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Maternal Mental Health in Refugees and Migrants: a Comprehensive Systematic Review

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Abstract
The first years of motherhood are often difficult for women, requiring large emotional and biophysical adjustments and increased health risks that may combine with social disadvantage and psychosocial conditions towards decreased maternal well-being. Those outcomes are usually worse in vulnerable populations, as refugee and migrants. Comprehending mothers' needs regarding mental health and psychological well-being must be prioritized. A systematic review using MEDLINE, EBSCO, and SCOPUS databases was carried out, searching for population-based studies published between 2012 and 2022 reporting on maternal mental health in displaced populations. A total of 2881 articles were retrieved; 35 publications met the inclusion criteria, being included in the final evaluation. Displaced women tend to be at higher risks of maternal mental distress, due to life stressors, isolation, intrapersonal and background characteristics, mental health stigma, discrimination, and barriers in accessing adequate healthcare. Refugee and asylum-seekers are at the most vulnerable positions. Postpartum depression is the most assessed condition regarding mental health but is manifestly insufficient for public health systems in assuring an adequate state of maternal well-being. Maternal mental healthcare must be patient-centered, more accessible, and available to both native and displaced mothers. PROSPERO Registration Number: CRD42022335343.

Keywords Maternal mental health · Migrants · Refugees · Recent motherhood

Introduction

Pregnancy is, generically and socially, a happy celebrated event, culminating in the consubstantiation of a life. The changes involved in pregnancy and early motherhood (e.g., hormonal, biopsychological, and social) can however be very stressful in

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normative stable conditions (Navodani et al., 2019). Social attention is usually more focused on the baby rather than the mothers (Huschke, Murphy-Tighe & Barry, 2020).

Mental health is an area that has always had little investment worldwide. As stated in the World Health Organization's Mental Health Atlas (WHO, 2021), the percentage of governments' health budgets spent on mental health still hovers around 2% of gross domestic product. The greatest investment made over the years around perinatal mental health is in scientific research (overall), although little has been translated nor transformed in knowledge or practice, towards communities and population. An enlightening comprehensive fact resides in realizing that, according to Mental Health Atlas, only 21% of WHO Member States have a mental health policy or plan (globally, not directed to mothers) that is in the process of implementation and fully compliant with human rights instruments. The same report stated that only 25% of WHO Members assume the integration of mental health into primary healthcare, from which only 10% are devoted for "parental/maternal mental health prevention and promotion" (WHO, 2021).

The postpartum period is often difficult for recent mothers, requiring large emotional and biophysical adjustments and increased health risks that may combine with social disadvantage and psychosocial conditions, resulting in decreased maternal well-being. International agenda has been underlining the need to improve maternal attention to assure fairer and improved outcomes in vulnerable populations (Huschke et al., 2020; Navodani et al., 2019).

Research and policy in maternal mental health usually focus on "measuring and evaluating the effects of negative aspects of wellbeing," that is, on perinatal mental health problems, which include postpartum depression (PPD), anxiety, obsessive-compulsive disorders (OCD), post-traumatic stress disorder (PTSD), and postpartum psychosis (Huschke et al., 2020). Despite that, most research limited itself to studying PPD, leaving all other clinically significant and distressing conditions and symptoms uncovered (Lubotzky-Gete et al., 2021; MacKinnon et al., 2017). Some studies often highlight that PPD decreases from pregnancy to the first few weeks of postpartum. This data is subliminally dangerous as it ignores studies that are beginning to point out that prevalence of depressive symptomatology is not always present in more severe forms of maternal mental illness, as suicide (Fellmeth et al., 2021; MacKinnon et al., 2017).

Literature shows that the leading cause of maternal death during the first year of a child is suicide (Bauer et al., 2014; Pilav et al., 2022). Beyond the loss of life due to perinatal suicide, the effects on family and community are profound and have a lasting metacontext impact.

Maternal mental health problems are associated with numerous risks for mothers' and children's development, both short-term and long-term. Studies have found that stress and anxiety during pregnancy lead to less emotionally stable infants (e.g., lower levels of emotional self-regulation) (Huschke et al., 2020). There is an intergenerational impact and a strong dose-response relationship between exposure to adversity and poor health outcomes, including depression, anxiety, substance use, sexually transmitted diseases, suicide attempts, and a range of complication at birth and chronic diseases, and there is increasing interest in the role maternal mental health plays in the intergenerational transmission of experienced adversity (Eastwood et al., 2021).

As vulnerable populations, due to displacement, migrants and refugees are systematically at a greater risk of suffering from psychological distress and mental health issues (Almeida et al., 2016; Ganann et al., 2020). During a susceptible period as recent motherhood, the risks are also higher: displaced mothers not only are more prone to have mental health conditions but also are more likely to have worse symptoms, to went undiagnosed or untreated, and to more complex comorbidities (the case of refugees and asylum-seekers) as often associated with trauma, PTSD, and anxiety disorders (Gagnon et al., 2013; Ganann et al., 2020).

Accompanying the stress of migration (which varies with its type: planned or forced), difficulties grow exponentially: feelings of insecurity, isolation, self-perceptions of affective deprivation, missing local culture and family, strangeness in relation to new cultural habits, linguistic and religious differences, and sometimes hostility and discrimination from host population becomes dramatic and weakening, making these women particularly vulnerable to distress, anxiety, and postpartum depression (Ahmed, Bowen & Feng, 2017; Almeida et al., 2016). When it comes to mental health, culture can play a significant role, as mental health is shaped by cultural beliefs, values, and norms. Even more so when talking about maternal mental health, a subject laden with expectations, beliefs, expected conduct and behaviors, traditional and cultural recipes, and models. Culture can impact not only the way an individual understands and copes with mental illness but also how he/she seeks help and support (Cetrez, Atchulo, Garosi, Hack & Rajon, 2021).

Maternal mental health surely deserves the attention that has not been given yet. It is crucial to consider the possibility of aggravated risks due to preventive public health measures arising from the pandemics (likely to endure after its end) — home isolation, remote consultations, inability to obtain expected level of healthcare and support, prenatally and postpartum (Pilav et al., 2022). Though most postnatal mothers in the context of COVID are experiencing worsened mental health outcomes, several studies show that migrants and refugee women are significantly more likely to experience postpartum symptoms—at a rate three-to-five-times higher than native women (Pilav et al., 2022; Stirling Cameron et al., 2021).

While discussions about physical health are open, issues on mental health are conspicuously absent worldwide. An inclusive human rights-based approach that guarantees availability and accessibility of psychosocial support and mental healthcare for all migrants, host communities, and vulnerable populations can contribute to positive social, economic, and cultural outcomes for societies (WHO, 2021). Thus, several questions lead our study: What conditions do we have — globally — to assist for migrant and refugee recent mothers? Are the efforts undertaken by states regarding mental health prevention and intervention programs well targeted? What conditions still account with no response? Are mothers' needs being considered? Are people being listened? What about the cultural aspects, so often overlooked, and working against interventions' success?

Our study intends to address all these issues, combining them into the following: What are the main issues and needs regarding mental health and psychological wellbeing arising during the first years of motherhood, namely on refugee and migrant women, which should be addressed (preventively or proactively) by health systems? Our aims are to highlight the state of the art and to map the needs regarding maternal

mental health that arise along recent motherhood, namely on migrants and refugees, that should be tackled (preventively or proactively) by health systems. To maintain congruency with developmental psychology theory — as there is no defined or commonly accepted period for the mother — we will ensure to match the timeframe of early motherhood with the one defined for early childhood — the 6 first years on a child's life. Additionally, our target is to provide not only measures, reliable numeric indicators but also first-handed experiences and perspectives to guide further research as well as to help outline the much-needed care and implementation of effective policy strategies on maternal mental health, namely among displaced mothers.

Material and Methods

One of our goals was to provide not only measures, reliable numeric indicators, and outcomes regarding maternal mental health during the first 6 years of motherhood but also first-handed experiences and perspectives of immigrants and refugee mothers to guide further research, appropriate healthcare, and implementation of effective policy strategies among these women.

The systematic review was registered at PROSPERO (registration number: CRD42022335343), and PRISMA guidelines and recommendations were followed. MEDLINE, Scopus, and EBSCO databases were searched for original manuscripts, published between 2012 and 2022, with abstracts written in English, using the following base search sentence: (Maternal OR Postpartum OR Perinatal OR Childbirth OR Postnatal OR Motherhood) [in title, abstract, keywords] AND ("mental health") [in title, abstract, keywords] AND Migrants OR Immigrants [in all].

The findings were exported to the online literature review programme Rayyan.

A total of 2881 articles were obtained. The abstracts were evaluated by two of the authors (LMA and JC) to select studies that met the following inclusion criteria (additional information in Supplement 1): (a) refugee and/or migrant women (displaced women), focusing on maternal mental health evaluation targeting the first 6 years of motherhood, (b) assessment of maternal mental health conditions, symptoms, and experiences, and (c) providing relevant outcomes (e.g., PPD, stress/anxiety, PTSD, isolation/lack of social support, borderline states and self-harm behaviors, OCD, and postpartum psychosis, among other relevant outcomes).

The following exclusion criteria were also defined: (a) studies whose participants were not displaced, (b) studies not based on maternal mental health, (c) studies out of the targeted period (postpartum — extended until 6 years of motherhood), (d) quantitative studies with absence of control group* or comparable health indicators for native population, (e) studies whose participants are registered as having pre-existing health conditions as well as substance abuse and domestic violence or sexual assault, and (f) studies relating to practitioners' views, experiences, and perspectives.

After application of the inclusion and exclusion criteria, a total of 35 articles were retrieved for analysis (19 quantitative and 16 qualitative studies) (flow chart in Supplement 2). Two authors (LMA, RM) screened full text of qualifying articles. The

reference list of systematic reviews and/or meta-analysis published in the last 2 years and related to the topic was checked manually to identify studies that may not have been retrieved using the defined search strategy. No further papers were yielded.

Data extraction was carried out independently by three researchers (LMA, RM, FS) and discrepancies were resolved by consensus. When data from the same study was reported in different publications, only the more recent paper was selected. No quality scoring system was applied in this review, as it purposefully included both quantitative and qualitative studies.

Results

Tables A (quantitative studies) and B (qualitative studies) provide a summary of the main characteristics and findings of the evaluated manuscripts. Most quantitative studies were conducted in Asia and Europe, as qualitative ones were mainly led in Canada and USA. Most countries where the studies were performed are members of WHO and have specific legislation towards mental health protection.

Table A, Quantitative Studies (Supplement 3)

Few studies assess maternal mental health overall; those that do measure it, find no major differences between mental and/or psycho-emotional functioning and well-being between migrants and natives (Almeida et al., 2016), despite significant differences in poorer self-rated health in non-naturalized migrants (El-Koury et al., 2018). One study conducted in Australia, however, identified higher risks of suboptimal mental health in all migrants (previously diagnosed as stressed (OR = 5.28, 95% CI 2.63–10.63) and not stressed (OR = 1.50, 95% CI 1.22–1.84)) when comparing to native women (Eastwood et al., 2021).

Similarly, the results regarding stress and anxiety (e.g., perceived stress, stressful life events, and stress vulnerability) are somewhat heterogeneous: while some studies seem to find no significant association between stress and being a migrant (Almeida et al., 2016; Daoud et al., 2019a; Navodani et al., 2019), one conducted in Israel raised questions about the validity of instruments used for measures compared with self-reports, showing that immigrant mothers were more likely to report somatic symptoms, that psychosomatic symptoms were associated with both anxiety and depression, but somehow those values were not statistically different from natives at postpartum (Lubotsky-Gete et al., 2021). The only study whose results were in line with scientific literature was one conducted in Spain that clearly stated a significant difference in vulnerability to stress (M = 14.40 (5.61) vs. M = 7.73 (4.16)) and perceived stress (M = 39.03 (11.25) vs. M = 25.70 (4.64)) among migrants, when compared to native mothers (Pérez-Ramirez et al., 2013). Another study found that ethnic natives were more prone to have had emotional/traumatic stressful life events than migrants (Stanhope and Hogue, 2020), reflecting about issues related to potential confounders regarding ethnicity, discrimination, and social support.

Effectively, impoverished mental health scenarios tend to emerge when discrimination (single vs. multiple forms), isolation, and social support are targeted: several studies found an expected association between being a migrant and lack of social support (OR(adj) = 6.12 (95% CI 1.99–18.80)) with 54% of migrant mothers manifesting feelings of isolation (54.3% (95% CI 51.5–57.3)) (Almeida et al., 2016; Daoud et al., 2019a), depleting displaced women of much needed resources to be resilient in such a demanding phase as the first years of motherhood. Additionally, one study conducted in Israel analyzed the role of discrimination in maternal mental health, using several classes: single vs. multiple forms of discrimination and a composite measure. It found that all measures were higher in migrants and the most prevalent forms of discrimination were ethno-national, socioeconomic, and religious discrimination; it also found a dose-response relationship between the composite measure of discrimination (multiple forms) and PPD (Daoud et al., 2019b).

Maternal depression was the most popular variable assessed (wide use of EPDS, with different cut-offs per country): higher risks for PPD were consistently found among immigrants (Almeida et al., 2016; Ceballos et al., 2016; Daoud et al., 2019b; Hamwi et al., 2021; Navodani et al., 2019; Simhi et al., 2019), even when compared with native-stressed mothers (Eastwood et al., 2021). Only one study reported no PPD differences between migrants and native mothers (Zlotnick et al., 2022). One study reported an interesting significative association between PPD and ethnicity in native-born mothers (Daoud et al., 2019). Another one highlighted the role of language skills proficiency in prevalence and risks of developing PPD — comparing the differences between mothers with limited proficiency (18%; aOR = 2.55 (95% CI 1.64–3.99)) and full proficiency in language skills (11%; aOR = 1.63 (95% CI 1.21–2.19)) (Hamwi et al., 2021). Only two studies assessed PPD in refugees and asylum-seekers: overall, migrant women had significantly higher rates of depressive symptoms at 16 weeks postpartum compared to native-born women, and the highest rates were found among refugee (11.5%) and asylum-seeking (14.3%) (Dennis, Merry & Gagnon, 2017). The other study, a pilot conducted in Lebanon, showed incredible high rates of PPD among both Syrian refugees (74.3%, M = 21.3) and native mothers (52%, M = 19.2), even with EPDS ≥ 13, emphasizing the imperative importance of addressing the social determinants of health and mental illness among deprived backgrounds (Stevenson et al., 2019).

Only three studies considered more severe symptoms, namely psychotic perinatal episodes (PPE) and disorders, psychiatric symptomatology, affective and neurotic-stress disorders, and thoughts of self-harm and suicidal ideation. The results pointed that refugees were more likely to have PPE than natives (aOR = 1.31, 95% CI 1.08–1.58). Conversely, family-reunified immigrants were less likely to have PPE than natives (aOR = 0.35, 95% CI 0.20–0.60), confirming the protective role of social support among recent mothers. No differences were reported regarding affective disorders between refugee and native mothers, but risks for psychiatric and neurotic-stress disorders (e.g., PTSD) were significantly higher among refugee women (aOR = 4.72, 95% CI 2.18–9.84 and aOR = 1.31, 95% CI 1.01–1.72, respectively) (Castaner et al., 2021). Immigrants were also found to have increased risks of experiencing delusional ideation during perinatal period, prevalence probably underestimated due to fear and stigma of reporting severe symptoms (Mackinnon et al., 2016). A cohort with

only migrant and refugee mothers identified that, during the perinatal period, 5.3% of all participants experienced suicidal ideation, and refugee women were more likely to experience it when compared to migrants (8.0% vs. 3.1%) (Fellmeth et al., 2021). The same study found that women with suicidal ideation were 24 times more likely to have PPD; however, over half of women with suicidal ideation had either no depression or mild or moderate depression, diagnosed using a clinical interview — these data settle that screening only for PPD is manifestly insufficient to assess and ensure maternal mental health and well-being (Fellmeth et al., 2021).

Finally, a study conducted in Japan focuses on the unavoidable nature of cultural dimensions in healthcare provision and evaluation, not only because of the measures used but mainly due to obtained results: migrants' cultural communication styles and literacy levels (both from migrants and native care providers) interfere with mothers' expectations of postpartum care, inducing feelings of not only respect and understand but also loneliness and perception of cold treatment, depending on women's ethnic background (Igarashi et al., 2013).

Table B, Qualitative Studies (Supplement 4)

The analysis of the results revealed by the studies in Table B allows us to understand in some depth the motivations and human behaviors that underlie and justify the numerical indicators shown in Table A.

The most prevalent and transversal theme in almost all studies concerns mental health stigma. The stigma associated with mental conditions is one of the biggest barriers to seeking and obtaining appropriate care worldwide, irrespective of nationality or displacement. For migrants, it is assumed as taboo because they believe it makes them weaker in the eyes of not only the host society — turning them unable to work — but also before their family — felt as a bless or a burden (Ahmed et al., 2017; Baiden et al., 2021; Gagnon et al., 2013; Goyal et al., 2015; Markey et al., 2022; O'Mahoney et al., 2013; Rao et al., 2020; Saherwala et al., 2021; Sampson et al., 2021).

Many migrants and refugees were in denial about their depressed feelings because of not only the cultural stigma associated with mental illness, social pressure, but also profound unawareness on the subject, as it was not relevant (or even more stigmatized) in their country of origin. Therefore, in addition to stigma resulting in mental healthcare delay, misconceptions on mental health — perceived by some cultures as curses, being bewitched or possessed by demons (Baiden et al., 2021; Saherwala et al., 2021), being "crazy" and lacking self-control (O'Mahoney et al., 2013; Skoog et al., 2019), or laziness and dull (Sampson et al., 2021) — and the lack of knowledge about available care in the host countries, as well as — again — the stigma associated with seeking mental healthcare (Markey et al., 2022), often worsen the scenario towards a hard-to-break cycle of suffering (Saherwala et al., 2021).

Feelings and experiences of motherhood among migrants and refugee were frequently challenging, as poor emotional health exacerbated physical symptoms and vice versa. The most common physical symptoms were exhaustion (extreme tiredness) and pain, either acute or chronic (Ahmed et al., 2017; Ganann et al., 2020; Hoban et al., 2013; Rao et al., 2019). Nevertheless,

migrants and refugee tend to normalize being overwhelmed (Markey et al., 2022; Rao et al., 2020; Saherwala et al., 2021) or feeling depressed (deeply stressed or very sad) (Baiden et al., 2021; Cameron et al., 2021; Pilav et al., 2022; Pineros-Leano et al., 2021; Sampson et al., 2021). In addition, they had to deal with perceived discrimination both from native counterparts and health professionals (Baiden et al., 2021; Saherwala et al., 2021), which aggravated mental health conditions and helplessness.

Migrants and refugee mothers tend to cope with their mental health issues and psycho-emotional distress on their own, often devaluing it, seeking to focus on baby/childcare, work, domestic tasks, looking for comfort in spirituality and religion, as well as in fundamental emotional support from spouses (Ahmed et al., 2017; Baiden et al., 2021; Li et al., 2021; Saherwala et al., 2021). Key and successful coping strategies were mainly associated with maintaining culture and intrapersonal characteristics: adaptability, entrepreneurship, and language learning as first steps for the inclusion process (Gagnon et al., 2013).

The issue of family and social support is deeply associated with culture and traditions at birthplace and carry several expectations. Having family support was mostly a "feel good factor" during the postpartum (Goyal et al., 2015; Rao et al., 2020) as it is a well-known protective element of maternal mental well-being. On another hand, the lack of family around (especially their own mothers) contributed to exacerbate exhaustion, mental health symptoms, and helplessness (O'Mahoney et al., 2013; Pineros-Leano et al., 2021; Sawehala et al, 2021). Nevertheless, several studies reported not only a burden that mothers felt regarding family tasks and obligations but also family judgement when seeking support and admitting their tiredness or negative feelings, in a complex process involving social expectations, gender roles, and unreasonable cultural beliefs about motherhood (and womanhood, in general) being associated with suffering and sacrifice (Pineros-Leanos et al., 2021; Sampson et al., 2021). A cultural attitude that "mothers should put the needs of their children and husband first, and that she comes last" emerged in some studies, conducted among Latin migrants, and women reported that admitting PPD or psycho-emotional distress would be a signal of ingratitude, a potential way to harm their children or a mean of losing their families (Pinero-Leanos et al., 2021; Sampson et al., 2021).

Societal and cultural expectations of womanhood and motherhood had critical connotations in the way that women described their lived experiences, but culture also mediates resilience, acceptance of care, seeking appropriate care, and coping with challenges. In almost cultures, talking with peers and family is perceived to be better than the stigma of seeing a mental health professional in a clinic setting (Li et al., 2021; Markey et al., 2022). Seeking formal healthcare is often a last resort for any new migrant or refugee, which resulted frequently in suboptimal care and severe symptoms (Gagnon et al., 2013; Goyal et al., 2015).

Discussion

Latest literature and research are consistent in indicating that a significant proportion of women develop a perinatal mental health problem during pregnancy or within the first years after having a baby. Without treatment, these problems can have a devastating impact on women and their families, with long-term costs to society. All mothers deserve receiving the quality of care for their mental health that they can rightly expect for their physical health. Women, their families, and professionals are united in calling for parity of care between mental and physical health and an end to the huge, costly and avoidable, suffering, and disability caused by perinatal mental health problems (Maternal Mental Health Alliance, 2022).

Investing in public health policies and effective mental health programs for soon-to-be and recent mothers is a matter of social justice, a manifestation of legit human rights in responding to urgent and well-documented needs. These programmes need to be made available and accessible to women in a structured routine health approach, encompassing the personalization and quality of care in public health: a systematic and regular assessment of health conditions, personal and cultural contexts, specific needs, access to care, and support network (Almeida et al., 2016; Bauer & Evans, 2014; Maternal Mental Health Alliance, 2022).

Several individual level maternal mental health conditions and risk factors have been identified for migrant women: low levels of social support, pre-migration histories, refugee or asylum-seeking immigrants, relationship quality, shorter length of time in host country, poorer physical health status, minority status, and higher support needs (Dennis et al., 2017; Charlson et al., 2019). Community-level risk factors for PPD and other mental health conditions in immigrant women include all social determinants of health burden, namely living in low-income communities or in communities with a high prevalence of immigrants (Ganann et al., 2020).

Establishing conclusions from a systematic review has inherent limitations. The methodological quality of the evaluated studies differs considerably, as do the subjacent definitions of migrant (often misconcepted with ethnic population, second and further generation migrants), refugee and asylum-seekers, and local populations evaluated. Main study samples lack robustness, as this population is frequently found in adverse social surroundings, severe pre-mental health conditions, and in illegal status (all competing to suboptimal access to care and treatment adhesion), is difficult to reach and to establish contact. Fear of being reported to authorities and mental health stigma are both common problems (Almeida et al., 2016; Markey et al., 2022). These characteristics necessarily hinder the quality of the investigations.

This review presents additional difficulties in establishing quality patterns concerning decision about included studies, as it contains methodologically very distinctive ones. Regarding the inclusion of qualitative research, our target was to purposively incorporate migrants' perceptions and self-reports about mental health and well-being — as subjective measures that favor or inhibit symptom recognition of emotional distress and mental conditions, care-seeking patterns, treatments adherence, and its success. Literature is consistent with showing that cultural aspects have a huge impact in health behaviors and patterns, and ultimately in migrants'

integration through fostering their sense of belonging (which affects retrospectively all the previously mentioned dimensions). Therefore, we did not exclude qualitative studies based on the absence of a control group*, as it did not make sense to, considering our intents. We assumed that any health guidelines, programmes recommendations, and policies that do not serve the needs identified by their target populations (here, displaced women) will most certainly be doomed to fail (Markey et al., 2022).

Conclusions

All recent migrant mothers, irrespective of their migration history, must be considered at risk for adverse mental health outcomes. Those women should be assessed for recent life stressors, intrapersonal and background characteristics (not only at an emotional and epidemiological level but also regarding their social determinants of health), and their need for social support. This is particularly relevant among those who have had limited contact with health and social services (Dennis et al., 2017), both at their country of origin and host country. Refugees must always involve additional caution, as not all countries are ready nor have the means to effectively assess their needs. In such cases, cultural awareness and sensitivity by the professionals, the integration of intercultural mediators, interpreters, key stakeholders (e.g., religious leaders), family members — whoever the mother accepts and feels comfortable with — or asking directly to women what do they need is crucial for any successful healthcare intervention. Scientific literature has been pointing out that mothers belonging to different population groups experience different prevalence and risk factors for PPD and mental distress (Daoud et al., 2019; Dennis 2017).

Programs tend to have a focus on identifying after-birth reactions, namely postpartum depression. However, migrant women are screened less often, and such screening tools do not capture stress-related symptoms or psychotic symptoms which could be more common among migrants and mainly refugees. Identifying pre- and post-migration factors, such as discrimination, daily stressors, and family and community support, would allow public health systems to target the root causes of maternal mental health inequalities among some migrant groups and the overall native population (Castaner et al., 2021).

Formal healthcare settings can be daunting, both for migrants and native mothers — as mental health stigma prevails globally and affecting all. Informal settings and spaces where women feel comfortable in expressing their feelings are pointed as essential to improve maternal mental health (Markey et al., 2022). Despite the higher risks of impoverished maternal mental health associated to migrants and refugee, one must not forget that more than 18 months after birth, studies still report that over 70% of both native and migrant mothers are suffering extreme exhaustion (Navodani et al., 2019). Therefore, maternal mental health must be considered seriously, accessible care should be patient-centered and tailor-made to meet women's needs and provided to all.

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Data Availability All data will be made available immediately upon request to the corresponding author.

Declarations

Conflict of Interest The authors declare no competing interests.

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