was in Nigeria with my mother-in-law, sometimes my mother and I was not feeling so angry. For the third pregnancy (it was twins), I came in Germany around the seventh month. I was happy to join my husband. For this fourth pregnancy (twins), from the first day, I feel bad. Maybe it due to the combined effect of age and the presence of my husband. I felt like being in another world, I experienced the worst for this pregnancy (the sickness, loss of appetite, anger). I think the age has a lot to do because I had 21 years at my first pregnancy, 23 at the second, 27 at the third pregnancy and 31 for this last one. This last pregnancy was like hell for me, nothing was going well, I thought I was going to die.

Q5: According to you, the difference between your first and second pregnancies is that you were in Nigeria with your family-in-law, what was special there?

A5: it is not that people in Nigeria were treating me better. I was calling my husband every day, we were laughing. This time, the fact that I was with him, I wanted him to do everything. My husband was right, he was doing all he could for me, I was just not satisfied, I did not appreciate at that moment of anything coming from him. I cannot even explain how I want things to be done.

The stressing factors were the fact that was with my husband, the age and the environment. It is colder in Germany. The seasons also are different. In Nigeria, even when it is hot, there are trees and plants, bringing some fresh air but here it is hot and humid.

Q6: Which measures did you take to relieve your stress?

A6: In these situations, I tried myself to calm down. I think it is a normal feeling that comes with pregnancy. My blood pressure was low constantly low during this last pregnancy. To relax myself, I was watching movies, listening to music, and walking to get some fresh air. It is not easy but I try my best for the babies.

Q7: Did you discuss this situation with anybody?

A7: I was discussing with my friend. I did not say anything to our families because they would get afraid. I did not tell my mother that I am pregnant until I give birth. I did not want them to get afraid by explaining them the situation (what the doctors tell me, which situation I am facing), I don't want to lie so I just don't talk about it. I was discussing all these issues with my friend.

Q8: How did your family and friends react when you just announce them that you gave birth?

A8: My family knows me. I told to my sister-in-law at the sixth month of pregnancy. She did not really appreciate it. And later on, I was also discussing some issues with her.

Q9: Do you think this stress could have been prevented?

A9: Everybody do not experience anger during pregnancy, I think it is manageable. When I was watching movies, singing and walking around, I was feeling better apart from these moments, I was feeling again this anger. When I was listening music, I wanted to annoy my husband and when I succeeded, I was happy. But he was ignoring me. For the other pregnancies, if I was angry, I was not as serious as time. When I was lonely, I could listen to music to relax. This time, it has nothing to do with loneliness because my husband is there for me.

Researcher: As I understood, you were finding your own ways to relieve the stress by listening to music, watching movies, walking and by discussing with your sister-in-law, your friend and not your husband

Interviewee: My husband understands the situation because he comes to the hospital with me and listen to what the doctor. When I don't understand the German language, he was explaining; so I don't need to explain to him again. The problem I have is that whatever he does, it is enough for me, I don't know, he is doing the right thing. Even the things he used to do when I was not pregnant which were making me to laugh, did not have the same effect during pregnancy and I will not forget for the next three to four days. I don't know why but since the second pregnancy I just behave strangely.

Researcher: how does he reacts in these situations?

Interviewee: he just ignores me and moves away. I tried as much not to but I could not. I was talking even nonsense but still talking.

Q10: Do you think women in Nigeria face stress and discuss about the difficulties they face?

A10: The women discuss with people very close to them. I don't need to hide from my family because they will see it by themselves. People will ask about how thing are going with the pregnancy, what did the doctor said, how is the baby? And they will tell me you have to do this or that. In Nigeria, we are always with family, it not like here where you go far away to see the next family. In Nigeria, even when we live far away from each other, we still visit each other frequently. My sister can

come to visit and stay for a week or one month.

Regarding what you feel, some people would see it by themselves, you don't need to tell them again. They can see always which practice you use. For this anger during pregnancy, people would just avoid annoying you and they will know that no matter what you do, the pregnancy is the origin. No matter what you decide even if you say to a person, not to come close to you within the next month, the person will accept and understand that you are not yourself. But if the situation stays even after the pregnancy then they will consider that it is no more normal and you have to visit a psychologist.

Q11: Does psychological support exists in Nigeria?

A11: this type of support exists only for rich people, not for all. Most of the times, it is difficult to know if a behavior is due to poverty or psychological reasons. When you are rich, you can have everything you need as food, money so it will be easy to detect psychological problems. When a woman is pregnant, carrying a baby on her back, she is selling under the sun and the children are crying of hunger, it is difficult to know if it is tension, the stress of the baby, trauma or anything else. The people with money can make check-up but for the majority, the poor people, they only fight for their survival so are not interested in psychological problems.

Researcher: I discussed with a Cameroonian lady who told me that psychological issues are not discussed because you will be considered as mad. People do not look at it as a person passing through a difficult period due to stress, jobless, pregnancy or grief. There is a lot of taboos, people close themselves and hide the reality.

Interviewee: that is why I said that we do not discuss with everybody. There are special people to whom you talk about your problems, those who can keep them not those you meet on the streets because they will twist and turn the story the other way around.

Q12: Did you ever think to ask for an external help except your family?

A12: Apart from my friend and my sister-in-law, I know how to manage myself. I know that is a temporary situation. If it get worse, then I can ask for an external help. Normally, I am fine it is only during this phase that I have this feeling so I know, it will pass after the pregnancy. I am just counting the days for it to come to end, asking myself in which situation did I got into and wondering if I will survive this situation or will I die.

Q13: Can you say had a prenatal depression?

A13: I think it is something normal. In Nigeria, I did not get into this situation because I had nobody to pumper me maybe if my husband was there the same thing could have happen. This burden has to be for both of us not only one person to suffer from it. The other person has then to understand and do all possible even if it is 300% for him to experience the same thing as you. If I am annoyed, I have to do something to annoy him also. For the other people, they are not concerned about this situation so I am fine with them.

I still think it has to do with the age because the pain that I experience is higher than the previous pregnancies. I have join pain, I cannot stand for a long time and I will feel dizzy. I also lack of nutrients, I am not eating enough. In Nigeria, I could get anything I wanted. Here, there is only

German food. The fruits are different and even when you find the same fruits, the taste is different. During pregnancy, there are some food that I have hunger for but I cannot get them here. I cannot find the spices here. Some fermented foods that I like, are not here. The alternative that I can find here does not please me. Eating something I like also help to have good mood. There are a lot of sweet food which I don't like, during pregnancy, I prefer sour fermented foods. As I cannot find, my friend gave me the little she had but it quickly finished. Even the vegetables that I like, I could not find them. I was hungry but did not know what to eat.

Q14: Do you think migrant pregnant women need a particular support? What kind of help would you have like to receive to face this situation?

A14: regarding the feeding, it is important for a pregnant woman to eat properly to help in the child development so if the Government could facilitate the import of foods, it would be good.

Transcription interview 4

Interviewer: the researcher

Interviewee: [redacted]

Date and time: 19/03/2020 at 10.27am

Q: What comes to your mind when I tell you antenatal or prenatal depression?

A: Hmm, I have heard that it exists that some women face this situation but it does not happen to me. The causes (...) Many things can cause depression; the first things are a migrant who is alone, does have her mother nearby, no family in the host country. But with a good husband you don't need the other family members. Still a husband is not like a mother but in our case we have to manage it. Having a good husband is a very helpful but a husband cannot replace a mother. In our case, we have to deal with. My mother used to say:" wherever your husband is, your nation/ your country is" it means that no matter where you are, what matters is to be with your husband, your husband is enough"

Q: Depression is associated with stress; during your pregnancy what kind of situation stresses you?

A: hmm, during my pregnancy, I experience only back pain as physical problem.

My problem is that my family is not here and my husband too, is absent because he works as a consultant for a company and has to travel a lot. He spends the whole week abroad in consultancy and comes back home only on Thursday evening. I was feeling stressed because I was alone. Sometimes, I don't want to see people because they will see that I am tired, they will feel for me sorry and I don't like this feeling. I cry immediately when I see that somebody is feeling sorry for me.

I stop some of my activities like German courses not because I was tired but I did not like the attitude of the lecturer who was only talking and dealing with the from desk students and did not care about the rest of the class. She was not normal. I was irritated and could not cope with so I decided to stop the course.

Now that I look back I realize that it was not such a big deal and maybe I was going through a prenatal stress.

My physical appearance was another problem. You don't look good when you are pregnant. I don't know if all women experience that but I see myself ugly. My friend used to tell me that I have to wear tight dresses because it is nice to see pregnant women belly but I can't do it. I wear always very large sized dresses. I like to see pregnant women belly but not mine.

Q: Do you think prenatal depression can be prevented?

A: yes, I think it can be prevented. It is like during pregnancy a woman is not herself, little and sometimes even stupid things irritate her and she just can't control herself.

When we started our discussion, I told you that I do not experience prenatal depression but now I realize that what I faced was part of it.

This is due to the fact that we are alone here. In my country of origin, I would have had my family and my family-in-law around me, everybody taking care of me. Here, the loneliness pushes to think about stupid things in your apartment.

Q: Are you the kind of person who overthink when alone at home and thus prefer to stay outside?

R: I am this kind of person but when there is nothing that upsets me at home, then I don't overthink.

Q: How do you relieve our stress?

A: When my husband is there, I like to go out.

I also have to possibility to discuss with friends but, I do not want to see anybody. I know some other Islamic neighbors who advise to meet with other people to feel better but I don't want to, I feel I want to stay alone.

I have no special activities, nothing to relax that why I am always stressed.

I have a good friend, we do not meet or talk to the phone because of lack of time but when I feel bad, I record her a message and she does the same, when she is bad.

Photography is my hobby but I do not practice it often since I am in Germany but I used to be a professional in Yemen. I had the opportunity to teach photography and I enjoyed it because I felt being myself once again not only a pregnant and useless woman. I wish to do again something for myself once the child grows. The fact that I am not doing anything for myself makes me feel bad.

Q: Do pregnant women express their feelings in Yemen?

R: I think people in Yemen understand better the situation than here. Here you are with your husband and he does not understand what you go through especially during the first 3 months, only a woman will. My husband tells than only Yemenite or Arab women have this discomfort during pregnancy.

I have a big family, 3 sisters. When one of my sisters is pregnant, she can easily go to stay with our mother. You need people you are used (our family) to when you do not feel good.

"Eyafa" swinging of hormones during pregnancy, is well known in Yemen so the people understand better that during the first 3 months, women need more care because they are not feeling well. Here, a women has to cook for her husband even though she feels discomfort due to the smell of the food or any other smell.

In Yemen, they are not aware of psychological discomfort during pregnancy. The assistance is more for cooking, pain release.

Regarding the psychology, only talking to somebody who can understand can provide a relief but when your husband does not understand you, it makes it worse.

Q: As your husband cannot understand, can you think about discussing with someone else?

R: I have a friend with whom I express my problems and she does the same, this relieves me. We meet rarely because of time but before the pregnancy, it was more often. I have a friend but we can only communicate through the phone. We understand each other well.

I have only one family member, my cousin but he is a man. My husband does not have any family member in Europe.

Q: Do you think immigrant pregnant women need particular assistance during pregnancy?

R: Immigrant women face a problem of integration in their host country. For example, she may want to work in the same field as she was performing in her country but she does not find it and with the pregnancy it makes things worse.

Q: Do you have any special needs? Something that could have made the situation better?

R: in Germany, there is already assistance to pregnant women like prenatal course. It is more the situation around you and not something that the country can do.

In my case, even if there was a health counsellor, I would not go because I thought it is normal to feel so in this stage. I did not acknowledge it as a problem, a depression.

In nature, I cry a lot. I visit my doctor and while explaining her my situation, I started to cry and she told me that it is normal and it is due to the hormones swing that relieved me. I felt good to know that someone understand me.

Now, I realized that I made a lot of stupid choices during this period. Now, I look back and think it was maybe part of prenatal depression.

Transcription of interview 5

Interviewer: the researcher

Interviewee: [redacted]

Date and time: 21/03/2020 at 10.30am

Q: What do you think prenatal depression is?

R: I think it is a form of stress because someone cannot conceive; a woman difficulty to have a child due to her age or other.

The interviewer: Prenatal depression is a form a stress that women experience when they are pregnant. Prenatal means before birth so during pregnancy.

Q: What do you think can be the causes?

R: I think financial difficulties, the support from people around you, the relationship with your partner (for those who are in a relationship) and your health status, can be the causes.

Q: Do you think prenatal depression can be prevented?

R: I think it can be reduced but not completely prevented. It depends on your partner character and origin. It is a bit complicated but I think for example you know that your partner is violent or that when he faces some situations, he gets easily angry, you should know how to react. The beginning of the pregnancy is not always easy, if the partner is not strong or prepared enough he might get angry so to avoid this situation, you should hide things that might create his discomfort. The maturity of the partner also has an impact because in the first pregnancy, everything is new to both of you and you don't know how to deal with.

The first 3 months of my pregnancy were very difficult for me, I was feeling so bad that I could take care of our house. My partner has to do everything (financially and housework). He might think that you do it in purpose and get angry.

Q: Depression is often associated with stress, what kind of situation stress you?

R: At the beginning, it was more my physical health, I have no appetite; I was vomiting and feeling weak. I was really stressed because I was asking myself if it is normal for somebody to suffer this way because she wants to give birth; I was really considering it like suffering.

Another stress was my financial situation; before I was financially independent but now I depend on everybody, I cannot work anymore as I was doing and sometimes it might the point

that someone tells you that it is too much. Before you were doing it alone because you had your money but now it is no more possible, that might hurt and stress you.

Another stress comes from that fact that you feel useless, you feel bad and cannot take care of the house. When your partner comes back, he might think that you are lazy and get angry. You fight for your health and at the same time, you do not have a good mental status, all these situations makes you feel like if you carry the world on your head.

The studies: I am a student but I have to stop completely because I was afraid to vomit on the street, or in the classroom, or have discomfort.

I will not consider it like stress but I would like to mention it, the consultation, understanding the medical language in a foreign language. Certainly, I speak German but the medical jargon during pregnancy is not easy to understand. The doctor tells you something but you do not really understand, you say something but you are sure that the doctor understood it. This is stressful and consequently you have to make by yourself a lot of research.

When you do not feel good, you cannot eat properly, you are stress because you ask yourself if the baby is growing well.

Q: How do you deal with these stressful situations?

R: I discuss a lot with my elder sisters about the topics related to pregnancy because it is my first experience but not so deeply about everything, I am facing because I would like to protect my relationship.

With the time, I develop self-attitudes to strengthen myself and to understand others. Sometimes, you get angry because your partner said something and he gets angry too, consequently, it brings you further than it was supposed to.

The first pregnancy is not easy, it is a new experience for both parents. Sometimes, the partner can react in a certain manner because he does not know but if you want to thing to get better, it is your role as a woman to make concession agreement or explain to your partner. You have to tolerate because you depend on him if not you might end up being obliged to ask for social help.

Q: Some people, to relieve their stress, sing, dance or watch movies. What kind of activities do you perform to distract you or relieve your stress?

R: I really like to walk, visit friends and family members. I stay mostly at home because the actual weather is not good (it is cold), I would not call it a hobby but I distract myself with social media to change my mind, I like to play games and sometimes listen to music.

Q: How do you live your pregnancy in a foreign country?

R: I did not have this experience in my country of origin but I think, it would have been better. I feel that I do not benefit from the same support as if I was in Africa. You have your family particularly your mother. I chat with my mother but it is not the same as if she was next to me. I do not get the advice that I could have directly when I face a particular situation. Like when I feel bad and do not know how to deal with, someone more experienced would have advised on how to get rid of the pain or discomfort. It is true that I benefit from medical monitoring but I lack this familial affection and support. I think we really miss this social support.

Q: During pregnancy, women have special nutritional needs. What about you?

R: I would say that maybe my pregnancy is exceptional because I did not experience this situation. I know this because I have sisters that I assisted during their pregnancy. For my case, I do not have this appetite, I eat normally and have no special needs. When you look at me, I did not take particularly weight. At the beginning there were some foods that I could not eat but after the first 3 months, I did not feel it anymore. It is true that I like cakes for example and a traditional food called “kwasap” luckily, I can find it in the African stores, it does not exactly taste the same as in Cameroon but I deal with. It is not often that I want something special.

Q: Do you think women in Cameroon discuss freely about their feelings?

R: I think it depends. I would say that women can discuss their feelings according to their education, the relationship and harmony in the couple or the people around. I can also say that they do not express their feelings because since decades, women have learn not to complain about anything. The pregnancy is a normal stage in a woman’s life, all women face this situation so she should not complain. But if a woman has a husband with whom she discusses freely, she can express her feelings and gain his support and help. My mother told that when she was pregnant, she used to cook in many small bits, not straight away. She was starting and when feeling tired, she was going to rest and continue later because the food has to be ready when her husband and her children will come home. In my case, I was not doing the same because I

was not feeling good and my partner understands it and he could make something by himself or order some foods. This was not the case before.

Q: Do you think there are taboos regarding pregnancy in Cameroon?

R: I don't know if things have changed but according to what I remember, people were not talking about sexual education, how to become a mother. Nowadays, people are more open and there is literature but read is different from explanation from the parents.

Q: Do you think women can express psychological feelings like stress in Cameroon?

R: I think in Cameroon, mental health is not developed. Women endure a lot, they do not complain nor express their feelings because of the culture particularly women submission.

Q: Do you think the women keep their culture while abroad?

R: some women keep parts of their culture but it is difficult to keep it entirely because life in a foreign country is completely different; there are many other circumstances. For example, in a couple before the woman's pregnancy, she has to take care of her house, cook while having a professional life. In Cameroon, women also have professional life but it is different; here we have to help each other and put parts of our culture aside like the woman submission and being to one to deal with all home duties.

Q: Do you think immigrant pregnant women need special attention compared to others?

R: The German health system is good for those who are insured. For example, with my student health insurance, I benefit from adequate medical assistance, there are lessons offered during the prenatal period regarding the pregnancy as a whole (from beginning till the end), I benefit from regular check-ups.

You have the possibility to have a midwife who will assist you at home. There are psychologists, family counsellors for those in need, there are many institutions. During consultation, one can express her difficulties. Even for those with financial difficulties, there are Diakonie and Caritas granting help. I have some friends who benefit from financial help because both partners were students and during the pregnancy, the woman could not work anymore. In this case, language can be a barrier for immigrants not speaking the language so they will need a translator.

The language might be a problem especially when it concerns a domain and a specific words are used. Even when you speak fluently the language, there are always words that you do not

understand because they are technical words. It would have wonderful to express oneself in a well-known language. I have been consulted in my workplace by a Doctor assistant in French, which I speak the best and I felt very good because she explained to me a lot of things. I was lucky but I would not say that it is something that can be improved.

Q: do you think you are at risk of developing a prenatal depression?

R: There is always a risk. At the beginning, I think I was a bit depressed due to the symptoms and this new life, not being able to work so not having money, not able to study, even at home you do not feel good. It is a situation that you understand with time but at the beginning, it is difficult. There risks varies according to the situation you face. If you are pregnant, you are healthy, have no financial problems, have entire support from people around you, there is no reason for you to be depressed.

Even if I am no more independent financially, I think, it is just for the moment and it is for a good purpose. I do this for my child so I can overcome it.

Pregnancy is not an easy period especially when you are both students. You have to overcome many difficulties. Sometimes, you have to ask for help through different associations. Those who already have a professional life do not face the same situations.

Interview participant 6

Interviewer: the researcher

Interviewee: [redacted]

Date: 23/04/2020

Q1: How do you experience your pregnancy as a migrant?

A1: there are many myths that come in play. If we think about how things are going on here in Germany, compare to Africa particularly Ivory Coast regarding health. We can congratulate the German health system which allows the pregnant women to receive good care and follow-up. Another aspect to compare is the family system in both countries. In Africa, we have witnessed how pregnant women are cared for. I am living with my husband, my elder sister is living in Mannheim but is not always there, so I could say that I was alone during my pregnancy. In this situation, you have to do everything by yourself cleaning, cooking and other. No matter how you feel, you have to do it because no one will help you. The husband just makes the little he

can to support but the big is yours. I did not have so many difficulties during my first pregnancy because my husband was very understanding and helped me a lot. I told him that I needed his help because it was the first experience and we don't have family. I also benefit from the support from my Ivorian friends who living in different cities in Germany. With the help of my sister too, I managed this situation.

Q2: Did you experience some problems, illness during your pregnancy?

A2: Not at all. I did not experience any particular health problems except the normal disturbances. When I talked about support earlier, I mean when you are tired and you want to eat other go to the supermarket and your husband is not there, how do you do?

Q3: You mentioned the advantages of the German health system in regards to pregnant women. What types or kind of support did you benefit during your pregnancy?

A3: First of all, the health insurance allows you many benefits: having a Gynecologist who informs you about your health and the baby's health. As the pregnancy progresses, you can have a Midwife paid by the health insurance scheme who takes over the Gynecologist after the delivery. In Africa, it is not the case. During the pregnancy, the continuous check-ups help to avoid maternal and child death during the delivery.

Q4: Have ever heard about prenatal depression?

A4: Yes. I heard about it. Here as soon as you are pregnant and even after the delivery, the Gynecologist and the Midwife tell you that if you have any problem, they are there to listen.

Q5: Researcher: according to some researches, the postnatal depression can be due to a non-treated prenatal depression. As you did not experience prenatal depression, what can be according to you can be the causes?

A5: Prenatal depression can happen when a woman is young and she does not benefit from any support. A pregnancy is nine months within which many thing happen tiredness, physical change and other. As long as the pregnancy progresses, you find yourself with a big belly, a huge weight gain particularly for those who care about their physical appearance, at that time you ask yourself "what is going on to me? I have to keep my shapes" and some refuse to accept their new situation, the pregnancy and that body change is part of it, normal. All this can cause depression.

Q6: How did you experience your transformation from young woman to mother?

A6: It has been a positive transformation, I thought I have moved from the status of young woman to a greater status. It was good without any difficulties. I have no problem with physical change, I do not bother about it, if my belly stays big or not. Apart from the fact that it implies a new wardrobe, I don't have any other problem.

Q7: Which kind of stressful situations do you face during your pregnancy?

A7: The only stress that I have is the fear to give birth to a sick or premature child because the child is the womb and we don't know how he looks like. The medicine here is advanced but it also have limits so nobody could 100% sure that the child will be healthy or have some malformations. It thinks is a fear for all mothers.

During the delivery, life or death can occur only God knows so one might ask herself if she is going to overcome it. I am asking to myself, Will I come back with the child or not? That is the other source of stress.

Q8: Many pregnant women are very sensitive and people prefer to avoid contacts with them. How are your relationships with people surrounding you?

A8: It is true that pregnant women make caprice but apart from that I do not feel any particular changes in my behavior. It might be due to the fact that I eat too much. I did not have any problem with my relatives or friends regarding my humor, sensibility.

Q9: Many pregnant women are stressed because they have hunger for particular dishes which they cannot find here. What about you?

A9: On this aspect, my problem is different, there are meals that I liked but during the pregnancy I do not tolerate them. Meals made with tomato for example that I can no more eat. I liked very much to eat "Aloko" or fried plantains as it is called in Cameroon, the "Atieke" with fish, I liked spicy food but I cannot eat since the pregnancy. I do not tolerate the smells of perfume, alcohol, and smoking.

There is something called "kaolin" that I really really like to eat but it is difficult to find it. I even ask to some friends in France to find it for me. If I cannot find something here I ask to my friend to send it to me and luckily they find it easily in other cities or in France.

Q10: When you think about the child development, how do deal with? What do you do to relieve this stress?

A10: I pray, whenever I have a stressful thought. I pray and ask God to protect us during the pregnancy. I present it to God because He is the One who has the last word.

When I am stressed, I talks to my husband or my parents in Africa. When I have some fears, I call my mother to ask how to do.

Q11: Do you think pregnant women in Ivory Coast express their emotional feelings?

A11: Not really. People know more about the caprices during pregnancy. In case women express themselves, it is to very close people not to everybody as it is the case in Europe, to go hospital to discuss about some emotional problems or depression, no no no no.

The women try to be strong with the help of their husband or their mother but it is not common for a woman to express her worries and stress. Even if she does, they will tell her that everything will be fine, it is just a temporary situation, many women have passed through it why not you.

It is difficult for women in Africa to express themselves as it is the case in Europe.

Q12: Why do you think it is the case?

A12: There are two possibilities: in Africa, people never feel alone. When someone face a situation, she can discuss with the people close to her, there is always an attentive ear for one in need or to pray as Religion is an important belief in Africa. Here, there is more individual life, women may not have close people to discuss with and when they are stressed, they just close themselves.

Our education is the other possibility: we are brought up with values like courage, perseverance, never give up. So we always think that man should be strong, never give up, this mentality helps us also to face difficult situations during pregnancy.

We also have in Africa the culture of minimizing everything. We always say “everything will be fine” even when nothing is going well, we always have this hope that it will be fine, God will help. When the problem is more serious as a medical issue then, counsels, discussions, prayers and search for the causes of this situation are considered.

Q13: Does it exist in Ivory Coast special services to deal with such issues?

A13: I cannot say much about it because I did not give birth there but officially it exists. There are social services in place. There is an organization called AIBF which is women centered and in which all problems related to women are discussed as family planning, when women face difficulties, it represents a refuge for women. The only problem is that it does not interest many people because the psychological health the women during and after the pregnancy is a not really considered as an important issue. During the pregnancy when a woman face stressful situations, people do not think to go to the hospital because they don't believe in any positive effect that medical intervention would bring. They always find another way to resolve the issue.

Q14: how do you think African women here in Germany deal with these situations as their system has changed?

A14: I cannot really say anything about because it depends of people and it is personal issue. I can just make general remark. Here I think if a woman face a very stressful situation that she cannot manage, she will discuss about it with her husband and then her gynecologist or her midwife. If they see that it is necessary to refer to a psychologist, it will be done. The decision to visit a psychologist or not and refer to family practices depends on her.

Q15: Do you think immigrant women are more exposed to depression?

A15: I think yes because the social condition plays an important role, here we do not have the same social condition. The health system is an advantage but is not all, a pregnant woman needs also a good social system. According to the financial situation, one starts to think about what to do after the delivery. This continuous thoughts can bring stress and even depression without the person even realizing what is going on. The questions about how is to be after delivery, who is going to take care of the child, how I am going to deal with the child, how I am going to do for the kindergarten, who is going to take care of the child if I do not find a place in a kindergarten as we do not have family members here. All these worries can play a role in the mental of migrants.

The natives have many advantages they have their family members, grandparents who can care for the child. According to their social condition, even if they do not find a kindergarten, they can pay for someone who cares the child. Here is a luxury for migrants to afford the services of a "nounou". All these can bring a stress that could worsens to depression.

The migrant's women are more prone to depression for many reasons: financial, social and even more for those who are illegal in the country.

Q16: As they are more vulnerable, what can be done to assist them?

A16: The medical assistance is already there. A familial financial assistance from the Commune. For those who are illegal, the gynecologist can advocate according to the mental state of the patient which can play an important and positive role against her repatriation.

Q17: Do you have something else to add, an advice to give?

A17: the mental health of migrant women is important to consider because there many factors related, because it is a different culture, these can be disadvantageous for women and impact her mental health. Many situations may be neglected and later get worse. I advise women not to waste time as soon as they see that they are not feeling good, have many problems and are overwhelmed to ask for help.

Transcription interview 7

Interviewer: the researcher

Interviewee: [redacted]

Date: 15/05/2020

Q1: How do you live your pregnancy?

A1: My pregnancy is going well; I do not have any particular problem. As immigrant, everything is going well too. The pregnancy itself do not disturb me, I cannot say that it is because I am in Germany but I think even if I was in Cameroon, I think it would have been the same.

It is only the prenatal visits that were sometimes weird, some doctors give strange answers to your questions. For a first pregnancy, you can panic when you don't feel the baby's movements. For this reason, I went twice to the gynecologist. I called first to ask for appointment but the secretary did not answer so I went directly there. When I reached the gynecologist office, they asked me "don't you have a phone? Do you know what a phone is?" I was a bit chocked, I thought it was devaluating me because I am not sure they would have answered the same way

to a German woman. I asked myself if for my next pregnancy, I would go to the same gynecologist but apart from these times, he was kind and patient.

Regarding my workplace, now I am on maternity leave. I had the feeling like I was slowing the enterprise's activities, that they did not have a good opinion about me because of my pregnancy. In my work, I travel a lot and the more you travel the more bonuses you get. Before my pregnancy, I was traveling sometimes twice a week, it was ok. I decided to inform about my pregnancy after a journey to Austria, I went there alone and the travel was quite long and driving starts to be very exhausting for me and I was feeling dizziness. Since that moment, the ambiance was strange and cold. I not could get any work proposal only when no one else was available because most of our work we have to go to the client, we do not have anything to do in the office so I was bored. After revealing my pregnancy, I had only one more opportunity to work outside, to travel until I enter in maternal leave. I discussed with my boss and explained that I am pregnant but not sick so if there is something to do, he can trust me I can still do, I do not have any problem. My pregnancy is going well, I do not a particular problem, I can work. He answered me that he understood but I could see how the other colleagues not even those with more experience that me but even those with whom I started and who started after me, and I was there bored. I asked many times for something to do but the answer was always the same that when there will be something to do, they will give me. Only once, I was asked to do some tasks because my colleagues did not do it before traveling so I had to do it and send to them. Apart from that, they asked me to read to increase my knowledge. I had the feeling that my pregnancy was a bad news so I felt bad, guilty of something even though it was a good thing. Nobody congratulated me so I was waiting with impatience for my maternity leave. I was always trying my best to go even when I was not feeling good because I did not want them to say that I am pregnant so I take sick leaves. Only two colleagues were showing concern and asked sometimes how I was feeling, if everything was going well.

Q2: Do you think it is because you were a migrant or just that the pregnancy was slowing the work?

A2: I think it is both. Before me, another colleague, a white, gave birth, they were so happy that we collected some money and congratulate the person. I waited until I go to maternity leave to see. Actually, the collect is not mandatory, people give what they want. I understood that my case was embarrassing because when you give some money you sign and when I received my collect only two people have contributed. I do not know how to interpret this behavior but I think it is because I am a migrant.

Q3: Where your trips to the client far away and did you always have to drive?

A3: mostly I was driving and once with airplane. The longest trip I did was to Austria and I had to drive for about seven hours. When I was driving for too long, I felt sometimes bad. The pregnancy has not been easy for me but I was trying to hide these discomfort when I was working. Normally, driving for long is not good during certain periods so I withstand it because I did want them to say that they put it into the account of pregnancy. When I was driving for long, I was feeling bad and I had to stop many times. Once it happened, and I screamed in the car because I felt that the car was going backwards while it was at the same place. After this event, I decided to inform about my pregnancy. (14.54)

Usually we travel in group of two and we alternate driving according to the distance but that time, i was alone.

Q4: Do you know if during your pregnancy there were short distance missions?

A4: yes, there were missions, for example, in Stuttgart which is two hours distance and where I used to go. They prefer to send a colleague who recently started.

Q5: does it exist in your contract a statement regarding pregnancy and it is the reason why your boss did not send you to the same missions as before the pregnancy?

A5: nothing as such is stated in my contract. Our work does not particularly demand physical efforts, nor a dirty work. During my mission to the client, I was making more computer programming, analysis. I could sometimes help a colleague when needed to work on machines but he was doing mostly the whole work. Even this help, I could do it while pregnant because it did not need special physical effort. It was for example, assemble the materials to fix the cameras, cut some cables or make measurements.

Q6: you mention that you had a difficult pregnancy

A6: at the beginning, but after the fifth month it was ok. Only driving for a long distance was a problem but when I had to, I could drive and rest when i was feeling tired.

Q7: which problems did you face during the first months of your pregnancy?

A7: I experience nausea, vomiting, loss of appetite and stomach pain. It is true that I lost a lot of weight but I was feeling fit.

Q8: how do you feel with your physical appearance?

A8: I feel good since the pregnancy; it is only at work that I had some problems. I feel good with my clothes, wearing pull over when cold weather and large size clothing. I was hiding it so people won't ask too many questions. Many people realise it when I was already in maternity leave. My belly was not big.

Q9: Did you like your body image?

A9: I like my body because, normally I have weight and during the first months I lost to much weight, ten kilos so it was fine for me. I was vomiting a lot even having hematemesis and not eating. I think what saved the baby were the vitamins that I was taking. I am feeling light and I like it. People who know me realised that I lost weight but it was not so bad as I was still wearing size 38.

Q10: which situations are stressing or stressed you?

A10: apart from the workplace, looking for a house has also been stressful. My partner and I, we were living in a student hall where we had to share the kitchen and toilets with other people so it was urgent to find something bigger and comfortable. I was looking in the region of Mannheim first as it is close to my workplace by car or train and in Ludwigshafen. It was difficult as when people see a pregnant woman, they say that they don't want someone who is going to depend from the social services. I used to answer that I am working but they replied that I am going to maternity leave and I will depend on social services and they are not sure that I will be able to pay the rent. I had as proof my payslip but it was not enough. I used even to lie that I will go back to work four months after delivery so that the person understands that it is only for a short period of time. The pregnancy has been a handicap to find a new house. We, finally got a house in Frankenthal, which was not even where I was looking for and in the ceiling, it shows how difficult it was and we did not have a choice. We are living on the fourth floor of a building without elevator. You can just imagine a pregnant woman in her third semester having to go through all these stairs.

I went to the different places in Mannheim, Ludwigshafen where I could get help to find a house but the waiting list was too long. I got the contact of a Turkish man, my partner did not like this offer but I was too stressed and ready to accept anything, when his mother saw me she understood the situation. I just show them my work contract and they did not disturb us. Nevertheless, they told us that it would be difficult with the baby. We were looking for a three room apartment, it is actually a three room apartment but the third room is cannot really be used because the walls are low, a wardrobe cannot get inside unless you buy shelves. During the

summer, it is too hot, one cannot breathe there, definitely I do not consider I like a room. The only bedroom, we have to manage to find a place for the baby too. When we have guests and the weather is good, someone can sleep upstairs otherwise, it is not possible.

Another source of stress has been where to give birth. I have heard many people experiences regarding the treatment during and after delivery when you are not a German citizen. I went to many hospitals, I was reading people's comments, and only Frankenthal had many positive comments so my wish is to give birth there. The only negative aspect was that if your baby has a problem during delivery, they would have to bring him to the Uniklinik Ludwigshafen because they are not equipped for these situations. During the whole pregnancy, I did not have any problem with the baby; the development was good so normally, there were no reasons to be anxious about any difficulties during delivery.

I decided to go to the Immigration office to get the correct information because as I am working, I have to send it to my employer and my insurance scheme as soon as the baby is born so that I can get my salary and other benefits during my maternity leave. I have a close friend who gave birth in Mannheim and whose baby is now one year old but does not have a birth certificate, so I really wanted to avoid such situation. I went to the immigration office to know which documents I need to provide to establish my baby's birth certificate, they answered me that as a Cameroonian, they will have to verify my own birth certificate and it can take three to six months for the procedure. It has been a shock because, I have already planned after all investigations to give birth in Frankenthal and I am delivering soon. The person told me that as I have applied for citizenship, she advises me to do it as soon as possible so that the birth certificate of my child can be established. I went also at Ludwigshafen to gather information but it was difficult to get any answer, I went in different offices but nothing. As I could get anything from the authorities, I ask other Cameroonians about their experiences, and I heard that there I a woman who got the same problem as in Mannheim. I was so stressed that I decided to go to give birth in France where my partner's aunt is living and at least there, I know, I can get the birth certificate of my child. I had already gather all documents from my insurance scheme to go to deliver in France. I went again another day to the Immigration office in Frankenthal to ask about my partner because according to his status, the child is supposed to be a German citizen. the person told us that the child will be German only if I deliver in Germany. That was another stressful situation because I already planned and prepared everything to deliver in France. I did not know which decision to take between suspend my application for German citizenship in which I could include the child if I give birth in France or I stay here

with the hope that in Ludwigshafen, I will not have difficulties because few people commented that they had problems in establishing the birth certificate. I thought if it happens then I will lose because without birth certificate you cannot get any parent or child benefits meanwhile you have expenses, you have to survive so I needed this paper and did not want to hear anything that could cause a delay. I was hoping that if I get the birth certificate after six months then I would lose three months of parental benefits as they give only three months recall. The same as for child benefits because the laws have changed since 2008 and they recall only three months.

A friend told me to come to deliver at Giessen where she lives because there is no problem regarding the child birth certificate there. I went to the immigration office of Giessen to ask, what are the documents to establish the child's birth certificate, as I would like to deliver in Giessen. A woman answered that they do not give these kind of information, that when I will deliver they will send me a letter with requirements. I went to her colleague who gave us the requirements but our concerns were our birth certificates as we are both Cameroonians, to know if they need to verify them, which costs each 365 euros. That was already too much money to spend while we are expecting the baby to come. At least, we came out there with a little satisfaction that I could give birth in Giessen even I was still worrying that things can change at the last minute. I contacted again many other people in Giessen, who assure me that when the child is born, they give you an appointment and the birth certificate is available the same day.

The fact that I am a foreigner had a negative impact; at the last stage of my pregnancy, I was under so much stress. If I were a German, I would have given birth at any place but because you are a foreigner, you do not feel comfortable but you have to overcome it.

Q11: You mentioned that you were looking a lot for information; how and where?

A11: I was searching a lot on Internet and asking to friends. Many of the women around me delivered through caesarian section. Only one delivered normally. It is true that sometimes asking to friends is not always the best idea because they do not explain correctly and rationally the facts but they add their own interpretation, which make a difference. Regarding the proof of my birth certificate, I could have done it as soon as I knew that I was pregnant if I got the right message from my friends. The fact that they took it as a racist/discrimination act instead of a new law that is in place did not help me to prevent this situation.

Q12: Have heard about prenatal depression?

A12: yes, on internet, I read something like. At the beginning of my pregnancy, I had some difficulties. I cannot say that it was a depression even if sometimes I was crying. Maybe if I was alone, I could have done a depression but the fact that I had people around to support me, my partner for example, helped me a lot. Sometimes, I was crying because I was feeling so bad, vomiting blood was stressful. I could not eat, my daily meal was one yoghurt Activia, if I do not vomit. I was vomiting even water. While the other pregnant women that I knew were normal, without complaints. It is the way I was also expecting my pregnancy to be, but when I got pregnant, it was the opposite and a shock. I was happening once a while particularly when my partner was not there.

The fact that my mother is no more alive was also making me cry because I was thinking that maybe things could have been different if I could talk to her and gain some comfort. It also happened rarely.

Q13: Did you had some else apart from your partner to comfort you?

A13: No one else. I was also talking on the phone with my sister who is not living in Germany even thought it does not really count, talking though the phone is different, someone cannot really care for you.

Q14: Do you think it would have been different if you were in Cameroon?

A14: Yes, sure. In our country, we are more cared for. Here, if you do not have the possibility to bring someone from your family to help you, you find yourself alone. In Cameroon, there is always someone to help, assist and an ear to listen.

Q15: Do you think women in Cameroon discuss about their psychological status during pregnancy?

A15: No maybe to their doctor. In Cameroon, we are not yet advanced regarding the mental or psychological health. If you personally know someone in your care team, then you can receive this psychological support. I say it because my brother's wife recently gave birth and one of the person in the team during her delivery was well known by my mother-in-law so she had a special support.

In family, it depends on the relationships that you have with your parents, your family members. I think if my mother were still alive, she would have been my confident. I wouldn't have hesitated to tell her how I feel. I also discuss with my mother-in-law. I had an anemia and was

feeling very weak. My gynecologist advised to eat a lot of meat but I do not tolerate red meat nor chicken not even at sight, I was not eating at all. The gynecologist prescribed me tablets. When I explained the situation to my mother-in-law, she advised to eat Bettes to solve this issue.

Q16: do you think migrant women are more exposed to prenatal depression?

A16: I think yes. In my case, if I had a partner who did not accept the responsibility of my pregnancy, I do not know what would have happen. It was already difficult even when together that I do not imagine living that alone. The fact that he was he was a great comfort. I used to tell my friends that if I were alone, I would have been hospitalized in a psychiatric institute because it was very difficult at the beginning.

I have also very three good friends like sisters to me; we know each other since in Cameroon. Two of them have already passed through this situation so I do not hesitate to tell them about my feelings. It is difficult to find people who keep your privacy (do not report to others what you confess to them). They helped me a lot, when I was feeling something, I explained to them and they reassure me that it is normal; they also felt that at some point of their pregnancy. Having people with whom you can discuss freely, helps a lot.

Q17: Do you think having German friends would have make a difference?

A17: No, I do not think so. I used to discuss with two women who already gave birth, they cannot know what you feel as a migrant, as a foreigner, our discussion cannot go in the same direction. Even if I had a German friend unless she has lived for a short in Cameroon to understand a little of our concept, she cannot really understand. With my status of foreigner, the Europeans cannot help me even regarding administrative issues.

Q18: Do you think migrant women need a particular support during pregnancy? What would you like?

A18: I think yes. It is important to have someone to discuss about your difficulties. A German who has ideally spend some time in Cameroon or in Africa. There are some who never been in Africa but they are supportive and it helps. There are many women whose partner is living far away, in another country and who do not have good friends like mine. Anyway, during pregnancy we need some support, someone to feel free to talk to.

Q19: In your case, would you have accept to visit a health professional to discuss your issues?

A19: A doctor is always better. After the time my gynecologist has been weird because I went to his office without appointment, I did not feel the desire to go there even when I was feeling something. I remember my vomiting stopped suddenly; I called my friend who already had a miscarriage to ask what she experienced when she lost her baby. She told me that she stopped suddenly having pregnancy symptoms. I started to tremble, to panic. When it started early in the morning, I told my partner and he replied that it will be ok. I could not work that morning. I searched on internet to learn about miscarriage. I called my partner and explained again my feelings, and then he suggested that we go to the doctor. We called but no one answered, we went there even if once more I felt that I was disturbing. For a first pregnancy, the doctor has to understand and be supportive. I was sometimes very stressed because I could not feel any baby movement maybe the baby was sleeping; I was doing some massages until the baby reacts but meanwhile, I was spending many hours in stress. I was not going to the hospital only when I have an appointment.

Q20: Do you have an advice to other migrant pregnant women?

A20: I advise them to start the administrative procedures as soon as possible if they are Africans, because only the Africans are checked that way, to avoid what I passed through. It is important to choose a good gynecologist with whom you feel comfortable, who treat you as a human being, without discrimination. I had a friend who changed her gynecologist because she felt that he did not want to touch her. Do not be afraid to tell your employer about your pregnancy.

Interview Experts Caritas

Interviewer: the researcher

Interviewees: [redacted]

Date: 25/05/2020

Q1: Since when does Caritas provides help to pregnant women?

A1: According to my researches, Caritas exists in Germany since 1890. Caritas provide help for many different groups included the pregnant women but also to poor people, homeless people, people with medical problems were the first targets of Caritas. The counselling for pregnant women started since the 70s and in Worms since 1976. The Caritas Group was created in Worms a little bit late in 1925. In the 50s, there were only two official workers who were socially engaged since then it has grown to more than 500 employees. Caritas exists worldwide and in Germany, in all the federal states. It exists also as Caritas International which is engaged and reacts in situations of crisis, catastrophes. The pregnant women counselling is very tiny part of Caritas offers. We have many other offers as counselling, support, and involvement in old people, children and young people institutions.

Q2: How do people learn or are informed about Caritas offers?

A2: The majority of the people come from the propaganda. One has been here and informs others with the same issue. People are also informed through advertisements and offers published in journals, on Internet, in public places. Some people are referred by the Job center. We are very connected with social and public institutions, associations, hospitals. We offer monthly a family breakfast with counselling for pregnant women by a midwife and it is published in the journals; parents with young children can also attend, information about how to get a midwife and many have their first contact with a midwife. We receive people who just moved in the city and do not yet have social contacts, those who have difficulties during the pregnancy, they read the newspapers and realize that there are also pregnancy counselling. Some people receive clothes from donors who don’t use them anymore. There is the possibility to receive online counselling through online chat opened 24h/24 where someone can inform him/herself about possible help and support. Generally, the help is offered according to the place of living and you are asked to register to give your address or telephone number as first step.

Q3: What is the percentage of migrant benefiting from these offers?

A3: for the last year we have 299 in which 131 Germans (43,8%), 168 migrants (56,2%) coming from 35 countries. The more representative are Turkey, Syria, Romania, Bulgaria, Somalia women. Within the Germans, we could also identify 37% who took the German citizenship and have a migrant background. We realize that there are more and more people with migrant background. We receive around 300 people per year. According to what is going on in the world, we also experienced it in the counselling and it can change over the years; for example, we have many refugees from Syria, Afghanistan, Eritrea, Somalia. Many women come for the first time because they need financial help for the coming baby, it is like the door opener and when they feel comfortable here, then they can expose other problems not only themselves but also the person who accompany them, even the men. We also encounter insurance issues, problem with the partner, lack of social contact, loneliness, without family, separation with partner. Our mission is to always to look for ways to improve the baby's life, what kind of support the women or the family needs. We provide information according to the problems like in which office they can go, we provide translation in an easier language. The propositions are not always so easy and the people do not come.

Q4: Do you have an idea about their age, status and occupation?

A4: For the last year, I have copied and filtered to determine the age and status. We have 27 people from 17 to 20 years in which 6 with migration background. For the 21 to 30 years, we have 168 in which 94 migrants. For the 31 to 40 years, 102 in which 61 migrants. For the 41 to 48 years, the older group, 8 in which 7 migrants.

Many have a special status "Freizuhigkeit" (people from the European Union who are in Germany for work or other purpose) 46, within those with permanent establishment because they are living here since a long time, 38. We also have 71 with residence permit, 3 with "Aufenthaltsgestatung" (temporary residence permit Asylum) 3 with "Duldung" (asylum seekers still waiting for their temporary residence permit) , the answer come quickly so that they can have a permit; 7 with "sonstige" status in which some are illegal migrants.

Regarding the migrants, it is difficult to identify their occupation because in our formula it is not specified. We can only identify from our statistics those who have a training or not but not which kind of job. We can identify in the 168 migrants, 3 in professional training, 47 with professional diploma, 118 without qualification.

Q5: Which other problems the pregnant women face, apart from financial issue?

A5: At the moment many look for house. They live with many other people in the same house which is small. Some continue to live in collective living flats even when they have been recognized. Some are living in one or two rooms' apartment with their children and it is another stress for the family. Affordable apartment are difficult to find in Worms now. When someone just come in a new country, a small apartment is satisfying but with the time when the family grows, it becomes narrow. We tied hands because we can only propose small apartments and sometimes cannot find a location so we provide information on where to look for house to rent, the residence building companies. It is already difficult for the Germans and even more for the migrants. Today, we found families with four children living in a one or two room's apartment and urgently need a bigger one. We have difficult situations, where we find a place for a family and when the child comes, we have to find another place. Another difficulty is when the partner is living in another city and we have to make family reunification. The other difficulty is when someone receives allocation from the State because the house' owner is reluctant to rent his house. The limitation in rent price is another issue because it is difficult to find house at a certain price.

There are migrants who come from conflicts zones and the man for example has to wait for years to find something before he brings his family. When the family comes, you stay in community camps and you realise that the fight for life is constant. It is traumatising for the whole family and has repercussion on the couple relationship. Some are happy because there is more war but another type of daily fight.

Q6: Did you came across with women with psychological problems, who are not happy and depressed?

A6: it happens often when someone has an illusion of the host country and you find something else and/or when you divorce or when an unexpected pregnancy arrives. The person has first to settle; it happens not only for migrants but also for Germans. The problem with migrants is that they are not well integrated because they are new in the country, cannot communicate in the foreign language and so cannot express themselves regarding such issues and it is a pity. We can see that there is a problem but because of this language barrier, we cannot go deeper, so it better when there is translator. But sometimes, even with the translator it is difficult to interact and explore the whole situation.

Q7: is your support equal for all migrants or there are differences between students and refugees for example?

A7: First of all, we are there for all migrants. We work in collaboration with a colleague in the Migration' office so when there is a situation that we cannot solve, we send to her. We can bring them for further or more support. According to the problem, we can figure different types of solutions so that there will not be a great difference in the support in the different groups.

Regarding the financial resources, we provide the same for all. Our support is regardless of religion, nationality, but according to what the person, the family needs; juridical issues, or financial and according to that we see what we can offer. We also look at the person's rights; for example, the help for the single mothers is bigger from a couple. The students cannot benefit from the JobCenter, but from another type of social help called BafoG. Those who are still waiting for recognition cannot benefit from help of the JobCenter but from the Social office "SozialAmt". We have to verify each case so that we can help according to the problems. We also play an orientation role. After, we have checked what a person deserves, we can act.

The health insurance is another big issue. How do the women without residence permit get health assistance? The EU who are not working are automatically out of the system when they are not married and cannot get health insurance or any type of help, they are actually illegal. Caritas acts always according to the needs. We are in collaboration for one year with some "Gesundheitsläden" and they take care of homeless people. It was planned as such at the beginning but because the demand is high, they also take of pregnant women without health insurance. There are also doctors who are benevolent and can help them in their first prenatal check-ups. There are also gynaecologists. The final goal is that they can get a health insurance through this way. There are limits abut we try our best.

Another issue is that when the baby is born from a single mother, and there is no one who can help you in caring for. We can help with the assistance of a midwife who is going to make the baby first check-ups; provide assistance for the firsts months, find some contacts and offer counselling so the mother does not feel alone.

Our job is not boring, we deal with a lot of people and we find satisfaction in this interaction. We cannot find all the solutions but we do our best to solve them.