Policy Brief: Migrant and Refugee Women's Perinatal Mental Health

Multicultural Centre for Women's Health

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Multicultural Centre for Women's Health is a feminist organisation led by migrant and refugee women to achieve equity in women's health and wellbeing.

Background

This policy brief has been developed by the Multicultural Centre for Women's Health (MCWH). MCWH is a Victorian-based women's health service established in 1978 that works both nationally and across Victoria to promote the health and wellbeing of migrant and refugee women through advocacy, social action, multilingual education, research, and capacity building.

This policy brief outlines the key issues pertaining to migrant and refugee women's perinatal mental health and wellbeing, as well as considerations for perinatal mental health policy, programs and service delivery. The issues outlined in this brief have been obtained from a variety of sources, including a comprehensive literature review of current research on migrant and refugee women's mental health.[i]

This Policy Brief focuses specifically on migrant and refugee women's perinatal mental health. As with all health issues, MCWH applies an intersectional lens to understanding and analysing perinatal mental health. This lens goes beyond explanations that use single categories such as gender or ethnicity to describe issues. Instead, it recognises that individuals are shaped by many factors and that women's experiences of inequity are influenced by specific social, economic and political contexts, systems and structures.

The issues

Perinatal[ii] mental health conditions are common and can affect up to one in five mothers in Australia.[1] Women's experiences of perinatal mental health issues, such as depression and anxiety, can present differently as panic, agitation, frustration, anger, low mood, sadness, hopelessness, or

[i] For more information, please see: **https://www.mcwh.com.au/project/migrant-and-refugee-womens-mental-health-and-wellbeing/**

[ii] The perinatal period refers to the period during pregnancy and the first year after birth.

long-term withdrawal. There is increasing recognition that perinatal depression and anxiety creates challenges to maternal and infant wellbeing, and contributes to maternal mortality, adverse neonatal, infant and child outcomes.[2, 3]

One third of women giving birth in Australia are migrants, with the majority coming from mainly non-English speaking countries.[4] The proportion of mothers born overseas has increased over the last three decades, and demographic projections show that it will continue to increase in the coming years. Evidence consistently indicates that perinatal mental health is considerably worse among migrant and refugee women.[5] Compared to Australian-born women, migrant and refugee women experience higher rates of depressive symptoms and anxiety during the perinatal period.[6] Australian research found that pregnant refugee women have also reported higher rates of major depressive disorder (32.5%) in the antenatal period[iii] compared with pregnant Australian-born women (14.5%).[7]

During the perinatal period, migrant and refugee women experience similar risk factors for mental health issues as the Australian-born population, such as isolation, socioeconomic difficulties, and physical health problems.[8, 9] However, there are distinctive and intersecting risk factors for migrant and refugee women including low levels of social support, precarious immigration status, and violence against women. In addition, migrant and refugee women experience significant barriers to accessing perinatal mental health services. Some of these barriers include: the complexity of the healthcare system, lack of culturally and linguistically responsive services, and the high cost of services, particularly for women on temporary visas who are not eligible for Medicare.[10]

Despite the evidence that migrant and refugee women experience higher rates of perinatal mental health issues, the perinatal support needs of migrant and refugee women and their preferred support interventions have received inadequate attention within government policy and service design. At the policy level, there is a tendency to discuss migrant and refugee communities as a homogenous group, which fails to meaningfully consider the impact of gender on mental health, and the differing needs of both individuals and communities. At the organisational and sector level, lack of gendered, culturally relevant or appropriate perinatal mental health services for migrant and refugee women, as well as cost of services, are complex barriers which prevent migrant and refugee women from seeking help.[6] As such, there is an urgent need to create more gendered, culturally appropriate and equitable perinatal mental health services for migrant and refugee women. An intersectional, evidence-based analysis of the risk factors that contribute to migrant and refugee women's perinatal mental health is crucial in order to develop the policy reforms required to meet the needs of migrant and refugee women during the perinatal period. The following section of this Policy Brief will outline some of the risk factors impacting migrant and refugee women's perinatal mental health, while recognising that many other factors also impact on the mental health of migrant and refugee women in the perinatal period.

Lack of social support and social isolation

Evidence shows that for migrant and refugee women, limited social support and social isolation are risk factors for perinatal mental health issues.[5, 11] Both informal support provided by friends, families, and communities, and formal support, such as that provided by healthcare and social work

[iii] The antenatal period refers to the time from conception to before birth.

practitioners[12], play a vital role in helping women cope with challenges during pregnancy and obtaining better postpartum mental health.[13] Evidence suggests that social support can help migrant and refugee women during the settlement period and contributes to positive mental health outcomes. For example, adequate social support can help prevent depressive and anxiety disorders, and increase access to care and services.[14] However, due to separation from family and social networks through the migration process, and social isolation after settlement, levels of social support are frequently reduced and lower among migrant and refugee women.[12, 15] Women's connections with informal and formal social supports after migration can be further constrained because of systemic barriers such as the lack of gendered, culturally and linguistically appropriate support services available.

In addition to limited social support, social isolation is also associated with perinatal mental health issues among migrant and refugee women.[8, 15] Limited English proficiency is a consistent risk factor for social isolation, especially among women who migrated as refugees or are from low-income and conflict-affected countries.[5, 16, 17] The health care system can also be complex and difficult to navigate. Lack of culturally responsive services and inadequate use of trained interpreters lead to difficulties in communication between practitioners and patients,[18, 20] which can prevent migrant and refugee women from achieving a safe pregnancy and positive perinatal mental health outcomes. For example, several studies have highlighted how inadequate awareness of perinatal and postnatal cultural beliefs and practices on the part of health professionals can negatively impact migrant and refugee women's mental health.[18, 21] The lack of culturally appropriate health service delivery may cause migrant and refugee women to feel excluded from health care decisions made by health professionals in their perinatal period. As a result, migrant women may be less likely to use perinatal mental health services, and less likely to seek help for their emotional difficulties during pregnancy and after birth.[10, 20]

Precarious immigration status

Australia's immigration policies have played a role in contributing to migrant and refugee women's mental health issues.[22, 23] Issues related to immigration visas create challenges and hardship for migrant women.[24] For example, research shows that women who arrive in Australia under partner visas face a heightened risk of experiencing mental health issues. Women who arrive in Australia on temporary visas and who are waiting to transition to permanent residency are often placed in precarious situations,[24] and many women may be forced into dependent relationships, in which sponsoring partners have disproportionate opportunities to control decision making. [25, 26] Living with such uncertainty may contribute to feelings of isolation, depression, anxiety and suicidal ideation.[24, 26]

Eligibility for many social services, including eligibility for a Medicare card which enables access to a range of health services and interventions, depends on visa status. As only permanent residents are eligible for Medicare, Health Care cards, financial support (Centrelink), and childcare or housing support, many migrant women who are asylum seekers, and those on temporary and bridging visas, are denied access to essential services due to their visa status. In some rural areas, antenatal care is provided only through GP clinics which require Medicare cover. While some health services are covered through private health insurance taken out by women on temporary visas, not all services

are covered, and in many cases, pregnancy related health care is only available after a 12-month waiting period. These exclusions within the public and private health care systems are a significant barrier to accessing and receiving antenatal care for migrant and refugee women.[6] Women who receive regular and appropriate antenatal care are more likely to be linked in and made aware of available perinatal mental health services. Additionally, migrant and refugee women on temporary visas may have limited work rights, leading to financial disadvantage and insecurity.[24, 27] They may not be able to pay for health care, pathology tests or access basic services. Many migrant women are unable to seek support for their perinatal mental health issues because of the high cost of services [6] and the gap between the Medicare subsidy and upfront fees.[28]

Family violence

The impact of family violence on mental health is well documented. According to the World Health Organisation (WHO), intimate partner violence is linked to an increased risk of mental health issues such as post-traumatic stress disorder, sleep problems, eating disorders, and emotional stress.[29] During pregnancy and postpartum, women are at greater risk of experiencing violence from an intimate partner. Evidence from data collected in a large Australian prospective pregnancy cohort study indicated that around one in six Australian-born women (16.9%) and more than one in four migrant women (22.5%) experienced intimate partner abuse in the first 12 months postpartum.[30]

Pregnant women who experience family violence may have difficulty obtaining appropriate and sufficient social support, including support from family, friends, and professionals, which can result in severe perinatal depressive symptoms.[31] There is evidence to suggest that migrant and refugee women may experience a higher burden of these symptoms and intimate partner violence.[30] The compounding impacts of displacement-related trauma and resettlement processes with greater social and economic disadvantage have been found to negatively impact perinatal mental health outcomes among migrant women.[17]

In particular, post-migration issues such as immigration policy, temporary and dependent visa status, and social isolation are additional complicating factors contributing to migrant women's vulnerability to violence. However, the family violence system remains inaccessible and/or unadapted to many migrant women and women may experience considerable challenges and barriers when seeking support. Recent research has shown that while family violence reports increased among the general population after the Royal Commission into Family Violence (RCFV), this was not the case for migrant women where reporting remained low.[32]

COVID-19

The COVID-19 pandemic has created considerable uncertainty and challenges for migrant and refugee women. As the *Left Behind Report*[30] showed, the pandemic had a profound impact on the mental, physical, and financial wellbeing of migrant and refugee women across Victoria. Of the 75 migrant and refugee women interviewed, over 90 per cent reported experiencing multiple hardships such as household financial stress, family separation and isolation from communities, housing insecurity, discrimination in accessing government support, loss of employment, reduced income, increased hours of unpaid care work, mental health issues, and difficulty accessing healthcare.[33]

The COVID-19 pandemic has added new levels of stress for migrant women in the perinatal period. Strict quarantine and prolonged lockdowns exacerbated isolation and loneliness for many migrant mothers. Border closures during the COVID-19 pandemic disrupted families' travel plans and forced migrant mothers to raise their babies alone without support from extended family members.[34] Migrant and refugee mothers have experienced overwhelming challenges, including inadequate social support, which is a strong predictor for perinatal mental health issues.

Support for migrant and refugee women

While there remains many gaps in our understanding of migrant and refugee women's experiences of perinatal mental health, particularly from an intersectional lens, several initiatives have sought to tailor service support programs to address migrant and refugee women's perinatal mental health and wellbeing.

For example, a health screening program for women from refugee backgrounds, codesigned by maternal health service stakeholders, community-based refugee health services, NGOs, and community members, was developed as part of a dedicated refugee antenatal clinic.[35] The clinic employed bicultural workers and refugee health nurse liaisons from a community-based refugee health and wellbeing service and introduced the use of the Edinburgh Postnatal Depression Scale (EPDS) tool. An evaluation of the program from the perspective of health professionals found that the program has been rated as positive by staff and was determined by the evaluators to be acceptable and feasible.[35]

Another community-based antenatal service, involving a midwifery model of care for migrant and refugee women was also developed in Perth. This initiative enables women to ask questions and receive assistance in relation to pregnancy and non-pregnancy issues, as well as providing social support that was not necessarily available through women's personal networks.[36]

Additionally, migrant-women led initiatives and programs are important when it comes to developing awareness of mental health and wellbeing in the perinatal period. For example, MCWH's in-language education on mental health prevention and support, delivered by highly skilled and trained health educators in women's preferred language, provides migrant and refugee women with gendered, and culturally appropriate information about perinatal mental health.

Although these particular programs have sought to address the perinatal mental health needs of migrant and refugee women, there is a need for further research and evaluation in order to determine their efficacy, and identify best practice when working with migrant and refugee women, more broadly.

Recommendations

- Invest in and strengthen intersectional policy development and analysis to ensure that Australian government policy at all levels impacts positively on migrant and refugee women's perinatal mental health. For example, analysis and evaluation of the mental health system and perinatal service delivery options should address the multiple forms of disadvantage and barriers to accessing services experienced by migrant and refugee women

- Develop perinatal mental health services for refugee and migrant women and ensure the services are high quality, gender equitable, accessible, and culturally and linguistically responsive

- Provide ongoing investment to multilingual and ethno-specific organisations to facilitate tailored education about perinatal mental health and available support services. These programs should be delivered by trained bilingual health educators and work to increase understanding about migrant women's perinatal mental health, promote perinatal mental health and emotional wellbeing, and decrease risk factors impacting the mental health of migrant women in their perinatal period

- Develop an appropriately qualified workforce by training mental health service staff and interpreters in gendered and cross-cultural awareness

- Continue to develop and enhance the existing models of perinatal mental health surveillance/screening and assessment to improve early identification and intervention at the primary care level that meet the specific needs of migrant and refugee women

- Ensure all mental health prevention, early intervention, support and treatment services, as well as interpreting services, are available to migrant women free of charge, regardless of migration status

- Conduct further participatory action research that is inclusive of or focusses on migrant and refugee women's perinatal mental health needs

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