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Factors associated with antenatal depression and obstetric complications in immigrant women in Geneva

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ABSTRACT

Objective: immigrant women are at increased risk for health problems during pregnancy, and for antenatal and postnatal depression. This study aimed to identify sociodemographic and specific psychosocial risk factors of antenatal depression and obstetric complications in an economically and culturally heterogeneous sample.
Design: prospective cross-sectional design.
Setting: the study was conducted in a midwifery office.
Participants: the community sample included 228 immigrant pregnant women with low French proficiency referred to birth preparation classes between 2006 and 2014 in Geneva, Switzerland.
Measurement: depressive symptoms were measured during the third trimester of pregnancy using the Edinburgh Postnatal Depression Scale. A cut-off score ≥ 12 was considered to be indicative of antenatal depression.
Findings: more than half of the participants had been living in Switzerland for less than five years and had a short-term residence permit. Thirty-seven per cent of women scored above the clinical cut-off score. Women with several risk factors, such as a precarious legal status, lack of marital support, difficult living conditions and being a newcomer to Switzerland, were at higher risk of depression. Women who encountered difficult living conditions were at higher risk of obstetric complications.
Implications for practice: these results confirm the findings of previous research, and highlight the need for early detection. Public health prevention policies should consist of multidimensional programmes to address simultaneously psychosocial, cultural and obstetric issues in pregnant immigrant women.

Background

Nearly one-quarter (23.8%) of Swiss residents are immigrants. Most (85%) foreign nationals come from a European country, and women account for half (50.7%) of the total immigrant population (Federal Statistical Office, 2012). Geneva is the second largest city in Switzerland and is the most populous city within the French-speaking part of Switzerland. In 2013, the population of Geneva included 194,623 immigrants from 187 different nations, representing approximately 40% of the total population of the Canton of Geneva (Federal Statistical Office, 2013).

In a recent referendum, Switzerland tightened the law concerning asylum and irregular immigration, while promoting the immigration of highly skilled workers. The majority of immigrants living in Geneva have a long-term residence permit. However, Switzerland is a destination country for a rising number of asylum seekers (5.6% of the total population of Geneva in 2013), coming from non-European countries such as Eritrea, Somalia, Afghanistan, Syria, Sri Lanka and Iraq (Federal Office for Migration, 2013). After these individuals apply for refugee status, they receive a temporary residence permit until the national authorities decide upon their claim for asylum. They are not allowed to work and are housed in special centres for asylum seekers, usually located in rural areas. Switzerland also has to deal with irregular migration. Most undocumented women come from Latin America (Brazil, Ecuador, Peru and Colombia) and work mainly in the domestic area (Bolzman et al., 2007).

Among immigrant women, asylum seekers, refugees and undocumented women represent an economically and socially disadvantaged group. Additional problems face these women during resettlement, resulting in a perception of marginalisation from mainstream society

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(Gagnon et al., 2006; Goguikian Ratcliff et al., 2014). Migration and pregnancy are often regarded as stressful life events in their own right; however, little is known about the effects of additional stressful life conditions, unstable environment and forced migration on pregnancy experiences and outcomes. As such, this study compared the overall perinatal health of two subgroups of immigrant women with different migration profiles: undocumented or refugee women with a temporary residence permit (i.e. precarious legal status); and women with long-term or permanent residence permits (i.e. non-precarious legal status). Given the high number of births among migrant women shortly after their arrival to Switzerland (Bollini and Wanner, 2006), and the rising number of asylum seekers, it is of great importance to detect at-risk mothers as early as possible. Solid evidence has shown that antenatal exposure to maternal depression and stress, and prematurity or low birth weight are factors associated with unforeseen difficulties in the child's subsequent development in various domains: emotional regulation, motor co-ordination, cognitive development, concentration, language and learning (Foss et al., 2004; Nanzer, 2009; Pottie et al., 2011). Thus, early diagnosis of emotional distress and obstetric complications, and treatment interventions are imperative for the health and well-being of the mother and the child.

Reproductive health of immigrant women and barriers to health care

Immigrant women are often at risk of poor pregnancy outcomes. Perinatal obstetric complications, preterm birth, low birth weight and maternal mortality have been reported in several international studies (Essén et al., 2000; Gould et al., 2003; Philibert et al., 2008). In Switzerland, two national studies have shown that immigrant women are at higher risk of obstetric complications than native women, with higher rates of caesarean section, low birth weight, and infant and maternal mortality (Bollini and Wanner, 2006; Bollini et al., 2009). On the other hand, some groups of immigrant women have unexpectedly favourable birth outcomes (Guendelman et al., 1999; Hessol and Fuentes-Afflick, 2000). The international research collaboration Reproductive Outcomes and Migration reviewed 133 studies published between 1995 and 2008 in Canada, Australia, the USA, the UK, France, Italy, Norway, Sweden and Spain to assess whether migrants in industrialised countries have consistently poorer perinatal health than native women (Gagnon et al., 2010). The results showed that perinatal health of immigrant women was at least as good as that of native women in 50% of the studies.

The reasons for these conflicting results remain unclear. The heterogeneity of the experimental designs and the variables chosen to define immigrant women (current nationality, country of birth, racial or ethnic category), as well as the elevated number of confounded sociodemographic and psychosocial characteristics of the samples (age, parity, duration of settlement in the host country, language proficiency, socio-economic status, social support) limit the conclusions that can be drawn, and make it difficult to generalise the findings.

Differences in pregnancy outcomes between immigrant and native women have been linked to underutilisation of health-care services and delayed follow-up (Pottie et al., 2011). Various barriers may hinder or delay the access of pregnant immigrants to care, such as lack of knowledge of the host country's social and health-care system (Ahmed et al., 2008; Pottie et al., 2011), language proficiency (Timmins, 2002; Jacobs et al., 2004) and low socio-economic status (Lindert et al., 2008).

Although health insurance is mandatory in Switzerland, it is unaffordable for most undocumented immigrants (Syndicat Interprofessionnel de travailleuses et Travailleurs, 2004), or they fear being denounced to the authorities by the medical services. This tends to discourage this 'invisible' population from seeking help. A study on pregnancy follow-up in Geneva showed that the first visit to a gynaecologist was one month later for undocumented immigrant women compared with native women, and highlighted high rates of unintended pregnancies among undocumented immigrant women (Wolff et al., 2008). Asylum seekers and refugees do benefit from health insurance funded by the government, but their use and knowledge of the health-care system are poor due to a combination of poor language proficiency, low education level and poor health literacy. In the Swiss context, most health-care practitioners speak at least one of the three national languages (German, French and Italian), but they often share no common language with new immigrants coming from non-European countries (Bischoff et al., 2003).

Antenatal depression

Pregnancy is a period of physical and emotional vulnerability and stress (Cox and Holden, 1994; Stewart et al., 2003; Nanzer, 2009). Perinatal psychiatric disorders may extend from pregnancy to one year after birth, and range from mild antenatal anxiety or postpartum 'blues' to severe postpartum psychosis (Cox and Holden, 1994; Dennis, 2003).

It has been shown consistently that common risk factors for perinatal affective disorders include personal or family history of psychiatric illness (O'Hara and Swain, 1996; Robertson et al., 2004), stressful life events (O'Hara and Swain, 1996; Robertson et al., 2004; Le Strat et al., 2011), perceived social isolation and lack of social and marital support (Beck, 2001; Robertson et al., 2004 ; Zelkowitz et al., 2004), violence associated with pregnancy (Karaçam and Ançel, 2007; Stewart et al., 2008), young age (Da Silva et al., 1998; Le Strat et al., 2011) and unintended pregnancy (Christensen et al., 2011).

Antenatal depression has received less attention than postnatal depression although its prevalence is at least as high, ranging from 12% to 25% (Green, 1998; Zelkowitz et al., 2004; Le Strat et al., 2011). The highest prevalence of antenatal depression has been observed during the last trimester of pregnancy (O'Hara and Swain, 1996; Bennett et al., 2004). Similar rates have been reported in Switzerland (Kammerer et al., 2009; Alder et al., 2011). Available research has shown that experiencing depressed mood or anxiety during pregnancy is a significant predictor of postpartum depression (O'Hara and Swain, 1996; Righetti-Veltema et al., 1998; Beck, 2001). The high prevalence of antenatal depression and the potential existence of continuities between the emotional state during pregnancy and after birth stress the importance of screening for depression during pregnancy (Green, 1998; Robertson et al., 2004).

Antenatal depression is strongly associated with social and environmental stressors (Brockington et al., 1990; Kitamura et al., 1996; Le Strat et al., 2011). Its prevalence is considerably higher (ranging from 25% to 50%) among women from low-income or minority groups (Da Silva et al., 1998; Kelly et al., 2001; Adouard et al., 2005). Immigrant women are at particularly high risk of developing antenatal depression and/or anxiety (Zelkowitz et al., 2004; Zelkowitz, 2007; Ahmed et al., 2008). In addition to the common risk factors, specific difficulties related to the immigration process may result in heightened psychological distress. Immigrant women often cumulate psychosocial risk factors that interact and exacerbate worries related to pregnancy, including financial problems, housing difficulties, social isolation and loss of pre-existing social support systems, separation from the extended family, language barriers, premigratory losses and trauma (Zelkowitz et al., 2004; Gagnon et al., 2006), cultural maladjustment and unfamiliarity with Western obstetric practices (Moro and Drain, 2009).