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Good Practices in Perinatal Mental Health for Women during Wars and Migrations: A Narrative Synthesis from the COST Action Riseup-PPD in the Context of the War in Ukraine

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A B S T R A C T

Background: Since February 24th, 2022, the beginning of Russia's aggression against Ukraine, more than 80,000 women were expected to give birth. Therefore, understanding the impact of war on the perinatal health of women is an important requisite to improve perinatal care. This narrative synthesis has two main purposes: on one hand, it aims to summarize the current evidence available based on perinatal health outcomes and care among perinatal women; on the other, it attempts to identify the gaps still present in research in relation to perinatal care. *Method*: A literature search was completed in diverse databases (e.g., Medline, PsychInfo). *Results:* Emergent matters related to practice and research in perinatal refugee women have been discussed. *Conclusions:* In the face of the war in Ukraine, we need to build up further research to provide an evidence-based foundation for preventing and treating the psychological consequences of pregnant women exposed directly to war and those who have been forced into a refugee status during this vulnerable period. Also, it is essential to support not only women transitioning to motherhood, but also supporting midwives and nurses in their work.

Las buenas prácticas en salud mental perinatal para mujeres en periodo de guerra y migraciones: una revisión narrativa de la Acción COST Riseup-PPD en el contexto de la guerra en Ucrania

Palabras clave:
Salud mental perinatal
Crisis de Ucrania

R E S U M E N

Antecedentes: Desde el 24 de febrero de 2022, el comienzo de la agresión de Rusia contra Ucrania, se esperaba que más de 80,000 mujeres dieran a luz. Por lo tanto, comprender el impacto de la guerra en la salud perinatal de las mujeres es un requisito importante para mejorar la atención perinatal. Esta revisión narrativa tiene dos propósitos principales: por un lado, tiene como objetivo resumir la evidencia actual disponible basada en los resultados de salud perinatal y la atención a las mujeres perinatales y, por otro lado, intenta identificar las brechas aún presentes en la investigación en relación con la atención perinatal. *Método:* Se completó una búsqueda bibliográfica en diversas bases de datos (p. ej., Medline, PsychInfo). *Resultados*: Se han discutido temas emergentes relacionados con la práctica y la investigación en mujeres refugiadas perinatales. *Conclusiones:* Frente a la guerra en Ucrania necesitamos más investigación para construir una base partiendo de la evidencia con el fin de prevenir y tratar las consecuencias psicológicas de las mujeres embarazadas expuestas directamente a la guerra y de aquellas que se han visto obligadas al estatus de refugiadas durante este período vulnerable. Además, es esencial apoyar no solo a las mujeres en transición a la maternidad, sino también a las matronas y enfermeras en su trabajo.

Since February 24th, 2022, the beginning of Russia's aggression against Ukraine, over 5 million refugees from Ukraine have crossed the European Union border, mainly women and children. In addition, over 35,000 people crossed the Polish border, over 972,000 the Romanian border, 654,000 the Hungarian border, 473,000 the Moldavian border, and 446,000 the Slovakian border (Verner, n.d.). Most arrivals are women and children from all parts of Ukraine. However, the exact number of pregnant and postpartum women war refugees is unknown. According to the United Nations Population Fund, an estimated 265,000 Ukrainian women were pregnant when

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the war broke out and 80,000 women were supposed to give birth in the following three months. In 2020 there were 293,400 live births in Ukraine, so a similar number of children will be born in 2022 in Ukraine and abroad (Verner, n.d.).

The perinatal period (from pregnancy to the first year after childbirth) is a vulnerable time. The onset and recurrence of mental disorders are high, estimating that 1 in 5 women would develop a perinatal mental disorder (Andersen et al., 2012; Fawcett et al., 2019; Shorey et al., 2018), with perinatal depression, anxiety disorders, and PTSD as the leading diagnoses. The experience of war and the associated stress, anxiety, and destabilization may have various and long-lasting negative consequences for mothers and infants. According to Monk et al (2019), pregnant and postpartum women who are under distress (defined in terms of perceived stress, life events, depression, and anxiety) show a higher risk of impacting fetal and infant brain-behavior development. Maternal distress and high maternal anxiety seem to increase the risk of potential mental disorders in children (Marcos-Nájera et al., 2020; Monk et al., 2019).

With this rationale it is important to raise awareness and understanding of what would help meet the mental health needs of war refugee women during the prenatal and postpartum periods.

The Riseup-PPD project is a Cost Action (18138) founded by the Horizon 2020 Framework Programme of the European Union created with the purpose of promoting best practices in maternal mental health during adverse circumstances ("Research Innovation and Sustainable Pan-European Network in Peripartum Depression Disorder"). Despite this initial purpose to which Riseup-PDD was created, the program is still interested on researching about the needs and struggles that women experience during peripartum, specially throughout adverse circumstances. This is the case of Ukrainian women who are living the negative consequences of the war in Ukraine. Because of this, Riseup-PDD joins forces once again to support this narrative review and promote good practice in perinatal mental health.

The aim of this paper is to conduct a critical overview of the current emerging issues and questions concerning perinatal mental health in refugee women. Based on this narrative review, we aim to present a consensus about the main lines of action related to assessment and intervention for this population, as well as to present the most important topics that should be researched on this area.

Method

This paper reports findings from a comprehensive narrative synthesis of previously published information on the topic of perinatal mental health in war – affected and refugee women. A narrative review can be defined as a scholarly report of a body of literature that includes interpretation and critique (Baumeister and Leary, 1997; Greenhalgh et al., 2018). A common goal of narrative reviews is to provide authoritative argument based on published primary evidence that is convincing to readers with more specific aim to enhance understanding of a specific topic.

A literature search focusing on perinatal mental health in war affected and refugee population was completed between June and July 2022 to identify relevant publications in this area.

The literature search utilized various databases (e.g., Medline, PsychInfo, and Google Scholar) using a combination of broad search terms, including peripartum depression (e.g., peripartum depression OR prepartum depression OR postpartum depression), AND anxiety (e.g., peripartum anxiety OR prepartum anxiety OR postpartum anxiety) AND posttraumatic stress disorder (e.g peripartum posttraumatic stress disorder OR prepartum posttraumatic stress disorder OR postpartum posttraumatic stress disorder) AND diagnosis (e.g., diagnosis OR diagnostic criteria OR diagnostic tools), AND prevention (e.g., preventive interventions OR prevention OR prevention approaches), AND treatment (e.g., psychological treatment) AND refugee pregnant women AND internally displaced pregnant women AND mental health of refugee pregnant women AND support services for refugees.

A representative sample of the existent literature was summarized in the form of a narrative synthesis, joined with a critical overview of the current issues and questions that should be addressed, relate to good practice and good research in perinatal refugee women from Ukraine. Particular emphasis was given to prior systematic reviews and meta-analyses that systematize the state-of-the-art knowledge concerned.

Results

The literature was summarized and critically discussed in the context of the main topics assessment/intervention and research) in the perinatal mental health of refugee women.

How Do the War and Refugee Status Experiences Affect Perinatal Mental Health?

The war experience affects maternal health, stress level, and mental health. It is a risk factor for adverse negative outcomes in pregnancy and after childbirth (Arnetz et al., 2013; Fatusic et al., 2005). War exposure is associated with premature birth and low birth weight (Davis & Sandman, 2010; Keasley et al., 2017). However, the rate of preterm births, stillbirths, and miscarriages depends on the direct exposure to armed conflict. For example, the adverse outcomes are often related to exposure to chemicals, radiation, exhaust fumes, contaminated water, or food during wartime (Arnetz et al., 2013). Also, access to health centers and medicines may be largely limited in a war zone making very difficult for pregnant women to attend to follow-up medical appointments. Also, it might be challenging to find a doctor/midwife and catch up with required medical visits in the host country.

In general, migration and refugee status are additional risk factors for depression during pregnancy and postpartum (Hyman & Dussault, 2000; Mechakra-Tahiri et al., 2007). A systematic review found 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). Some older studies (Bhui et al., 2003; Lin & Cheung, 1999) also mention other serious mental health problems such as post-traumatic stress disorders (PTSD), suicide, and psychosis as more frequent in immigrant and refugee women. Sources of distress for refugee women during birth also include use of technology, unfamiliar procedures, lack of understanding of birth options, and language barriers (Brown-Bowers et al., 2015). A study conducted in 2016 on a sample of pregnant women internally displaced as a result of military operations in eastern Ukraine (Ancheva & Morozova, 2016) demonstrated PTSD frequency is 34.8% and an anxiety level that is significantly higher in comparison with control group. These women have increased indicators of reactive and personal anxiety, depressive manifestations, the presence of autonomic dysfunction, and insomnia (Romanenko, 2020). According to some authors (Zhabchenko et al., 2018), anxiety and neurotic states characterized by high levels of reactive and personal anxiety. In pregnant internally displaced women, reactive anxiety is 3.3 times higher than in pregnant women who were not internally displaced; personal anxiety in pregnant internally displaced women is 2.6 times higher than in pregnant women who were not internally displaced. For women in this category (Romanenko, 2020), the risk of premature termination of pregnancy and higher specific weight of different somatic diseases obviously influenced the complicated course of pregnancy and childbirth. Therefore, the

authors agree that internally displaced pregnant women in Ukraine are a more vulnerable group compared to women who have not experienced similar problems, both in terms of somatic and mental problems.

Not surprisingly, studies conducted in war-affected countries, such as Syria, indicate a high percentage of women scoring higher on postpartum depression scale (28. 2%) (Roumieh et al., 2019). Stewart et al. (2008) also found that 35.1 % of immigrant and 25.7% of refugee women are much more likely to score above the cut-point in the Edinburgh Postnatal Depression Scale (EPDS), which is the most commonly used measure for peripartum depression, when compared with Canadian women. Similarly, the pregnant and postpartum women living in the Gaza territory during the times of the Gaza War experienced deterioration of mental health: increased PTSD symptoms, depression, anxiety, dissociative states, and pregnancy complications (Punamäki et al., 2018). In addition, their children were more likely to be born prematurely, which adds the stress and additional burden to war-exposed mothers. As a result, an infant's psychomotor and language development was delayed. Maternal mental health during pregnancy and postpartum mediated the negative impact of war trauma on a child's psychomotor and language development at 12 months. These authors' previous study also showed that a mother's ability to establish a strong bond with her unborn child, despite the experienced stress, is associated with more optimal sensorimotor development of the child and its language development (Punamäki et al., 2018). A study on refugee pregnant women in Slovenia during the 2015-2016 period in the so-called Balkan Corridor showed that these women had a higher incidence of preterm delivery and emergency caesarean section (Bombač et al., 2018).

Not all war refugee women will be affected by armed conflict exposure with the same intensity. Also, those not exposed directly to war can develop symptoms of mental health disorders. This is because there are substantial differences in vulnerability to stress, mental health problems, and poorer outcomes. This idea of vulnerability to stress refers to the impact on an individual rather than to the event itself and varies from person to person. It is also possible that a pregnant woman who has not been directly exposed to an armed conflict may be more traumatized than a mother hiding from shelling.

Pregnancy and childbirth can trigger a relapse of pre-existing mental health difficulties or symptoms related to past trauma, not only in war-exposed populations. For example, according to Atzl et al. (2019), early childhood trauma is associated with increased PTSD symptoms during pregnancy. Some refugee women with an earlier history of trauma may be additionally burdened. Pre-existing mental health problems are risk factors for developing postpartum PTSD. A study conducted by van der Kolk (2014) shows that people with PTSD often do not access treatment to protect themselves from painful memories (van der Kolk, 2014). Other studies (Snow et al., 2021; Villagran et al., 2021) show that immigrant and refugee women have difficulty meeting their mental health care needs. They often do not get the care they need even when health care is universally available.

The majority of studies reviewed, such as the study of refugee women in Toronto between 2008 and 2010 (Kandasamy et al., 2014), focus on women from disadvantaged social groups. They may be homeless, malnourished, and have limited access to health care in their home country. However, it is important to understand that the situation with Ukrainian refugee women is different and varies among individuals. The pregnant women, who managed to register their pregnancy in Ukraine obtain the help from the Ukrainian Ministry of Health (Наказ МОЗ України від, 2022). (n.d.). They have online access to medical services and receive financial support after the birth of a child. However, when these women found out about pregnancy after 24th of February, they may have not entered the medical system in Ukraine and do not benefit from this help.

Nevertheless, displaced Ukrainian war refugees experience additional risk factors such as the loss of previous life-style and safety, separation from partner/husband, the necessity to adapt to a new country and eventual difficulties, socioeconomic disadvantage, troubles with communication due to language (for example in the eastern part of Ukraine the Russian language was predominant, whereas in the west part the most common spoken language is Ukrainian), fear concerning relatives who stayed in Ukraine/joined the army, or intolerable recollections. Even for non-directly affected women the war-enforced migration could be stressful in many other ways. For example, in February 2022, temperatures were freezing, and many refugees reported spending days on the border waiting to cross with an average time of even 60 hours. The summary of the studies is presented in Table 1.

What Are Good Psychological Practices in Working with Refugee and War-exposed PPD Women in Perinatal Mental Health?

Several key features of psychological care may alleviate the negative impact of war and refugee status experiences described above (Table 2).

Facilitating Access to Perinatal Healthcare

Refugees and migrants on the move are often reluctant to stop and actively seek out medical care. However, according to the data gathered by the organization Doctors of The World, refugees and migrants are also struggling to access primary healthcare when they settle in Europe (Chauvin et al., 2015). More than half (n = 23,040; 54.2%) of the pregnant women surveyed had not had access to antenatal care and only one-third (34.5%) of children seen had been vaccinated against mumps, measles, and rubella and only slightly more (42.5%) against tetanus. According to the German Chamber of Psychotherapists (Medical Press. Psychology & Psychiatry, 2015), at least half of refugees arriving in Germany suffer mental health problems related to their experiences of war and fleeing conflict. Providing leaflets and information in Ukrainian on the organization of health care in Poland or other borders country can be an important step in finding a specialist and continuing care.

Information about Perinatal Practice

Providing clear information about perinatal care in the new country may help reduce psychological distress in pregnant refugee women. Ensuring that women understand how to gain access to care and the medical options might help them to feel in control of their own pregnancy and delivery process, which may be particularly important for trauma survivors. Also, acknowledging the cultural background and differences within healthcare organizations can promote mutual understanding. It can help to facilitate the monitoring of the baby, such as vaccinations or follow-up visits with the pediatrician, especially as the perinatal care or vaccination schedule may differ among countries. Also, research has pointed out that during pregnancy women anticipate their prospective childbirth experience and it has been shown that these childbirth expectations are important predictors of childbirth outcomes (Martínez-Borba et al., 2022). Information provided on these topics is mandatory to the perinatal refugee women for understanding the practice in every country.

Table 1. The Summary of the Review Studies Focusing on Perinatal Mental Health in Refugee and War-affected Population

Perinatal Mental Health	Rate	Method	Population	Study
Depression	- 1.5-2 times higher than those of the general population - 28.2% had a score of 13 (probable Depression) - 35.1 % of immigrant and 25.7% of refugee women are much likely to score above the cut-point in the Edinburgh Postnatal Depression Scale - Increased PTSD symptoms, depression, anxiety - A lack of social support significantly increases the risk of PPD	- Systematic review - Edinburgh Postnatal Depression Scale - Edinburgh Postnatal Depression Scale - Meta-analyses - PHQ-9 and the PDPI-R	- Migrant women - Postpartum women, Syria - Immigrant new mothers - Women living in the Gaza territory during times of the Gaza War - Spanish-speaking women in Spain and Mexico	- Falah-Hassani et al., 2015 - Roumieh et al., 2019 - Stewart et al. (2008) - Punamäki et al., 2018 - Marcos-Nájera et al., 2020, 2021).
Anxiety	- Anxiety level is significantly higher (44.1 ± 0.9 scores on PA scale and 45.4 ± 0.9 scores on RA scale) - The average score of reactive anxiety in the experimental group exceeded the analogous indicator in the control group by 1.6 times. The indicators of personal anxiety exceeded the normal indicator in the control group by 2.2 times - Increased PTSD symptoms, depression, anxiety	- PA Scale, RA scale - Spielberg's tests in the modification of Khanin - Reported PTSD, depressive, anxiety, and dissociative symptoms, as well as pregnancy complications, newborn health risks such as prematurity, and infant sensorimotor and language development	- Pregnant women internally displaced as a result of military operations in eastern Ukraine - Pregnant women in Ukraine-temporary displaced - Women living in the Gaza territory during times of the Gaza War	- Ancheva & Morozova, 2016 - Zhabchenko et al., 2018 - Punamäki et al., 2018
PTSD	- Post-traumatic stress disorder frequency is 34.8% for internally displaced females - Increased PTSD symptoms, depression, anxiety	- PA Scale, RA scale - Reported PTSD, depressive, anxiety, and dissociative symptoms, as well as pregnancy complications, newborn health risks such as prematurity, and infant sensorimotor and language development	- Pregnant women internally displaced as a result of military operations in eastern Ukraine - Women living in the Gaza territory during times of the Gaza War	- Ancheva & Morozova, 2016 - Punamäki et al., 2018

Table 2. Good Practice in Perinatal Care for Refugee Women

1. Facilitating access to perinatal healthcare
2. Information about perinatal practice (public health system, usual care during pregnancy, vaccination, …).
3. Activities aimed to introduce/force clear and effective communication in medical health care centers.
4. Overcoming personal and cultural barriers
5. Counteracting social isolation
6. Mental health screening in the language of the refugee woman
7. Implementing resources for perinatal mental health
8. Promote breastfeeding
9. Promote skin-to-skin contact
10. Overcoming help-seeking barriers
11. Support obstetrician and midwives volunteers

Activities Aimed to Introduce/Force Clear and Effective Communication in Medical Health Care Centers

Clear and effective health communication may help to reduce psychological distress and the feeling of isolation. Also, it will benefit refugees women by increasing their adherence to the new situation and promoting engagement with the display of more adaptive behaviors (Finset et al., 2020; Gureje et al., 2020; Hyman & Dussault, 2000; Mechakra-Tahiri et al., 2007). Although language can be a barrier, translating information into Ukrainian can be instrumental in bringing an important message to these women: that they are welcome.

Effective communication also means taking into consideration the other person's perspectives and feelings, along with understanding the impact of the psychological trauma and ways in which symptoms may present during the perinatal period.

Overcoming Personal and Cultural Barriers

Some cultural barriers exist not only between residents of different countries, but also within the same country. Therefore, refugees from Ukraine, escaping from war, face these barriers in both ways. On one hand, they experience these barriers when they leave their own country and move to another. On the other hand, they also face these barriers when they stay in their own country but move to another region. Also, some other cultural barriers exist between refugees from Ukraine and residents from other countries. A useful practice in helping Ukrainian pregnant women is to observe their concept of cultural humility which is opposed to the concept of cultural competence. The concept of cultural humility (Captari et al., 2021; Danso, 2018; Fisher et al., 2016) implies active and responsible self-reflection on "unintentional" patterns of racism, classism, and xenophobia.

Also, refugees and pregnant women, as a particularly vulnerable group, face personal barriers, such as shame, guilt, anxiety for themselves and the child to be born, as well as for loved ones who remained in the territories where military operations are conducted. Keyes and Kane (2004) conducted a research about the experience of seven Bosnian adult refugee females currently living in the United

States. According to these authors, these refugee women experienced "states of culture shock, loneliness, psychic numbness, grief, nostalgia, and feelings of dejection, humiliation, inferiority, and feeling as if they belonged nowhere". The authors also highlight two main themes in their text: 1) belonging, i.e., implied cultural memory, identity and difference, empathy and reciprocity, perfection of speech, and 2) adapting, related to coping with transitions, memories of past and losses, trying to fit into the new culture, learning the new language.

At the same time, some other studies (Peisker & Tilbury, 2003) claim that the medicalization of the refugee may be a factor that can influence refugees to adopt a passive "victim role". In this context it is important to establish critical health psychology (Brown-Bowers et al., 2015) that focuses not on facilitating behavioral change in the individual, but on changes in the social, political, and ideological health aspects of health care. Riggs et al. (2017) emphasize the need to include the bicultural workers in the multidisciplinary care team. On one hand, health workers, psychologists, and volunteers should promote overcoming personal and cultural barriers of pregnant women who have fled from Ukraine to another country or are internally displaced. This goal is achievable if they practice cultural humility, which takes into account the peculiarities of the mental state of these women. Practitioners should consider the importance of treating women with respect, acceptance of their uniqueness, and understanding the processes of adaptation of pregnant refugee women. On the other hand, it is necessary to point out the risks of medicalization and to promote the inclusion of these women in the normal process of adaptation. More research on of this problem has to include and identify psychological and social factors that influence belonging and adapting in Ukrainian women who are experiencing the war crisis consequences.

Counteracting Social Isolation

Findings from epidemiological and meta-analysis studies suggest that a lack of social support significantly increases the risk of PPD (Marcos-Nájera et al., 2020, 2021). Assuring the mother has adequate social support and encouraging regular contact with relatives (via telephone, social media, video calls) is vital. Covid 19 pandemic experiences show that such forms of contact may still constitute an important resource for women's needs for emotional and social support during the perinatal period (World Food Programme, 2015).

Studies have also noted the effectiveness of peer-to-peer groups for different categories of individuals, including refugee women (Emanuel-Correia et al., 2022; Jumaa et al., 2020; McLeish & Redshaw, 2017). A similar practice is a psychological intervention called Problem Management Plus (PM+). Uygun et al. (2020) adapted World Health Organization (WHO) psychological intervention PM+ for Syrian refugees to the population in Turkey. PM+ is a brief psychological intervention aimed at alleviating the symptoms of disorders such as depression, anxiety, PTSD, etc. by means of cognitive behavioral therapy. These are mostly group counselling conducted by trained and supervised non-specialist peer refugees who have a minimum of 12 years of education. There are interventions that can be used based on principles of peer-to-peer. Also, Sullivan et al. (2019) analyzed a project conducted with Rohingya community health workers (CHWs). These workers learned six simple relaxation techniques: four acupressure points and two breathing exercises. Then, they taught these techniques to 46 Rohingya refugees in the Kutupalong camp in Bangladesh. They also provided the participants with instructions about practicing these techniques daily for a whole week. After this week the participants were asked to complete a questionnaire. As a result, 78% of participants reported that the techniques were 'very good'. The complaints of difficulty in sleeping, stress, and pain had improved in many cases. The CHWs felt that the community would benefit from utilizing these techniques throughout the camp.

Different psychological interventions can be applied to Ukrainian pregnant women and women who have recently given birth, whether they are abroad or internally displaced. After all, location does not seem to make a difference since this group is all affected by the same problems and, therefore, the support of others who are in a "horizontal" relationship is extremely important for counteracting social isolation. There is evidence (McCarthy & Haith-Cooper, 2013) to suggest that friendly, supportive relationships between volunteers and clients have tangible benefits for both parties. Pregnant refugee women gain confidence and overcome social isolation, while at the same time volunteers become more involved, feel needed, and often move on to paid work. Interaction in support groups can be a useful resource for midwives and improve pregnancy outcomes for refugee women.

In order to overcome the social isolation of pregnant and postpartum refugee women, it is also essential to create interdisciplinary and cross-agency teams that, in addition to professional competences, are culturally competent and able to solve not only clinical care tasks, but socioeconomic and psychosocial issues (Fair et al., 2020).

Mental Health Screening in the Language of the Refugee Woman

There is a lack of tools used to screen refugee women, especially those in emergency situations. When developing psychological screening tools, it is important to consider cultural factors (language, traditions, etc.). Psychological screening tools are an integral part of mental health assessment and help to avoid severe mental health problems from emerging. There are a wide range of psychological diagnostic methods, including questionnaires and structured interviews, that can help identify individuals who may be at risk (Fonseca et al., 2020; Fonseca-Pedrero et al., 2021; Motrico et al., 2022). However, significant differences in culture, language and experience complicate the development and use of these mental health screening tools in refugee women. When choosing and applying psychological assessment methods, it is important to consider the maternal needs of refugee women and the likelihood of perinatal and postnatal mental health disorders (Donnelly & Leavey, 2022).

Diagnostic tools for the mental health of refugee women are aimed at the following areas: general mental state, PTSD, anxiety, depression, stress resistance, and others. According to NICE guidelines, EPDS or PHQ9 (Kroenke et al., 2001; Marcos-Nájera et al., 2018) and GAD7 (Soto-Balbuena et al., 2021; Spitzer et al., 2006) should be used in this group National Institute for Health and Care Excellence [NICE, 2020]). For the purpose of conducting an assessment.

Psychosocial assessment should include a comprehensive evaluation of current and past psychological status as well as and social circumstances, for instance, current availability of social supports, history of mental health problems, or ongoing stressful life events during this period (Snow et al., 2021).

Implementing Resources for Perinatal Mental Health

Cognitive behavioral therapy has been presented as the referral treatment in perinatal women (Fonseca et al., 2020; Fonseca-Pedrero et al., 2021; Motrico et al., 2022). Crisis assistance methods, cognitive-behavioral therapy, art therapy, existential psychotherapy, and client-centered psychotherapy are some of the most effective interventions for refugee women. Providing psychological help in the language of the refugees is highly important, as language barriers can significantly reduce the effectiveness of psychotherapy (Hawkins et al., 2021).

There is no single way or model for providing psychosocial support to refugee women in Europe. However, there are principles of good psychological care practice rooted on the guidelines a Multi-Agency Guidance Note (WHO, 2015). Based on this, we can formulate some

basic principles for psychological help for refugee women during the prenatal and postpartum periods:

- Treat women with respect and support their self-reliance.
- Maintain humane and supportive communication.
- Provide information about services, supports, and legal rights and obligations.
- Provide relevant psycho-education and use native language of refugee women.
- Make interventions culturally relevant and ensure adequate interpretation.
- Provide treatment for women with mental disorders.
- Begin psychotherapeutic treatment only if it is possible to monitor its continuation.
- Monitor and support staff and volunteers who are working with refugee women during the prenatal and postpartum periods.
- Coordinate and cooperate with staff and volunteers of different levels of socio-humanitarian aid to refugee women during the prenatal and postpartum periods.

Facilitate Breastfeeding

A survey conducted in 2012 indicated that in Ukraine only 19.7 per cent of children are exclusively breastfed (UNICEF, 2012) which is low in comparison with the Eastern Europe regional estimate of 33%. However, rates of early breastfeeding initiation (66%) appear slightly higher in Ukraine than in the region (57%). With shortages of water supplies and the need to hide in shelters, health experts advocate breastfeeding over infant formula to keep babies healthy amid bombardment and displacement. After the crisis in 2014, almost half (46%) of internally displaced mothers stopped breastfeeding children under six months due to conflict-related stress. Similar to this, 23-year long-term outcome study on children born in 1991 during the homeland war in Croatia showed that, despite the high percentage of breastfeeding (i.e., 81%), the duration of breastfeeding was evidently shorter, on average only 2.5 months (Habek et al., 2016).

According to UNICEF/CDC (World Food Programme, 2015), 44% of internally displaced mothers received infant formula as part of a baby food humanitarian assistance package. However, UNICEF outreached over 20,000 mothers in conflict-affected areas in eastern Ukraine, educating them on the benefits of exclusive breastfeeding and, together with the Swiss Agency for Development and Cooperation and the Ministry of Health of Ukraine, improved the capacity of almost 1,500 primary health care workers on effective counselling about antenatal care, including breastfeeding. However, the results of these actions are yet unknown.

For many years in Ukraine, in close cooperation with various international institutions, such as UNICEF, educational activities regarding such practices as breastfeeding and “skin-to-skin” have been ongoing. Pregnant Ukrainian refugee women can be advised of numerous Internet resources with relevant explanations. For women in difficult circumstances, information emphasizing the importance of these practices, even in wartime, easily explaining how to carry out them in specific war conditions, is much needed. And it is very important that this information can be found on familiar sites, without the need for a long search.

Skin-to-Skin Contact

Prolonged “skin-to-skin contact” and early and exclusive breastfeeding are evidence-based protective factors against depression (Kendall-Tackett et al., 2011). Similarly, as with the Covid pandemic (Motrico et al., 2021; Motrico et al., 2020), it can be recommended whenever possible. However, it is essential to acknowledge that new mothers should give extra help whose stress level may impact their lactation (White et al., 2012).

Seeking Barriers

Currently we do not know what specific types of barriers are identified by Ukrainian women. Identifying and monitoring which actions and interventions are found most effective in promoting wellbeing in different national, social, political European countries’ settings is crucial in the face of this crisis. This research and actions targeted to support perinatal mental health should be done in a collaborative way with the women. Making a woman centered approach rather than designing interventions based on only decisions of professionals in host countries’ perceptions of effective interventions is more likely to meet refugee women’s needs.

Support Volunteers, Obstetrician, and Midwives

Supporting staff working in maternity and mental health services, acknowledging the effects of vicarious trauma, and that the staff may have their own experiences of trauma, could impact their capacity to deliver trauma-informed care. In a humanitarian crisis, health centres’ main goal is to help their workers resist retraumatization actively. Repeating contact with traumatized, crying mothers with limited support options could cause some staff to be reminded of their own life experiences. Some European countries were more affected by the II World War, and some memories in some families or untold issues may appear. Some staff, particularly those in physical care settings, may not have received consistent training to help them recognize and understand trauma in themselves and others and may benefit from training on how to deliver trauma-informed care best to deliver trauma-informed care best.

It is important for medical staff and people caring for/helping refugees to be trauma-informed and know how to recognize the signs and symptoms of trauma in women. Recognizing and understanding the behavior and symptoms of trauma and responding sensitively and without judgement is key to being trauma-informed. The patients may not reveal the trauma. However, it still can be acknowledged by emphatic and supportive behavior by medical staff. For trauma survivors, it is essential that the person feels in control of physical contact with healthcare professionals. Staff should ask the woman before they lay hands on her, show/try to explain what they are about to do and if the mother is ready and okay with it. The aim would be to avoid a rushed, insensitive, service-centered approach and ensure an emphatic, sensitive, woman-focused approach.

In fact, emotional burnout in medical staff and volunteers helping Ukrainian people can appear (López-Araújo et al., 2008). According to the Theory of Disaster Curve (Prot-Klinger et al., 2019), the first month or months after the crisis is the “honeymoon period” increased mobilization of the society, which was very committed to helping people fleeing war. However, the “honeymoon period” is longer than expected in case of war in Ukraine. According to the “disaster curve” dynamics, the next phase is the disappointment phase. After a period of mutual solidarity – “the honeymoon phase” – there is a feeling of overload, abandonment, depression, and reactivation of past traumas. We emphasize the importance of preventing burnout and retraumatization. In the perinatal period, in the case of refugee women the individual, supportive care can have a crucial meaning for the transition to motherhood.

What are Good Psychological Practices in Researching with Refugee and War-exposed PPD Women in Perinatal Mental Health?

The impact of war and the refugees’ status on maternal mental health requires further investigation to inform best practices

in perinatal mental health care. Henceforward, considering the evidence presented, the following research issues in perinatal mental health (PMH) constitute important topics to be studied.

Creating a Comprehensive Definition for Psychological Distress in this Group

Research on perinatal mental health should address the full realm of psychological distress with a focus on depression and anxiety, which are the most prevalent psychological illnesses in the perinatal period but also in PTSD (Andersen et al., 2012; Fawcett et al., 2019; Fonseca et al., 2020; Hahn-Holbrook et al., 2017; Marcos-Nájera et al., 2018; Shorey et al., 2018). A recent umbrella reviewed has pointed out that prevalence for these diagnoses is higher in comparison with no refugee women (Heslehurst et al., 2018). Also, it is important to address which are the risk factors related to this situation.

Effects of Lack of Social Support

Lack of social support and lack of family support has been reported as an important risk factor for developing perinatal mental health problems (Marcos-Nájera et al., 2021; Marcos-Nájera et al., 2020). Having no relatives or friends and a lack of emotional support from their spouse is a common situation for women who are living so far from their home seems a special risk factor for this group.

Adjustment to Host Country

Hesleshurst et al (2018) have reported that the most commonly described risk factors for perinatal mental health disorders were difficulties with the host country language and also not being familiar with local life and heath practice. So, help-seeking barriers will help increase the quality of perinatal care by identifying obstacles that these refugee women might encounter along their adaptation process to the host country.

Assessment of the Impact of the War and Refugee Status

In our knowledge a few questionnaires have been developed for assessing this group (Snow et al., 2021). More research is needed on this topic.

Promote Research about Intervention Adapted to the Cultural Context

Balaam et al. (2022) revealed that for asylum seekers and refugees in perinatal period the most valued interventions were community-based befriending/peer support approach as these provided the most holistic approach to addressing women's needs. However, as war refugees from Ukraine face a range of unique challenges, further studies concerning effective interventions and well-being are crucial.

Conclusions

Only a few studies have been published on the impact of e war-exposure on prenatal and postpartum mental health. According to data gathered, it is therefore of highest priority to minimize the likelihood of re-traumatization of refugee pregnant women and new mothers. Mitigating stress and promoting resilience through providing trauma-informed and migration-informed perinatal mental health care is crucial for the neurobiological and emotional-behavioral mother-baby interactions. Maternal distress exposes both dyad members to the risks of psychophysiological transmission of traumatic stress, which paves a dangerous cascade of lasting health problems. Thus, in the face of the war in Ukraine, we need to strengthen research further to provide an evidence-based foundation for preventing and treating the psychological consequences of war exposure and forced refugee status in the vulnerable, perinatal period. Furthermore, it is essential to support women's transition to motherhood and support midwives and nurses in their work. Unfortunately, not in every European country the education on perinatal mental health in within the medical staff is enough. Due to the current crisis, perinatal mental health specialists are very much needed. We also need common European guidelines for the education of health professionals, so that they are able to care for both the mental health of patients and understand the processes and risks associated with re-traumatization.

Therefore, the main challenges and questions of further research about the implementation of good practices for perinatal mental health as well as identifying new challenges for refugee women should be taken within the Riseup-PPD cost action.

Conflict of Interest

The authors of this article declare no conflict of interest.

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Наказ МОЗ України від 22.04.2022 № 675 "Про внесення змін до наказу Міністерства охорони здоров'я України від 01 червня 2021 року № 1066 та Порядку видачі (формування) листків непрацездатності в Електронному реєстрі листків непрацездатності." (2022).