

Migration and perinatal mental health: time to act / a call for action / ?

(940 words)

The past century has been termed the “century of human mobility” as a result of unprecedented migration flows globally (Skeldon 2013). Of the estimated 1 billion people on the move today, an increasing proportion are women: according to the International Organisation for Migration, women account for just under half (48.2%) of all international migrants (IOM 2013). Though all migrants experience a multitude of challenges, migrant women – especially those who are pregnant or have recently given birth – carry additional health needs that warrant particular attention.

The perinatal mental health of migrant women is influenced by a wide array of stressors experienced across the migration trajectory (Collins 2011). Prior to displacement, many migrant women – whether refugees or economic migrants - have been exposed to conflict, natural disaster, severe poverty or long-standing unemployment. Transit itself is often arduous, and women in particular may experience trafficking, abuse and sexual violence (Collins 2011). Following resettlement, many migrant women continue to live in conditions of socio-economic adversity as well as social isolation resulting from discrimination and cultural and linguistic differences. For pregnant and post-partum women in particular, the loss of cultural, social and material resources can have serious implications on wellbeing (Shishehgar 2017). Furthermore, access to maternity care and social support may be impeded by a combination of legal factors in the host country, a lack of trust, and the difficulties of navigating complex and unfamiliar health and social care systems. Pre-existing vulnerabilities thus combine with on-going stressors to create a high-risk situation for mothers in a country that is not their own (Shishehgar 2017).

Contrary to media portrayal, the vast majority of global migration occurs entirely within low- and middle income regions: in 2016, for example, developing countries hosted 84% of the world’s refugees in 2016 (WHO 2017). In these low-income settings, the consequences of undetected and untreated perinatal mental disorders for women, their children and families are particularly severe. Adverse effects of conditions such as perinatal depression on infants and children – including emotional, behavioural, cognitive and physical developmental problems – are more likely to occur in circumstances of socio-economic adversity (Stein 2014). Similarly, a woman’s impaired ability to work or provide care as a result of a mental health disorder may have more serious ramifications in a resource-poor environment where household incomes are likely to be lower and more precarious, and where social protection mechanisms are weaker. Finally, existing mental healthcare infrastructure in resource-poor settings may be lacking or over-stretched, meaning women in these contexts may be less able than those in high-income destinations to access the care they need.

A systematic review and meta-analysis of migrant perinatal mental health suggested that as many as one in three (31%) migrant women from low- and middle income countries may experience depression in the perinatal period, though high statistical heterogeneity means this figure must be interpreted with caution (Fellmeth 2017). Multiplied across the vast population of migrants worldwide, this represents a significant burden of disease, and it is imperative that health and social care systems respond appropriately with interventions ideally spanning the spectrum of primary, secondary and tertiary prevention.

One of the most consistent risk factors for perinatal depression among migrant women is a low level of social support (Fellmeth 2017; Shishehgar 2017). Community-based initiatives – including those centred upon skills-based activities – have been successful in promoting social cohesion and facilitating the development of social networks within migrant communities. Though further research is required to establish exactly what works, such community groups that are accessible to migrant women and responsive to their needs may represent an effective way of reducing the risk of developing mental disorders.

Secondary prevention might take the form of case identification of perinatal mental disorders. In many countries, women are routinely asked about their mental wellbeing as part of their antenatal and postnatal care. Further work is required to determine whether existing protocols are applicable to migrant women, or whether adaptations are required to ensure culturally-specific manifestations of perinatal mental disorders are not inadvertently missed. In order to promote uptake of perinatal care, health services should be inclusive and welcoming of women from all backgrounds. The availability of interpreter services and culturally-sensitive healthcare professionals may help to facilitate this.

Finally, appropriate management options need to be available for migrant women found to be suffering from perinatal mental disorders. This includes the existence of clear referral pathways and the availability of effective therapies and follow-up. In low-resource settings, non-specialist healthcare workers have effectively delivered interventions to improve symptoms of mothers with perinatal depression, offering a sustainable and low-cost means of managing the condition (van Ginneken 2013). Given the general scarcity of evidence around interventions, particularly in low-income settings, interventions must be accompanied by rigorous evaluation efforts in order to improve our understanding of what works in different contexts and for different sectors of the migrant community. As far as possible, representatives of the migrant community should be involved in the design, piloting and implementation of any such interventions.

Pregnancy and the postnatal period provide a window of opportunity during which women have increased contact with health services. Healthcare professionals should seize this opportunity to ensure that migrant women at risk of or with existing mental disorders are identified and appropriately supported across the individual, family, community and societal spectrum. Given the increasing populations of displaced women globally, the challenges these women face and the long-term sequelae of untreated perinatal mental disorders for women and their families, the mental health needs of migrants represent an urgent priority for research and action. Failure to appropriately address this issue risks the perpetuation of ill health, disadvantage and ultimately health inequalities experienced by migrant communities into the next generation.

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