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REVIEW ARTICLE

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Experiences of postnatal care and support among Black women and birthing people in the UK: Systematic review and thematic synthesis

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ABSTRACT

The postnatal period is a time for recovery and social transition, yet it is often called the 'Cinderella service' of maternity care, due to its relative neglect in research and policy. Literature often conflates postnatal experiences with antenatal and intrapartum periods, risking overlooking distinct needs arising after birth. For Black women in the UK, structural barriers further shape experiences. This review synthesises literature on Black women's postnatal care and support experiences in the UK, up to the baby's first birthday, in both hospital and community settings.

We included qualitative studies and qualitative parts of mixed-methods studies on the postnatal experiences of Black women in the UK, published between 2004 and 2024. We also included studies covering the antenatal and intrapartum periods, provided they included sufficient data on the postnatal period. Searches covered ten databases, including MEDLINE, CINAHL, and PsycINFO. Methodological quality was assessed using the CASP qualitative checklist, and data were analysed using Thomas and Harden's thematic synthesis.

Nine papers met the inclusion criteria; only seven focused solely on Black women. Three key themes emerged: (1) inadequate and insensitive postnatal care, (2) barriers to formal mental health support, and (3) fragmented informal support and the expectation to cope. Women reported poor physical care in the wards, whilst community care was impersonal and routine, offering little opportunity to address emotional needs. Cultural stigma towards mental health discussion and cultural expectations of strength discouraged help-seeking.

Our findings revealed that inadequate physical and impersonal care and limited informal support left women with unmet needs. Cultural expectations of strength further intensified these gaps, often leaving women to navigate this period in isolation. Addressing these gaps requires co-designed interventions with

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Black communities, rooted in lived experiences, to ensure care and support over the first year are equitable, culturally competent, and responsive to Black women's needs.

1. Introduction

The postnatal period is defined as the time immediately after childbirth (WHO 2022). Black women and birthing people's[1] experiences during this time occur within intersecting racial, economic, and gender oppressions (Collins et al. 2021). These manifest as inequalities and poorer experiences (Felker et al. 2025). A recent UK report found that many Black women rated the care they received after discharge from their birthing place as poor or very poor, citing concerns about GPs' knowledge during their 6–8-week postnatal check-up (Peter et al. 2025). Women from ethnic minority backgrounds are at a higher risk of developing perinatal mental health difficulties (Watson and Soltani 2019). Black women also experience the highest hospital readmission rates within six weeks postnatally (Care Quality Commission (CQC) 2022). These inequalities emphasise the importance of understanding women's experiences during this period. The review aims to summarise existing qualitative literature on the experiences of care and support during the postnatal period for Black women in the UK. While literature on the maternity experiences among ethnic minority women in the UK is growing, many studies have examined experiences under broad terms such as BAME (Black, Asian, and Minority Ethnic) or BME (Black and Minority Ethnic) (Drake 2022; Toh and Shorey 2023). Such terms have faced increasing criticism for homogenising non-white populations (Hall 2024). These terms risk overlooking structural, historical, and cultural factors that shape experiences. Therefore, this review focuses solely on the experiences of Black women, which are shaped by specific forms of anti-Blackness and colonial legacies. We recognise that Black women are diverse and not a homogeneous group, differing in ethnicity, migration histories, socioeconomic status, and more. This review examines experiences up to one year after birth to capture the evolving nature of care and support experiences, recognising that this is a dynamic process that varies across social contexts.

Although overall satisfaction with maternity care has improved across all populations, postnatal care remains inconsistent (CQC, 2022) and remains under-prioritised in clinical services and academic research compared to antenatal and intrapartum stages (Womersley, Ripullone, and Hirst 2021). Reviews focusing on the postnatal period have taken a global view, providing valuable cross-cultural insights (Finlayson et al. 2020; Sacks et al. 2022), but they may overlook country-specific factors influenced by national healthcare systems, policy, and cultural expectations. UK-based reviews have primarily focused on midwifery-led care (Malouf, Henderson, and Alderdice 2019; Walker, Rossi, and Sander 2019), limiting understanding of women's experiences with other healthcare professionals (HCPs), such as GPs and health visitors, who play a key role in postnatal care and support. This can also overlook how care is coordinated between hospital and community settings and fails to capture experiences of formal and informal support networks. Furthermore, the postnatal period extends

beyond clinical encounters; it involves social and emotional adjustments and cultural expectations of motherhood (Fahey and Shenassa 2013). To our knowledge, no UK systematic review has synthesised qualitative research on postnatal experiences, particularly beyond early discharge. This synthesis aims to establish a foundation for future, more detailed research.

2. Materials and methods

The reporting of this review was guided by the standards of the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) 2020 Statement (Page et al. 2021). The review protocol was registered with PROSPERO (ID: CRD42024600617) in June 2024.

2.1. Eligibility criteria

The PEO (Population, Exposure, Outcome) framework guided the development of the inclusion and exclusion criteria (Bettany-Saltikov and McSherry 2024). We included qualitative studies that explored any postnatal experiences. Participants could be interviewed at any postnatal stage, provided the experiences they described occurred within the first year. When participants were interviewed after the first year, or when the time since birth was unspecified, we focused on data related to experiences during the first year. This included early parenting experiences, interactions with healthcare professionals, support after birth, or the transition home following institutional birth. We excluded free-text survey responses because brief comments rarely provide the richness and context needed for qualitative analysis and may be insufficient to yield the robust, standalone insights required for interpretive analysis (LaDonna, Taylor, and Lingard 2018; Table 1).

Table 1. Inclusion/exclusion criteria.

	Inclusion/exclusion criteria	
PEO	Inclusion criteria	Exclusion criteria
Population	Participants who self-identify as Black or mixed Black heritage, including but not limited to those of Black Caribbean, Black African, and other Black ethnic backgrounds living in the UK. Participants may be born within or outside of the UK. Participants may be first-time parents or previously had children (primiparous and multiparous).	Does not include Black birthing people. **OR** Includes Black birthing people but their experiences can't be distinguished from other populations in the study.
Exposure	Qualitative data on the postnatal period (up to 1 year after delivery), including studies that encompass antenatal and/or intrapartum periods as part of wider maternity experiences.	Studies where data on the postnatal period is absent, insufficient or indistinguishable from antenatal/ intrapartum periods.
Outcomes	Qualitative or mixed-methods studies that present significant findings relating to postnatal experience.	Quantitative studies, reviews, editorials, book chapters. Studies that report qualitative data derived exclusively from open-ended survey responses or free-text questionnaire data.
Date	Studies published from 2004-2024.	Studies published outside 2004-2024 timeframe.
Language	Studies written in the English language.	Studies not written in the English language.

2.2. Information sources

We searched the following databases: EBSCOhost (MEDLINE Complete, CINAHL Ultimate, Sociology Source Ultimate, Health Policy Reference Center, EBSCOhost Academic Search Ultimate, APA PsycINFO), and Ovid (Maternity and Infant Care, Ovid Social Policy and Practice, Ovid Health Management Information Consortium Database, Emcare). Searches were limited to the period from 1 January 2004 to 30 August 2024 to capture research conducted after the UK Department of Health's Maternity Standard, introduced in October 2004 as part of the National Service Framework for Children, Young People, and Maternity Services. After conducting database searches, we performed forward and backward citation tracking. This method helps identify relevant studies that keyword searches might overlook (Gusenbauer 2024). Subsequently, a targeted search for key authors in the field was conducted.

2.3. Search strategy

Using the PEO framework (*P* = Black women, E = postnatal period, O = experiences), we developed search terms for each component. A subject-matter librarian reviewed the preliminary terms and helped identify additional synonyms. An informal scan of systematic reviews in the field was conducted to identify gaps in search terms and refine synonyms for each PEO category. We adapted each strategy to suit each database. (See Appendix 1 for example search strategy details.) The PEO search terms were combined using Boolean operators (AND/OR), and truncation (*) was applied to capture different word forms. Free-text searches targeted the title and abstract fields. The complete list of search terms is provided in Table 2.

2.4. Selection process

Reviewer 1 (LA) imported search results into RefWorks, where an automated tool removed duplicates. Reviewer 1 independently screened titles and abstracts against the inclusion and exclusion criteria. Reviewer 2 (KW) independently screened a random sample (10%) of titles and abstracts using the same criteria. Any discrepancies were resolved through discussion until a consensus was reached. Reviewer 1 and reviewer 3 (EO) independently assessed the full texts of all eligible studies. After completing their independent assessments, they met to compare decisions, resolved discrepancies through discussion, and reached a consensus. Reasons for exclusion were documented at this stage.

Table 2. Search terms.

Population		Exposure		Outcomes
Black*		Postnatal*		Experienc*
OR	**AND**	**OR**	**AND**	**OR**
Ethnic minorit*ORAfricanORCaribbeanOR		Postpartum*		View*
People of colo#r		**OR** Maternity*		**OR**
OR		**OR**		Perception*
Afro Caribbean		Childbirth		**OR**
OR				Emotion*
BAME				**OR**
OR				Feeling*
BME				

2.5. Data collection process

Reviewer 1 extracted study and participant data into an Excel spreadsheet. All text labelled 'findings' or 'results', including verbatim participant quotes and the authors' interpretations, was imported into NVivo 14 for thematic synthesis. The study's context and population were also considered during the analysis. Survey data from mixed-methods studies were excluded from analysis.

2.6. Study risk of bias assessment

The Critical Appraisal Skills Programme (CASP) qualitative checklist was used to assess the methodological quality of the studies. Reviewer 1 independently reviewed all the included studies. Reviewer 3 independently assessed one study, which was consistent with reviewer 1's assessment; therefore, we decided that no further studies needed to be assessed by reviewer 3. Any uncertainties about appraisal decisions were discussed with the wider review team. We did not exclude studies based on their CASP rating; instead, we considered reasons for lower ratings, such as differing historical reporting standards. While quality appraisal helps prevent unreliable conclusions, there is not enough evidence to justify excluding studies on quality grounds in qualitative evidence synthesis (Carroll, Booth, and Lloyd-Jones 2012; Thomas and Harden 2008). Instead, we conducted a sensitivity analysis to assess whether findings from lower-quality studies differed from those of higher-quality studies. This was done by removing themes from lower-quality studies to check if their exclusion affected the overall thematic synthesis.

2.7. Synthesis methods

Adopting thematic synthesis (Thomas and Harden 2008), the analysis consisted of three stages, with iterative input from reviewers throughout. Reviewer 1 familiarised themselves with the data by repeatedly reading the text and then independently coded each sentence to capture its meaning. Next, reviewer 1 grouped the descriptive codes into themed clusters. Through discussions with reviewers 3 and 4, a final set of 12 descriptive themes was established. The final stage developed analytical themes that offered higher-level interpretations, addressing the research question. Here, themes and sub-themes were developed. Reviewers 3 and 4 provided ongoing consultation, resulting in refinement of the theme wording to more accurately capture the data.

3. Results

3.1. Study selection (Figure 1)

The database search identified 5,495 papers. After removing 2,963 duplicates, 2,532 papers remained for title and abstract screening. Of these, 36 papers were selected for full-text screening. Two papers could not be retrieved despite contacting the authors, reducing the number to 34 for full-text screening. After full-text screening, 27 papers were excluded: 9 were not conducted in the UK, 6 did not mention the postnatal period, 4 lacked sufficient data on the postnatal period, 1 did not distinguish findings specific to Black women, and 7 had inappropriate study designs. This process resulted

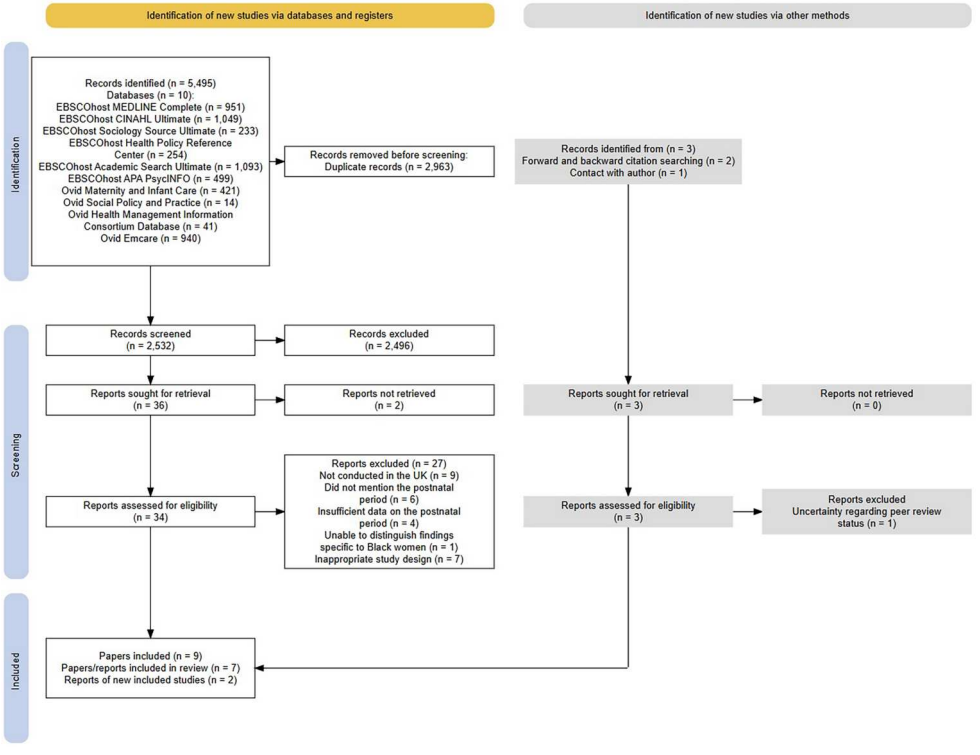

Figure 1. PRISMA 202 flowchart illustrating the study selection process. The diagram documents each stage from identification, screening, eligibility assessment, and inclusion. Reasons for exclusion during the full-stage screening are documented. *Source*: Haddaway et al. (2022).

in the inclusion of 7 papers. Forward and backward tracking, along with contact with an author, identified three additional papers. All three passed the title and abstract screening. During the full-text screening, one paper was excluded because its peer-review status was uncertain. One paper identified through forward and backward tracking was part of the same study as an included paper from the database search, but explored different aspects: maternity experiences (Puthussery et al. 2010) and breastfeeding experiences (Twamley et al. 2011). Both were included, as they addressed distinct research aims. Care was taken to ensure that the study's findings were not overrepresented due to separate publication and that quality appraisal considered the study. In total, nine papers were included, representing eight studies.

3.2. Study and participant characteristics

The included studies were published between 2005 and 2023 and involved a total of 155 participants. All studies included Black participants, with seven focusing solely on Black women. Six studies examined postnatal depression (PND). All employed qualitative methods, such as focus groups and semi-structured interviews. Women's ages were inconsistently reported but ranged from 18 to 45 years. Ethnicity was recorded in various ways, including categories such as 'Black Caribbean' and specific countries of Birth (Nigeria, Ghana, and Somalia). All studies were carried out in England. Most

women were born outside the UK. Only one study involved an entirely UK-born sample (Puthussery et al. 2010; Twamley et al. 2011), and some studies did not report country of birth or migration history. Marital status, educational backgrounds (from GCSEs to degrees), and employment statuses were diverse and inconsistently reported. (See Appendix 2 for participant details; Table 3).

3.3. Quality appraisal of studies

Findings from the quality appraisal were mixed. All studies reported clear aims, employed appropriate qualitative methodologies, and used suitable research designs and recruitment strategies. Reflexivity was the weakest aspect, with only one study adequately addressing the researcher-participant relationship. (See Appendix 3 for CASP findings). The sensitivity analysis showed that removing studies that scored lower during the CASP appraisal did not impact the overall synthesis.

3.4. Thematic synthesis

Following the synthesis, three analytical themes were identified: (1) Inadequate and insensitive postnatal care, (2) Barriers to formal mental health support, (3) Fragmented informal support and the expectation to cope. Sub-themes further detail these themes. Participant quotes are in italics.

3.4.1. Inadequate and insensitive postnatal care

3.4.1.1. Physical care in postnatal wards. Women expressed dissatisfaction with the physical care they received on postnatal wards, reflecting neglectful and dehumanising treatment. Reports of poor physical care were consistent across studies on PND and general postnatal experiences (Edge 2011; Gardner et al. 2014; Puthussery et al. 2010; Williams, McKail, and Arshad 2023). One woman remarked: '*… it's not one midwife; it was all of them … They just approach you as if you are like a log … I didn't feel like a human being at all.*' (Edge 2011, 258). Dehumanising care was also identified in another study, where a mother stated: '*… you're like an animal.*' (Puthussery et al. 2010, 8). Specifically, women recovering from caesarean sections experienced neglect from healthcare professionals (HCPs) (Puthussery et al. 2010; Williams, McKail, and Arshad 2023). One study highlights staffing shortages and resource constraints resulting from the COVID-19 pandemic and related regulations as factors contributing to compromised care. A mother, who had a caesarean section, was left unattended despite repeated calls for help: '*Having to constantly ask for help and constantly be like, please, can you help me […] you can see I'm in my own vomit*' (Williams, McKail, and Arshad 2023). Notably, reports of neglect following caesarean sections predate the COVID-19 pandemic (Puthussery et al. 2010), indicating ongoing institutional issues that were exacerbated by the pandemic. COVID-19 regulations also impacted care for one mother who faced a 36-hour wait on the postnatal ward, during which basic food needs were not met (Williams, McKail, and Arshad 2023).

3.4.1.2. Community postnatal care. Women in studies focused on PND, where diagnoses were either confirmed or not, described interactions with health visitors and GPs as impersonal, procedural, and lacking in relational depth, thus providing a limited

Table 3. Study characteristics.

Author(s)/ year of publication and region	Study aims	Study design, data collection, data analysis	Mode of recruitment, sample size	Theoretical framework (if available)	Reflexivity (if available)
Babatunde and Moreno-Leguizamon (2012) Southeast London, England	Identify cultural elements related to postnatal depression through women's narratives about their daily lives and to help health professionals recognise postnatal depression signs and cultural ambiguities in immigrant women.	• Qualitative focus group • Thematic analysis	Purposive sampling of African immigrant women registered on the general lists of health visitors at four health centres in Southeast London. n = 17	Not explicitly stated, however focus groups guided by feminist theory	Some discussion of group dynamics and researcher observations during focus groups
Dei-Anane et al., (2018) London	To examine the perception of Ghanaian migrant mothers living in London towards postnatal depression during the postnatal period.	• Qualitative semi-structured interviews. • Thematic analysis	Non-probability snowball sampling method. n = 25	Not stated	Not stated
Edge (2011) Northwest of England	To examine stakeholder perspectives on what might account for low levels of consultation for perinatal depression among a group of women who are, theoretically, vulnerable.	• Qualitative focus group • Framework analysis	Purposive sampling via posters in community settings, local media, contacts in churches with a mainly Black congregation, and NHS organisations. n = 42	Not stated	Not stated
Edge and Rogers (2005) Manchester, England.	To investigate how Black Caribbean women in the UK manage and cope with adversity and psychological distress during pregnancy, childbirth, and early motherhood.	• Mixed method/ qualitative data generated from in-depth interviews • Constant comparative (Glaser, 1978) approach, thematic analysis	As part of the study's quantitative component, 200 women completed both antenatal and postnatal depression surveys. From this, 12 Black Caribbean women were purposefully selected for in-depth interviews using theoretical sampling n = 12	Not stated	Not stated
Gardner et al. 2014. Manchester, England	To explore the lived experience of PND in West African mothers living in the United Kingdom (UK).	• Qualitative semi-structured interviews • Interpretive Phenomenological Analysis (IPA)	Purposive sampling through specialist National Health Service (NHS) provision for children under five in Manchester. n = 6	Not stated	Not stated
Ling, Eraso, and Mascio 2023 UK	Explore the lived experiences of First-Generation Nigerian Mothers (FGNMs) who suffer from PND, their coping behaviours and treatment experiences in the UK.	• Qualitative semi–structured interviews • Interpretative phenomenological analysis (IPA)	Purposive homogeneous sampling through posters displayed at parenting centres, GP surgeries, organisations and social groups attended by Nigerian mothers across different counties and cities in the UK. n = 6	Not stated	Reflective diary, and peer support

Puthussery et al. 2010 and Twamley et al. 2011 London and Birmingham, England	To explore the maternity care experiences and expectations of United Kingdom (UK) born ethnic minority women. And, To explore the factors that impact on UK-born ethnic minority women's experiences of and decisions around feeding their infant.	• Qualitative semi-structured interviews • Grounded theory	Sampling method not stated. Recruited mainly from six NHS maternity units in London and three units in Birmingham. n = 34	Not stated	Not stated
Williams, McKail, and Arshad 2023 London and Birmingham, England	To focus on the Black maternal experience and understand how have Black women experienced birthing and postnatal care in the Covid-19 context.	• Qualitative design semi-structured interviews • Reflexive Thematic Analysis (RTA)	Purposive and snowballing Recruited mainly from six NHS maternity units in London and three units in Birmingham. n = 13	Not stated	Reflexive diary

opportunity to address their emotional needs (Edge 2011; Gardner et al. 2014; Ling, Eraso, and Mascio 2023). The formulaic approach contrasted with relational caregiving. One mother expressed: '*… I felt she (health visitor) was just going through a checklist … she was using a set of questions … I wanted someone who would understand me*' (Ling, Eraso, and Mascio 2023, 747). This reliance on structured checklist-driven care often prioritised a baby-focused approach, such as infant checks over maternal wellbeing (Edge 2011; Ling, Eraso, and Mascio 2023). Consequently, this shaped one mother's perception of health visitors' roles, '*It's just about the baby, and has nothing to do with the mothers*' (Edge 2011, 259). Rigid interactions were especially challenging for women whose cultural norms prevented them from discussing their distress with friends and family (Ling, Eraso, and Mascio 2023). The critique of standardised, task-oriented care was echoed in women's experiences with GPs. A mother likened receiving postnatal information to being handed a 'deck of cards' (Edge 2011). Experiences with healthcare providers (HCPs) were not entirely negative. In two studies, on general postnatal experiences and one focused on PND, women reported that GPs and community midwives were helpful in addressing shortcomings arising from inadequate hospital care (Edge 2011; Twamley et al. 2011).

3.4.2. Barriers to formal mental health support

3.4.2.1 Eroded trust. In five studies, women's mistrust of mental health services was identified as a significant barrier to accessing formal support. Mistrust was developed through a complex interplay of factors, including negative antenatal and intrapartum experiences, discriminatory practices within mental health services, unfulfilled promises of support, and lack of compassion (Dei-Anane et al. 2018; Edge 2011; Edge and Rogers 2005; Gardner et al. 2014; Ling, Eraso, and Mascio 2023). Women in a study on factors for low consultation for perinatal mental health resisted consulting therapeutic support such as 'talking therapies' due to concerns around a culturally suitable counsellor and concerns about professionalism (Edge and Rogers 2005). These factors reinforced women's perceptions of healthcare systems as unresponsive or detrimental to their needs. Women who experienced treatment pathways for PND felt GPs prioritised a medicalised approach over preferred holistic approaches, resulting in women feeling they lacked autonomy (Edge 2011; Edge and Rogers 2005; Ling, Eraso, and Mascio 2023). In a study published over a decade ago, a mother lost trust when a GP failed to validate, diagnose, and treat their suspected PND (Edge and Rogers 2005). Such a response risks reinforcing the belief that help is unavailable, thereby reducing the likelihood of future consultation. In one study, women had mistrust of healthcare services in general (Edge 2011).

3.4.3. Cultural stigma around mental health and PND

Across five studies, women expressed reluctance to disclose emotional distress due to cultural stigma towards mental health concerns (Babatunde and Moreno-Leguizamon 2012; Edge 2011; Edge and Rogers 2005; Gardner et al. 2014; Ling, Eraso, and Mascio 2023). For African and Caribbean women, such discussion was taboo in their cultural contexts. Consequently, women did not share their distress with family members and HCPs. Some West African women avoided discussion, as it would be perceived as unnecessary attention-seeking (Ling, Eraso, and Mascio 2023). In another study, fear of gossip led one mother to withdraw from her community (Gardner et al. 2014, 760). For one Caribbean mother, community-based peer support was not perceived as a safe space, as the same

cultural stigma would permeate these spaces, leading to silence on discussion surrounding mental health (Edge 2011). In another study, a Caribbean mother's stigma was internalised, with resistance to the label of depression rooted in fear that accepting it would become a self-fulfilling prophecy, eroding her sense of self and ability to cope (Edge and Rogers 2005).

3.4.4. Fragmented informal support and the expectation to cope

3.4.4.1 Lack of practical and emotional support from partners. Partners often failed to provide practical support, such as caring for the baby or household tasks, leaving mothers to cope alone (Babatunde and Moreno-Leguizamon 2012; Dei-Anane et al. 2018; Edge and Rogers 2005; Gardner et al. 2014; Ling, Eraso, and Mascio 2023). One mother described this as an '*African thing*' and called for '*awareness training for some African men on issues in the postnatal period*' (Babatunde and Moreno-Leguizamon 2012, 7). In another study, women did not blame their husbands for the lack of support, as gender roles positioned husbands as financial supporters rather than as providers of practical support (Ling, Eraso, and Mascio 2023). Mothers also wanted emotional support from their husbands, which they felt was absent (Babatunde and Moreno-Leguizamon 2012; Gardner et al. 2014; Ling, Eraso, and Mascio 2023). This affected women's ability to cope and, in some cases, acted as a catalyst for their distress (Babatunde and Moreno-Leguizamon 2012; Dei-Anane et al. 2018; Gardner et al. 2014; Ling, Eraso, and Mascio 2023). In three studies, a lack of support was exacerbated by geographical separation from mothers' families (Dei-Anane et al. 2018; Gardner et al. 2014; Ling, Eraso, and Mascio 2023). One study explicitly linked mothers living away from their African family members as a catalyst for PND (Ling, Eraso, and Mascio 2023). The few mothers who received support did so through family abroad and their faith-based communities (Dei-Anane et al. 2018; Edge and Rogers 2005). For others, their love and bond with their babies helped them manage postnatal life (Dei-Anane et al. 2018; Edge and Rogers 2005; Gardner et al. 2014).

3.4.4.2. Cultural expectations of resilience. Women reported that motherhood intensified demands for resilience, self-sacrifice, and emotional fortitude, as well as the need to be strong (Babatunde and Moreno-Leguizamon 2012; Dei-Anane et al. 2018; Edge and Rogers 2005; Ling, Eraso, and Mascio 2023). This served as a barrier to help-seeking. The internalisation of the ideal contributed to reluctance to express emotional vulnerability, as it contradicted deeply held notions of strength and self-reliance. One Caribbean woman framed the expectation to be strong as an adaptation to adversity (Edge and Rogers 2005): '*I think it all relates back down to slavery when we had to be strong for our kids, we had to protect them, had to be strong for them. … '* (19). Studies showed the ideal was transmitted intergenerationally from mothers to daughters (Edge and Rogers 2005; Ling, Eraso, and Mascio 2023). The expectation of resilience manifested differently among Caribbean, African, and migrant women. For West African women, it was recognised as irrational and detrimental, yet impossible to abandon (Babatunde and Moreno-Leguizamon 2012; Ling, Eraso, and Mascio 2023). As one mother articulated, '*as an African woman, we are brought up to be strong … there's that expectation'* (Ling, Eraso, and Mascio 2023). For Caribbean mothers, the cultural expectation was further associated with financial independence, reinforcing the notion of personal agency and control over their circumstances (Edge and Rogers 2005). The inability to financially provide for their families resulted in significant emotional and psychological

consequences. Among migrant mothers, the ideal served as a necessary survival strategy in the absence of support networks in the UK (Dei-Anane et al. 2018). One study found that when women were willing to seek support, material deprivation restricted their ability to communicate by telephone or to commute (Gardner et al. 2014). Faced with inadequate formal or informal support, women adopted independent coping strategies, such as watching television, window shopping, or going to the park, to manage postnatal loneliness (Dei-Anane et al. 2018; Gardner et al. 2014; Ling, Eraso, and Mascio 2023). As such, a lack of support during the postnatal period may reinforce cultural expectations of self-reliance, even during periods of vulnerability.

4. Discussion

This qualitative synthesis analysed nine papers to explore postnatal care and support experiences among Black women in the UK. The review aimed to include diverse gender identities, but the evidence base did not reflect this. This can be attributed to the age of the evidence. While scholarly discussions of gender and language have existed since the 1970s, such discussions have only recently entered maternity research and practice (Crossan, Geraghty, and Balding 2023). Consequently, our synthesis is limited to women's experiences and does not represent gender diversity. Additionally, most included studies predate policy changes and practice shifts; the findings may not fully capture contemporary realities. Our focus on Black women revealed similarities and differences among Caribbean-, African-, UK-, and non-UK-born women. For example, one African mother framed a lack of partner support as a cultural norm (Babatunde and Moreno-Leguizamon 2012). This highlights the importance of not homogenising the experiences of Black women; instead, care and support must remain responsive to differing cultural expectations, requiring nuanced rather than generic approaches. Our findings highlighted predominantly negative experiences, contrasting with Obionu et al.'s (2023) review, which found positive and negative maternity experiences among ethnic minority and immigrant women. The overwhelmingly negative findings are likely due to the predominance of PND-focused studies (6 out of 8). This introduces a bias, as experiences are weighted towards women dealing with perinatal mental health concerns. This focus possibly creates a deficit-based narrative and fails to represent the diversity of Black women's experiences. This highlights the need for more research on Black women's general postnatal experiences in the UK, rather than research solely focused on perinatal mental health. Furthermore, the studies lacked contextual information regarding the types of births women experienced, despite the close relationship between obstetric complications and their effect on women's mental health and overall experiences post-birth (Cross et al. 2023). For example, one woman in the included studies attributed mistrust to poor antenatal and intrapartum experiences, but this was not explored in depth. Future research should consider the birthing context and its impact on the postnatal period and should include a diverse range of gender identities.

4.1. Experiences of care

Black women's experiences of postnatal care are shaped by the interaction of racism and institutional pressures. Many women described receiving physically rough and

dehumanising care in postnatal wards. Our findings align with other studies that have documented how racism manifests in experiences of neglect, dehumanisation, and a lack of compassion, with some Black women observing less supportive care than white mothers (Birthrights 2022; MacLellan et al. 2022; Peter et al. 2025). Quantitative data also show that women from ethnic minorities are significantly less likely than white women to feel treated with kindness on postnatal wards (Henderson, Gao, and Redshaw 2013). Such care reflects the enduring legacy of colonial institutional racism and unconscious bias embedded within the NHS (Bvumburai 2021). Experiences of racism are linked to adverse health outcomes and undermine trust in healthcare staff, discouraging future help-seeking. This is particularly relevant, given that Black women face a maternal mortality rate of 2.3% higher compared to white women (Felker et al. 2025). However, the impact of this disparity is not uniform and may be intensified by intersecting oppressions such as religion, economic status, and migration history. In light of our findings and the wider literature, postnatal ward settings cannot be separated from the context of racism in UK maternity services. Importantly, experiences of racism intersect with broader institutional issues. Postnatal care has long been referred to as the 'Cinderella service,' reflecting its low status and chronic underfunding and understaffing within the NHS (Dykes 2009; NCT 2026). Understaffing, particularly on postnatal wards, has been linked to negative inpatient experiences (Turner et al. 2022). These, however, are not experienced universally. A study found that women described a 'postcode lottery' in maternity care quality, in which those living in more affluent areas receive better-quality maternity services (Fernandez Turienzo et al. 2021). A positive postnatal experience is recognised as laying the foundation for improved short- and long-term health and well-being, while promoting a sense of achievement, self-worth, and confidence, which are key to healthy adaptation to motherhood and psychological growth (Bawazir 2023). When Black women are denied these positive experiences due to racism, they risk poorer mental health outcomes and greater difficulty adjusting to motherhood.

Within the community, institutional issues arose where care was not personalised, a finding echoed in the literature, independent of race (Finlayson et al. 2020; McLeish et al. 2021). In our review, care was task-oriented, focused on physical recovery rather than on relational and personalised care. This finding is consistent with previous research showing that such task-oriented care can leave women feeling ignored and ill-equipped to meet the challenges of motherhood (Hunter and Rayment-Jones 2017). Our review found that it is particularly problematic for women whose culture limits access to informal emotional support, making interactions with healthcare professionals vital. When these encounters are superficial or procedural, mothers' needs are easily overlooked. The included studies reflected changing policy contexts, spanning a decade (Edge 2011; Gardner et al. 2014; Ling, Eraso, and Mascio 2023). However, the concept of personalised care has been emphasised in maternity guidance and policy for over 30 years (Tompkins et al. 2025). Most included studies predate recent policy developments, such as the NHS England Three-Year Delivery Plan (2023), which pledges to address inequalities through personalised care. Our findings reaffirm the necessity of this approach, as generic models risk perpetuating health inequalities for Black women. These interrelated challenges, racism, underfunding, and geographic disparities, demonstrate the complex and multi-layered factors that shape Black women's experiences of care. Alternative models that emphasise continuity of care and relationship-building

show promise for fostering trust and improving outcomes among ethnic minority women (Beake et al. 2013).

4.2. Experiences of support

Women's experiences of support were influenced by a lack of formal support, often compounded by a lack of informal support. Across the studies, women's mistrust of mental health services was deepened by cultural stigma towards mental health. This mistrust reflects broader patterns of institutional and structural racism. Black communities have historically faced disproportionate coercive psychiatric interventions (Rogers and Pilgrim 2014). For example, Black people were 3.5 times more likely than white people to be detained under the Mental Health Act in 2023 (GOV UK 2024). Black mothers in the UK are also subjected to disproportionate threats and referrals by social services (Birthrights 2026), which can increase alienation and perceptions of risk when disclosing mental health concerns. Our findings correlate with Jovanović et al. (2025), who found that cultural stigma was a main barrier to perinatal mental health support among Black and Asian women. When formal support services are inaccessible to women, the reliance on informal support may intensify. However, our review found that a lack of formal support was compounded by a lack of informal support. A lack of informal support also intersected with gendered expectations rooted in the 'Strong Black Woman' (SBW) ideal. The 'SBW' ideal, identified in Black feminist scholarship and characterised by expectations of resilience, independence, and emotional restraint, originated in US contexts with roots in the Transatlantic Slave Trade, and positions Black women as able to endure hardship (Beauboeuf-Lafontant 2009). UK scholarship has shown that it also operates for Black women in the UK, acting as a barrier to help-seeking and demanding self-reliance (Graham and Clarke 2021). Our findings further align with those of Watson and Soltani (2019), who found that ethnic minority women encountered 'double stigma' at the intersection of racial discrimination and prejudice experienced in health services, alongside cultural stigma. Our review adds that the 'SBW' ideal creates a 'triple burden,' as the intersection of community-based stigma, racial discrimination, and cultural expectations to be strong effectively distances Black women from beneficial services. As a result, Black women may be left feeling isolated, unsupported, and at greater risk of poor postnatal mental health and well-being. Our focus on experiences in the first year allowed us to capture how women compensate for a lack of formal and informal support. Faced with inadequate support, women drew on their resilience, adopting solitary coping mechanisms such as watching television and aligning with cultural expectations to push through. While such coping mechanisms offer short-term relief, they are ultimately unsustainable and insufficient.

4.3. Strengths and limitations

This review offers the first known synthesis of the postnatal experiences of care and support amongst Black women in the UK. A comprehensive systematic search strategy was employed to ensure broad coverage of relevant studies. A key strength of this review is the consistency of themes across multiple studies, which reinforces the credibility of the findings. However, the study has limitations. Only nine papers met the

inclusion criteria, reflecting the limited number of studies explicitly focused on Black women's postnatal experiences, and six of these focused on women with PND rather than a general sample of Black mothers. The review's approach to treating Black women as a single group presents a methodological limitation, as it cannot fully account for cultural differences. However, the low number of studies would not have permitted an alternative approach. Although differing experiences were highlighted, there are inherent risks of oversimplifying a heterogeneous population and potentially obscuring critical within-group variations.

4.4. Implications for clinicians and policymakers

The prevalence of dehumanising experiences emphasises the need for midwifery education to adopt a decolonial lens to interrogate the legacies of colonial racism (Lokugamage et al. 2022). The review revealed that women often resorted to solitary coping strategies; community-based interventions grounded in lived experience, led by trained facilitators from similar cultural backgrounds, may help reduce some mothers' feelings of isolation and promote a sense of belonging (McLeish and Redshaw 2017). A recent review indicated that this sense of belonging could extend beyond the individual by empowering women within their wider families or communities (Horn et al. 2025). Faith-based and cultural organisations should be integrated into maternal health strategies to offer non-clinical spaces for emotional and practical support (Widmer et al. 2011). Their involvement can also foster open dialogue about mental health (Conner et al. 2024). Targeted educational initiatives can further boost fathers' engagement and support for mothers (Daniele 2021). At the policy level, addressing the root causes of socioeconomic deprivation for Black families through targeted interventions is essential.

4.5. Future research

This review revealed several gaps in understanding Black mothers' postnatal experiences. Future research should examine women's experiences with health visitors and their engagement with formal community services. The review did not cover the impact of childbirth on employment and daily life, and factors influencing postnatal transitions, as well as the role of financial hardship, inadequate housing, and maternal health. The impacts of geographical separation on family support and the stigma surrounding PND were not thoroughly examined. Research on community-led and peer-support interventions was notably absent. The review did not capture effective models of postnatal care and support for Black women. Additionally, there was a gap in understanding the long-term trajectory of postnatal experiences, with longitudinal studies. There is a significant lack of studies that focus exclusively on Black UK-born women.

5. Conclusion

This review highlighted how inadequate postnatal care and a lack of formal and informal support created interconnected barriers that affected women's experiences. The 'SBW'

ideal compounded service inadequacies by discouraging help-seeking and giving by HCPs, while structural inequalities created additional layers of vulnerability for immigrant and economically disadvantaged mothers. Our findings highlight the need for culturally competent postnatal care and support that addresses both individual and structural barriers. Without targeted interventions or care models addressing these multifaceted challenges, Black women will continue experiencing cycles of isolation and unmet needs, perpetuating health inequalities.

Note

1. This review aimed to include participants from diverse gender backgrounds, such as non-binary birthing people. However, all but one included study referred to participants as "women" without specifying gender identity. One study reported participants self-identifying as women. We therefore use the term "women/birthing people" initially but adopt "women" to be consistent with the terminology of the included literature. We acknowledge the importance of gender in shaping postnatal experiences, particularly regarding equity and power dynamics.

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Author contributions

CRediT: **Lorraine Ashley:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Writing – original draft; **Christine McCourt:** Supervision, Writing – review & editing; **Marina Daniele:** Conceptualization, Supervision, Validation, Writing – review & editing; **Ellinor K. Olander:** Conceptualization, Investigation, Supervision, Validation, Writing – review & editing; **Katherine Waterfall:** Investigation, Writing – review & editing; **Diana Yeh:** Supervision, Writing – review & editing.

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Appendix

Appendix A1: MEDLINE COMPLETE search strategy

Search ran 01/08/24.

Search key: AB: searched abstract only MH: searched database indexing terms.	Search terms:	
S1	AB Black* OR AB Ethnic minorit* OR AB African OR AB Caribbean OR AB People of colo#r OR AB Afro-Caribbean OR AB BAME OR AB BME	(368,078)
S2	(MH 'Black People') OR (MH 'Ethnic and Racial Minorities') OR (MH 'Minority Groups') OR (MH 'African People') OR (MH 'West African People') OR (MH 'East African People') OR (MH 'Central African People') OR (MH 'Sub-Saharan African People') OR (MH 'North African People') OR (MH 'Caribbean People')	(60,022)
S3	S1 OR S2	(397,692)
S4	AB Postnatal* OR AB Postpartum* OR AB Maternity* OR AB Childbirth	(212,515)
S5	(MH 'Postnatal Care') OR (MH 'Postpartum Period')	(38,268)
S6	S4 OR S5	(230,488)
S7	AB Experienc* OR AB View* OR AB Perception* OR AB Emotion* OR AB Feeling*	(2,233,308)
S8	(MH 'Perception') OR (MH 'Emotions')	(133,954)
S9	S7 OR S8	(2,277,069)
S10	S3 AND S6 AND S9	((1,042)
S11	S3 AND S6 AND S9 S9 Limiters – Publication Date: 20040101-20241231 Search modes – Proximity	(951)

Appendix 2: Participant characteristics

Author	Race/ethnicity, country of Birth, migration status:	Age	Gender identification	Time since giving birth	Marital status	Education level	Employment status
1.Babatunde and Moreno-Leguizamon 2012	Black African Born in: Nigeria, Ghana, Kenya, Somalia, Sierra Leone Arrived in the UK within the last decade	Not stated	Not reported; authors refer to participants as women.	Up to 1 year	Married = 10 Single Parent = 4 Not living together (boyfriend) = 1 Husband abroad = 1	Bachelor's degrees = 2 GCSE level = 12 In education studying for various qualifications = 3	Self-employed = 1 Maternity leave = 1 Unemployed = 12 Looking for a job = 1 Student = 1
2. Dei-Anane et al. (2018)	Black African GhanaianBorn and raised in Ghana, Migrants in the UK	18-45	Not reported; authors refer to participants as women.	Not stated	Not stated	Not stated	Not stated
3. Edge (2011)	Black Caribbean (ethnicities not specified) Majority UK born	18-43 years old	Not reported; authors refer to participants as women.	Majority had children under 2 years old.	Not explicitly stated but included lone parents, and women who were married or cohabiting	Not stated	Not stated
4. Edge and Rogers (2005).	Black Caribbean Not stated	Ages varied. Did not report specific ages.	Not reported; authors refer to participants as women.	6 months to 1 year	Not explicitly stated but included variations in marital status	Not stated	Professional women Relatively low-paid, Low status Occupations Students Unemployed Career breaks
5. Gardner et al. 2014.	Black African Born in Nigeria or Ghana	22–36 years	Not reported; authors refer to participants as women.	Not stated	Married = 4Single parents = 2	Not stated	Not stated
6.Ling, Eraso, and Mascio 2023	Black African Nigerian-born living in the UK.	30-45 years old	Not reported; authors refer to participants as women.	Not stated	Married = 5Partner-relationship = 1	Not stated	All employed
7. Puthussery et al. 2010 and Twamley et al. 2011	Black African & Black Caribbean Other ethnicities included: Indian, Pakistani, Bangladeshi, Irish Born in the UK, 1st generation	From under 20-over 40	Not reported; authors refer to participants as women.	3 months to 1 year	Not stated	Degree or above = 17 A-level = 5 GCSE or below = 12	A mixture of unemployed and employed, some occupations not recorded.
8. Williams, McKail, and Arshad 2023	Black (ethnicities not provided) Not stated	23 and 41 years	Self-identify as women.	Not stated	Not stated	Not stated	Not stated

Appendix 3: CASP results

Author/ date	Statement of aims	Qualitative methodology appropriate	Research design appropriate	Recruitment strategy appropriate	data collection method appropriate	Researcher and participants relationship considered	Ethical considerations	Data analysis rigorous	Statement of findings	Valuable research
Babatunde and Moreno-Leguizamon (2012)	√	√	√	√	√	?	√	√	√	√
Dei-Anane et al. 2018	√	√	√	√	?	?	√	?	√	√
Edge (2011)	√	√	√	√	x	?	√	√	√	√
Edge and Rogers (2005)	√	√	√	√	√	?	?	?	√	√
Gardner et al. 2014	√	√	√	√	√	?	√	√	√	√
Ling, Eraso, and Mascio 2023	√	√	√	√	√	√	√	√	√	√
Puthussery et al. 2010 and Twamley et al. 2011	√	√	√	√	√	?	√	?	√	√
Williams, McKail, and Arshad 2023	√	√	√	√	√	?	√	√	√	√