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Vulnerable migrant women and postnatal depression: A case of invisibility in maternity services?

Abstract

Vulnerable migrant women are at an increased risk of developing postnatal depression, compared with the general population. Although some symptoms are the same as in other pregnant women, there are specific reasons why vulnerable migrant women may present differently, or may not recognise symptoms themselves. Factors associated with migration may affect a woman's mental health, particularly considering forced migration, where a woman may have faced violence or trauma, both in her home country and on the journey to the UK. Vulnerable migrant women engage less with maternity care than the average woman for reasons including a lack of knowledge of the UK healthcare system, fear of being charged for care, or fear that contact with clinicians will negatively affect their immigration status. This article explores the issues surrounding vulnerable migrant women that increase their risk of developing postnatal depression and presents reasons why this may go unrecognised by health professionals such as midwives.

Keywords

Mental health | Postnatal depression | Asylum seeker | Migrant women | Refugee

Between 12% and 20% of women will experience a mental health issue during pregnancy or in the first year following birth. The most common diagnoses are depression and/or anxiety, first diagnosed in the postnatal period (National Institute for Health and Care Excellence (NICE), 2014). A recent report (Knight et al, 2016) demonstrated that maternal suicide accounted for 9% of maternal deaths in the UK; the leading direct cause of deaths in the post-birth to one year period. The report shows that, generally, women born outside of the UK are at an increased risk of death in the postnatal period and although not attributed to suicide, women born outside of the UK represented 25% of the total deaths within the report, with 12% being refugee women. These statistics demonstrate that there are stark health inequalities for migrant women, both in physical and mental health.

A systematic review found that there was a higher incidence of postnatal depression in migrant women, with rates 1.5–2 times higher than those of the general population (Falah-Hassani et al, 2015). In this context of this review, 'migrant' was defined as any person moving to another country with the intention of settling there. The review considered a variety of risk factors, which included perceived insufficiency in household income, isolation from friends or relatives, experience of stressful life events and living in the host country for less than 10 years. Nevertheless, some risk factors may further increase a woman's risk of developing postnatal depression depending on her migration status, and the review contained no consideration of how different types of migration might influence a woman's risk of developing postnatal depression.

This article will therefore focus on 'vulnerable migrant women'. This is a term that has different meanings globally, so this article will use the Public Health England classification, which includes asylum seekers, refugees, trafficked persons and those living in the UK without legal status, often termed 'undocumented migrants' (Public Health England, 2017).

Definitions

Migrant women enter the UK for different reasons, both voluntary (for reasons such as study, work and marriage) and forced due, for example, to circumstances in their home country. It is suggested that women forced to leave their own country are the most vulnerable migrants as they have often travelled alone, are a minority population and may have uncertain migration status (Latif, 2014; Phillimore, 2015). Forced migrant women or migrant have an increased risk of invisibility within maternity services (Phillimore, 2015).

The vulnerable migrant women referred in this paper are all considered to be forced migrants by the International Organization for Migration (IOM) (2011). This includes women seeking asylum; a person seeking safety from persecution or serious harm in her home country who, on entering the UK, submits an application for refugee status. 'Refugee' is the term for a person granted leave to remain in the UK (IOM, 2011), including resettled families, such as those from Syria being brought to the UK from refugee camps as part of the Government resettlement scheme (Refugee Council, 2017). Trafficked women have been forcibly moved from another country to the UK for the purpose of exploitation. A trafficked person is assessed by the National Referral Mechanism and may be assisted to return to her home country or may choose to make an application for asylum if she feels it would be unsafe to return (Council of Europe, 2005).

Improving mental health in pregnancy and the postnatal period is high the government agenda, with plans to commission new services and widen access to perinatal mental health specialist practitioners (Independent Mental Health Taskforce, 2016). Although it is positive that more women will be able to access care in future years, migrant women may have complex histories and needs, increasing their risk of invisibility within NHS systems (Bauer et al, 2014). Rates of postnatal depression can be as high as 42% in vulnerable migrant women, while their access to antenatal care is typically less than 50%, partly due to a fear of being charged for services (Beck et al, 2011; Shortall et al, 2015). It is essential that midwives recognise some of these complexities so that access to and engagement with maternity mental health provision can be improved.

Risk factors of postnatal depression in vulnerable migrant women

Risk factors may be classed as pre- or post-migratory. Women may be fleeing war or persecution based on their religion, sexuality and political beliefs, and vulnerable migrant women may have witnessed or experienced sexual violence either in their home country, during their journey to the UK or while in refugee camps (Zimmerman et al, 2009). They may have experienced gender-based violence and rape used as a weapon of war during the migratory period (Stewart et al, 2012; Urquia et al, 2012). Women may also be fleeing female genital mutilation—either of themselves or their young children (Casey, 2011). Often, women have had to leave some or all of their children behind holding the burden of risk in the decisions they have made (Zelkowitz et al, 2008). These experiences may lead to psychological conditions such as depression, anxiety or post-traumatic stress disorder, which are a documented risk factor for future long term mental health problems (Craig et al, 2009). Pre-existing or previously undiagnosed mental illness is highly correlated with

incidence of postnatal depression (NICE, 2014).

Post-migratory issues are frequently practical as well as emotional, and include social isolation, language barriers and separation from family members (Collins et al, 2011; Falah-Hassani et al, 2015). Asylum seekers face an application procedure that can be long and arduous, during which women can feel fearful of the application being rejected and being deported back home (O'Mahony and Donnelly, 2013). In addition, these women face dispersal (Feldman, 2014), whereby they may be moved by the Home Office with little notice, often at night, and relocated to new accommodation elsewhere in the country. Women have reported feeling de-humanised by the process, being removed from their support networks, facing hostility from dispersal staff and feeling abandoned in unfamiliar locations, with delays in accessing medical and maternity care due to language barriers and unfamiliarity with UK health system processes (Feldman, 2014). Due to restricted benefit entitlement, poverty also impacts on women's ability to make social networks and access consistent maternity care appointments (Merry et al, 2011). Consideration of these factors demonstrates some of the ways in which a vulnerable migrant woman can easily become an invisible member of society and consequently miss valuable maternity care. It also provides key indicators for the high maternal mortality rate in migrant women in Knight et al's (2016) report.

For many women, obtaining refugee status and a leave to stay in the UK does not resolve these problems. Support from formal agencies and services is rapidly withdrawn and financial aid must be reapplied for, frequently leading to a time of transition without any access to benefits or support, which may result in a period of destitution (O'Mahony et al, 2012). Although the health of asylum-seeking women may initially improve on entering the UK, where basic health needs are met, ongoing poverty and reduced social support increases the risk that the woman's health will deteriorate (De Maio, 2010).

Social isolation loneliness and lack of supportive friendship is a common theme among all migrant women (Latif, 2014; Falah-Hassani et al, 2015). Vulnerable migrant women describe additional risk factors, including hostile attitudes from the local community (Mulvey 2010). Accusations of producing 'anchor babies' to obtain citizenship are described in a Canadian study (Vanthuyne et al, 2013), and racism and discrimination is prolific in qualitative studies that explore the experiences of vulnerable migrant women (Berggren et al, 2006; Briscoe and Lavender 2009; Balaam et al, 2013). Women may have left matriarchal communities, where pregnancy and transition to parenthood was supported by female family members rather than midwives. Removing this cultural norm can further increase isolation (Collins et al, 2011; Stapleton et al, 2013a).

How vulnerable migrant women may describe and perceive symptoms of postnatal depression

A recent meta-ethnographic study (Schmied et al, 2017) synthesised the findings of 15 papers looking at the experiences of both forced and voluntary migrant women. Although it is not possible to extract the data for vulnerable migrant women alone, the authors concluded that all women in the synthesis attributed their experiences and symptoms

associated with postnatal depression to their position as a migrant woman. In addition, all women in the review reported difficulties accessing services, thus demonstrating their invisibility in maternity services.

Although many of the generalised symptoms of postnatal depression, such as low mood, apathy and fatigue, equally apply to vulnerable migrant women, these women may not verbally express these symptoms in the same way when questioned by a midwife. Instead, they may describe somatic rather than psychological symptoms (Jadhav, 2000). A study of Bangladeshi women in London found that women described physical symptoms such as aching, trembling and pressure in their hearts (Parvin et al, 2004). Similarly, another study found that black and minority ethnic women described physical exhaustion, rheumatic pain and even fibromyalgia (Templeton et al, 2003). In a further study, African migrant women associated depression with changes in body odour and feelings of their body being physically drained by the birth process (Ahmed et al, 2008).

Although the term 'depression' is now internationally recognised, the meanings and understandings across cultures is divergent (Kokanovic et al, 2008; Hayden et al, 2013). Non-western women may have symptoms of postnatal depression, but the concept may not exist within their language or culture (Jain and Levy, 2013). Stapleton et al (2013b) found that non-western women may hold a concept of depression as a collectivist 'we' (family/community) phenomenon. This is in contrast to the Western understanding of happiness being located at the level of the individual, a notion not recognisable to many other global communities (Oishi et al, 2008). Even when a woman recognises and discloses symptoms of depression herself, there may be hostility and stigmatisation from her family or local community. In some cultures, mental illness may be associated with sorcery or curses, leading to the woman being outcast or at risk of harm (Hanlon et al, 2009; Johnson et al, 2009). Knowledge of different ways of articulating symptoms of depression may aid midwives recognising signs of postnatal depression in vulnerable migrant women.

Considerations for midwives caring for vulnerable migrant women

Complex factors, such as reason for migration, social situations and cultural constructions of mental health, can present challenges for midwives who care for vulnerable migrant women. Research shows that clinicians may lack confidence in caring for asylum seekers or refugees and taking into account the relatively unique problems these patients may present (O'Donnell et al, 2007; Johnson et al, 2008). Suurmond et al (2010) found that access to and engagement with care can be improved when practitioners developed perpetually evolving cultural competence. This qualitative study explored the development of cultural competence in 89 experienced Dutch nurses, who stressed the importance of understanding the significance of pre- and post- migratory illness, and the situation that the

person had ed. Individual relationship-building was considered essential, acknowledging the diversity of experiences asylum-seekers bring with them as a population. Interestingly, nurses in the study reported that they often found it necessary to stress that they had no control over service users' immigration application, which encouraged patients to speak in confidence about mental health issues, safe in the knowledge that disclosure would not affect their application. These points can equally be applied to midwives caring for vulnerable migrant women in the UK.

Reflection on one's own attitudes and beliefs is an important consideration. A Canadian study by Vanthuyne et al (2013) used an online survey that was completed by clinicians, administrators and support staff. One-third of respondents felt that access to care was a privilege for pregnant women and described immigrants as an additional strain on a struggling healthcare system. UK midwives work in a similar healthcare system, and are required to balance their own views on migration with the pragmatic difficulties of working in an overstretched NHS, while ensuring that each woman receives the care to which they are entitled.

Assessing and caring for vulnerable migrant women in maternity services

A holistic approach should be adopted in the care of vulnerable migrant women, considering the wider context and how experiences in the woman's home country, her journey to the UK and subsequently living in the UK may have influenced her mental health. 'The pregnant woman within the global context' model (Haith-Cooper and Bradshaw, 2013) provides a visual tool to assist this holistic approach. The woman is placed centrally within the model, and factors influencing her mental health can be considered both within the macro layer (living in the UK) and global layer (experiences back home). In addition, it is vital that the midwife builds trust with the woman, who may be wary of health professionals, based on past experiences. Women are more likely to engage with healthcare when a clinician takes the time to explain both the host country's healthcare system and the clinician's role within it (O'Donnell et al, 2007).

Overcoming language barriers is an essential step in addressing mental health difficulties. Use of interpretation itself is a complex issue in vulnerable migrant women. Increasingly, women present with uncommon mother-tongue languages and there may be few interpreters available who speak that language (Henderson and Kendall, 2011). Women may therefore speak to interpreters through a second language or different dialect, reducing the accuracy of information conveyed. In this instance, interpreters are increasingly sought and trained from the local community but women may not trust them to maintain confidentiality (Stapleton et al, 2013b). A study by Binder et al (2012) highlighted the importance cultural congruence when communicating with migrant women. They report

that trust, engagement with care and disclosure of sensitive issues is improved when the clinician has a shared understanding of the woman's cultural background, including concepts of health (such as common ideologies of mental illness) and cultural differences in expectations of healthcare providers. This understanding must come from meaningful conversation with the woman herself, being respectful and upholding her preferences around choice of interpretation method.

Screening tools are commonly used by midwives to assess women's mental health both antenatally and in the postnatal period, and examples include the Generalised Anxiety Disorder Scale (GAD-2), the Patient Health Questionnaire (PHQ-9) or the Edinburgh Postnatal Depression Scale (EPDS) (NICE, 2014). Despite the suitability of these scales for many women, these tools may not adequately identify depressive symptoms in vulnerable migrant women and cannot be relied on in isolation. The EPDS may not have cultural relevance among vulnerable migrant women with diverse ethnicities, and may not be a reliable tool in screening for postnatal depression (Zubaran et al, 2010). Many tools have been validated for use in other languages, but they have not been psychometrically tested for use in refugee women, or for use through an interpreter (Tobin et al, 2015). Tobin et al argue that screening questions in the EPDS (and other American screening tools) may lack cultural relevance, describing western concepts that are not easily translatable. The authors also identified that due to language barriers, the screening tools are frequently not self-completed, relying on the presence of an interpreter to translate and possibly transcribe, potentially reducing the tool's validity.

Tobin et al's study found that refugee and migrant women who demonstrated significant symptoms associated with postnatal depression did not reflect this in the screening scores. Screening tools that use Likert scales (such as the EPDS) present difficulties for women from culturally and linguistically diverse populations, who may not understand the linguistic subtleties within the scale (Flaskerud, 2012). A study considering EPDS use (Stapleton et al, 2013b) reported that, during the screening process, interpreters felt uncertain about the accuracy of translation, and felt responsible for finding a cultural equivalence to the screening question. The study also found that women avoided disclosure via the interpreter (who might be known in their community). There is a scarcity of literature assessing the validity of new generation screening tools in vulnerable migrant women (Zubaran et al, 2010) and a systematic review suggests that women from all populations may prefer to talk through issues in person, rather than completing a questionnaire (Brealey et al, 2010).

Continuity of carer is especially important for vulnerable migrant women. The study by Suurmond et al (2010) study found that asylum-seeking women valued not being required to repeatedly discuss the conditions or political issues of their home country, as doing so led

to feelings of shame or interrogation. Although midwives should not pry into reasons for a woman leaving her home country, an understanding of the country's political situation can provide an insight into the experiences that a woman may have endured, which may in turn help the midwife to provide culturally sensitive care.

Conclusion

Vulnerable migrant women have an increased risk of developing postnatal depression, compared with the general population. It is clear to see there are risk factors for a woman's increased invisibility within maternity services such as dispersal, fear of disclosure affecting immigration applications, and lack of familiarity with UK healthcare systems, all of which may affect vulnerable migrant women with postnatal depression being identified and able to access timely treatment.

Midwives are in a key position to improve the recognition of women displaying symptoms of postnatal depression, which may present somatically as physical ailments, or be a response to the trauma surrounding leaving their home country and the journey to the UK. A common cause of distress amongst all migrant women in this article is the loss of identity and ability to enact cultural traditions associated with the transition to parenthood, increasing feelings of isolation.

Midwives also have the opportunity to explore concepts of depression with women who may not have an understanding of postnatal depression within their own culture or language, and who may associate it with stigma or discrimination.

Migrant women coming to the UK may not have a knowledge of the role of the midwife or the UK healthcare system, or may fear being charged for care. Clarifying the clinician's role and responsibilities, particularly regarding influence on immigration proceedings and access to free maternity care may increase a woman's engagement with services. Continuity of care, as for any woman, is more likely to lead to a trusting relationship and the ability to have sensitive, meaningful discussions about mental health.

Midwives are therefore ideally placed to increase the visibility of vulnerable migrant women and to improve the recognition of symptoms of postnatal depression in this population. BJM

Key points

- Forced migrant women are the most vulnerable women in this population.
- Risk factors for depression may be pre and post-migratory in origin

- Depression screening tools may not accurately identify depressive symptoms in this population
- Unfamiliarity with the UK healthcare system can be a barrier to accessing care available
- Dispersal is a significant barrier to women building relationships with midwives and accessing care

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