

Pregnant asylum seekers' perspective on mental health screening: A qualitative study[☆]

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ABSTRACT

Purpose: Psychiatric disorders are prevalent among pregnant asylum seekers and can have adverse effects on both the individual and newborns. There is limited research on the perspectives of pregnant asylum seekers on mental health screening. This study investigates whether pregnant asylum seekers consider the Refugee Health Screener 15 (RHS-15) suitable and acceptable as a mental health screening test.

Methods: Eight participants filled out the RHS-15. Semi-structured interviews were conducted in which mental health screening and the acceptability and suitability of the RHS-15 to screen for mental health disorders were discussed. Two researchers performed an inductive thematic analysis.

Results: Three themes were identified: 'Importance of mental health screening', 'Talking about mental health' and 'Use of the RHS-15'. Participants recognized how their past experiences and seeking asylum during pregnancy rendered them more susceptible to mental health conditions. Screening was considered important since participants valued talking about mental health with their midwife, but they would not initiate this conversation. Barriers and enablers to these discussions included a language barrier, cultural differences, family support, practical barriers, relationship with healthcare providers and limited access to and unfamiliarity with the Dutch healthcare system. Our participants considered the RHS-15 a suitable instrument for mental health screening.

Conclusions: Pregnant asylum seekers are often marginalized and underserved and experience high rates of psychiatric disorders. Our participants considered mental health screening in the perinatal period acceptable and necessary. Further research should focus on the implementation of the RHS-15 as a screening tool for perinatal care in this population.

1. Introduction

Pregnant asylum seekers are at risk of depression, post-traumatic stress disorder (PTSD) and anxiety. According to a recent systematic review, the prevalence of mental health disorders in pregnant refugees is

high, as one in three experiences perinatal depression and one in five experiences PTSD [1].

These high rates of mental health disorders may be explained by an increased prevalence of several known risk factors [2]. For instance, in the process of forced migration, pregnant refugees may be exposed to

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many stressors such as war, famine, abuse, gender-based violence, unwanted pregnancy, unhealthy and dangerous living conditions and little to no access to (reproductive) healthcare [2–6]. Once in the host country, other stressors emerge, including loss of social network, low social status, discrimination, racism, marginalization and insecurity regarding the asylum procedure [3,7]. During the Covid-19 pandemic, many of these stressors were further worsened and asylum seekers faced even more restrictive migration policies and even more limited access to healthcare, with many targeted health care programs being disrupted, and often their mental health distress was exacerbated [8].

Perinatal psychiatric disorders are associated with reduced prenatal care utilization and an increased risk of adverse perinatal outcomes such as preterm birth, small for gestational age infants and admission of the neonate to a neonatal intensive care unit [11,12]. They are also associated with postpartum psychiatric disorders and increased risk of neurodevelopmental impairment in the neonate [11,12]. To provide timely care and support and to reduce the potential adverse effects of perinatal psychiatric disorders, mental health screening is essential. In the general population, prenatal screening for mental health disorders improves detection, facilitates access to mental healthcare services and improves health outcomes [13].

Research on mental health screening in pregnant asylum seekers is limited. Studies mostly focus on the experiences and opinions of health care providers (HCPs), who consider mental health screening necessary and feasible for pregnant refugee and migrant populations [14–16]. HCPs may experience challenges while screening this population, including professional limitations, language barriers, sociocultural differences, and inadequacy of screening tools [14–17].

To our knowledge, only one previous study describes pregnant refugees' perceptions of mental health screening [18]. This Australian study shows that pregnant refugees consider mental health screening with the Edinburgh Postnatal Depression Scale (EPDS) to be feasible [18]. The EPDS is the most commonly used screening tool in literature, however, its transcultural appropriateness in refugee populations has been questioned [15,17,19–21]. Transcultural shortcomings of the EPDS that were identified were for example some questions needed rewording, other questions were considered disruptive or intrusive [19,22].

Alternative screening tools are available. One of these is the Refugee Health Screener 15 (RHS-15) which is validated for screening for PTSD, anxiety disorders and depression symptoms in refugee populations [23–25]. One study validated the RHS-15 for screening pregnant refugees on the Thai-Myanmar border [26]. In this study the RHS-15 was compared with a diagnostic tool, the Structured Clinical Interview for the Diagnosis of DSM-IV Disorders (SCID), which was administered by healthcare workers and not specialists. Furthermore, the perspectives of pregnant refugees were not investigated in this study. Building on previous knowledge, our study aims to evaluate prenatal mental health screening and the use of the RHS-15 from the perspective of pregnant asylum seekers.

2. Methods

In this qualitative study, we conducted semi-structured interviews with pregnant asylum seekers who were residing in the reception center of Ter Apel, the Netherlands. This paper followed the COREQ guidelines for qualitative research [27].

2.1. Participants

A convenience sample was recruited by midwives from the local midwifery practice, which facilitates perinatal care for all asylum seekers in the reception center of Ter Apel. Convenience sampling can be useful with hard to reach populations and qualitative research as it allows to reach specific participants and gain in-depth insights [28]. This reception center accommodates asylum seekers who enter the Netherlands at first instance. See also [box 1](#) regarding the different legal definitions. Eligible participants were pregnant asylum seekers older than 18 who applied for asylum in the Netherlands within the last 3 years. Asylum seekers who suffered from florid psychotic symptoms were excluded from the study, as informed consent for participation would not be valid. Eligible participants were approached by their midwife for permission to be contacted by a researcher about study participation. Information about the study was offered with the help of an interpreter and informed consent forms were translated in participants' first language. Six to twelve semi-structured interviews were considered enough to reach thematic completeness [29–31]. Inductive thematic saturation is reached when no new themes are identified during analysis [29]. A small number of participants in qualitative research, allows for in-depth understanding of participants' experiences [31].

2.2. The Refugee Health Screener 15

The RHS-15 is a brief (4–12 min) transculturally validated screening tool, available in multiple languages, for the detection of psychiatric symptoms in the refugee population across different languages and cultures. It has good psychometric properties with a Cronbach alpha of 0.93, high specificity and sensitivity for depression, PTSD and anxiety at a cut off score of ≥ 12 and adequate validity and reliability [23]. These good properties were confirmed in other studies later on in the refugee population in Germany and Italy [25,32]. A previous study has validated the use of the RHS in the pregnant asylum seekers population [26].

2.3. Study procedure

Recruitment and data collection were performed in November and December 2020. At the start of each interview participants were asked to fill in the RHS-15 in their language of choice. Interviews were audio recorded and led by a trained moderator (ES) accompanied by an observer (AV), a psychologist and a professional interpreter. Interviews were conducted in a private room either in the reception center or at the

Box 1

Definitions of asylum seeker and refugee.

Asylum-seeker: 'An individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which the claim is submitted. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee was initially an asylum-seeker.' [9]

Refugee: 'a person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of this nationality and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country' [10]

midwifery practice, ensuring convenience and privacy for the participants. Interpreters were selected from the official list for official certified interpreters, who have a duty to confidentiality and have professional training often in medical and legal related translation. They literally translated everything that was said back and forth, and therefore did not influence rapport and responses. After the interview participants filled in a questionnaire about their demographic, obstetric and psychosocial history. The questionnaires were anonymous to ensure participants' privacy. The content of the anonymous questionnaire and topic list (see Appendix A) for the interview were drafted by the research team and reviewed by a transcultural psychiatrist (WV), medical anthropologist (CC) and a former Syrian asylum seeker (KA) to ensure transcultural and psychiatric suitability. We pilot-tested the semi-structured interview with a medical student (AA). As an additional way to clarify difficult concepts we used artwork especially designed for this study (KMK). The moderator (ES) was in the last year of her Master of Medicine and was trained in qualitative research techniques. The interview team consisted of women only.

If the RHS-15 would show a high score or the psychologist present at the interview would observe psychological symptoms, the research team referred these observations to the treating midwife of the participants, after the participants had given consent.

2.4. Data analysis

Audio recordings were transcribed verbatim by the first author (ES) and checked by the other first author (AV). Non-English recordings were transcribed and translated by native speakers. Inductive thematic analysis was performed by two researchers (ES and AV) independently. For each interview, all meaningful text fragments were highlighted and assigned one or more codes (open coding). Afterwards, links between codes were identified (axial coding) and the codes were checked for validity. Finally, core labels were created, which were systematically interrelated and brought a broader understanding and relevance to the data [33]. Saturation was considered achieved once no additional core labels were identified during the analysis. Discrepancies were resolved by discussion between ES and AV until unanimity was reached. To ensure dependability and confirmability of the results the analysis was checked by and discussed with a third researcher (EF-dJ). For data analysis we used Atlas.ti 8©. As thematic analysis is interpretive in nature, researchers' cultural and linguistic backgrounds can shape how data are coded and organized into themes, particularly when working across language and cultural differences. Preparation work, with colleagues from different backgrounds, aimed to reduce possible biases.

2.5. Researchers' reflexivity

During the time of the study, ES was a last year medical student who was trained in qualitative research and who had worked multiple times in asylum seeker centers for medical NGOs in the Netherlands and abroad. AV was a PhD candidate researching the healthcare outcomes of pregnant asylum seekers. Dr. IP was a resident in Obstetrics and Gynecology and a postdoctoral researcher. Dr. EF-dJ is a midwife and has extensive knowledge in qualitative research. Professor WV is a transcultural psychiatrist. JS is a MD global health and tropical medicine, an obstetrician and gynecologist and professor in international safe motherhood.

2.6. Ethical approval and privacy issues

This study was approved by an acknowledged medical ethical committee of the University Medical Center of Groningen (2020/301). The participants gave written informed consent to the use of information from the interviews. All participants were assured of anonymity and confidentiality and could freely withdraw from the study at any time. Data was anonymized for publication.

3. Results

Eight pregnant asylum seekers participated in this study. In total, twelve asylum seekers agreed to participate and were invited for an interview, but three of them were relocated to another reception center before the planned date. One asylum seeker did not attend because they felt too tired. No participants left early during the interviews or withdrew consent afterwards. The duration of the interviews varied between 36 and 84 min. Thematic saturation was reached after five interviews. Significant response repetition was observed, despite participants' diverse backgrounds. As themes were identified from the data, there was consistent overlap between the new interviews and previously identified themes. After inductive thematic saturation was reached at five interviews, we performed three more to ensure accuracy of the identified themes.

Participants came from eight different countries of origin and they were between 18 and 30 years old. All participants except one, had family in the Netherlands and six out of eight had a partner. Four participants suffered complications in past pregnancies and two suffered complications in their current pregnancy. Five participants had been victims of either mental or physical abuse and three had a past psychiatric diagnosis [see Tables 1, 2 and 3].

Fig. 1 shows the three overarching themes that emerged from the interviews, 'Importance of mental health screening', 'Talking about mental health' and 'Use of the RHS-15', as well as all categories related to these themes.

3.1. Importance of mental health screening

The theme 'Importance of mental health screening' outlined why participants felt mental health screening is important for pregnant asylum seekers.

3.1.1. Vulnerability

All participants mentioned that pregnant asylum seekers face many hardships that render them vulnerable to mental health disorders. Issues that emerged were loneliness, not having a support system, traumatic past experiences, lack of occupation, worries about family and insecurities regarding the asylum procedure. The way participants dealt with stress differed from isolating oneself to calling relatives and friends or just trying to stay strong.

"If you are alone as a pregnant woman in a different country you can be depressed. If you don't have people around to help you and guide you. You are alone to deal with these kinds of issues that can be new for them. They need your support to help them, to guide them, to keep it up with this pregnancy because it's a very long journey."

(Participant 4)

3.1.2. You don't ask, I don't tell

Most participants would not spontaneously initiate a conversation about mental health with an HCP for various reasons such as a language barrier, lack of encouragement from their current HCP or not recognizing their own symptoms. Participants mentioned that encouragement to talk and guidance in navigating the system were the most important factors to help them seek mental health care.

"Because when I have a bad mood or I feel really sad or stressed, I want to be alone, like I will think alone and at the end I will try to push myself up. I will not really think of going to see a psychologist or to talk with somebody else."

(Participant 2)

3.1.3. Accept treatment

The participants agreed that HCPs should ask about mental health

Table 1
Demographic characteristics.

Participant number	Age group	Country of origin	Preferred language ¹	Arrival in reception center	Relatives in the Netherlands	Relationship status
1	25–30	Uganda	English	Last month	None	Single
2	30–35	Tunisia	English	12 months	Partner & Children	Married
3	25–30	Turkey	English	Last week	Partner	Married
4	25–30	Syria	Arabic	Last 3 months	Partner	Married
5	30–35	Nigeria	English	Last 3 months	Children	Partner, not married
6	18–24	Gambia	English	Last 3 months	Children	Single
7	35–40	Turkey	Turkish	12 months	Partner & Children	Married
8	25–30	Iraq	Arabic	5 months	Partner & Children	Married

¹ Preferred language for informed consent, RHS-15 and interview.

Table 2
Obstetric history as reported by participants.

Participant number	Gestational age	Gravida	Para	Previous mode of delivery	Complications in current pregnancy	Complications in past pregnancy
1	19 weeks	3	2	Vaginal	–	Premature birth
2	12 weeks	2	1	Caesarean section	–	High blood pressure
3	28 weeks	1	0	–	–	N/A
4	13 weeks	3	0	–	–	N/A
5	38 weeks	4	3	Caesarean section	Diabetes	Diabetes
6	40 weeks	2	1	Vaginal	Hepatitis B	Uterine rupture
7	22 weeks	2	1	Vaginal	–	–
8	37 weeks	2	1	Caesarean section	–	–

Table 3
Psychiatric history as reported by participants.

Participant number	Psychiatric disorder	Perinatal psychiatric disorder	Mental abuse	Physical abuse
1	Depression	Depression	Yes	Yes
2	–	–	No	No
3	Panic attacks	–	Yes	No
4	Anxiety	Anxiety	No	No
5	–	–	Yes	Yes
6	–	–	Yes	Yes
7	–	–	No	No
8	–	–	Yes	No

but also stated that “asking is not enough” and that HCPs should offer treatment if necessary. Seven participants thought that HCPs could help them deal with symptoms of mental health disorders or relieve stress. Ways in which HCPs could help pregnant asylum seekers with mental health disorders included talking, asking questions, providing advice, and offering medications for pain or sleeping problems. One participant stated that they did not think that an HCP could help them with mental health symptoms because they related their experienced symptoms and stress to the pregnancy.

Q: “Do you think it would be good if a midwife would start asking you this question?”

A: “That would be good, I think, but not only asking. ... if you give only those questions and then no treatment, that doesn't help.”

(Participant 3)

3.1.4. HCPs should know about mental health status

All participants preferred their midwife and doctor to know about their story, personal problems, and mental wellbeing. Understanding their context was considered necessary for proper treatment. Participants mentioned that nobody had asked about their past or their mental wellbeing since they arrived in the reception center.

“It is important for me that a doctor or midwife knows what I have been through. Especially under these circumstances”

(Participant 7)

3.2. Talking about mental health

“Talking about mental health” outlined whether participants would openly talk about mental health with HCPs and how they prefer to have

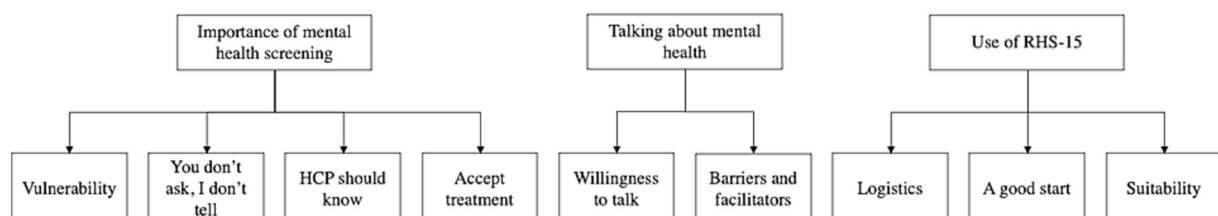


Fig. 1. Themes and subthemes.

such a conversation. All participants were willing to tell their story and express their feelings and symptoms if it was a certified HCP asking.

3.2.1. Barriers and facilitators for talking about mental health

Participants mentioned a language barrier, cultural differences, lack of family support, practical barriers, an untrusting relationship with their HCP and confusion about the Dutch healthcare system as potential barriers to talking about mental health. Practical barriers consisted of proximity to the due date, long waiting times and difficulties in making an appointment. One participant considered asking their midwife for psychological care but was afraid that this would negatively influence their asylum application procedure.

Q: *"Do you want them to talk with the midwife and let the midwife know that you would like some help from a psychologist if you still need it?"*

A: *"If this doesn't affect my permit application, yes no problem. I hope I will not get into problems because I am complaining."*

(Participant 4)

With regards to cultural differences, participants' perception of the treatment for mental health disorders in their countries of origin varied greatly. Barriers to care in participants' countries of origin included that psychologists were only accessible to the wealthy and that there was shame associated with mental health disorders. In the reception center, however, most participants mentioned that talking about mental health and seeing a psychologist became more normal to them.

"Before in Iraq, if you go to the psychologist, they think that you are crazy, but because of the situation now everything has changed. Because it has been too much now people already accept the idea, they accept to go to a psychologist because it helps them."

(Participant 8)

Considering family support, some participants worried about disapproval of their family or partner and would only consider referral to a psychologist if kept confidential. Others said their partner would support them, which could facilitate seeking psychological care.

"If your family doesn't support going to a psychologist, maybe they would tell the doctor: I don't have a mental problem. I am not crazy and my husband doesn't want it."

(Participant 3)

All participants interviewed had trust in their HCPs. Ways to earn this trust were taking enough time and showing interest. A clear introduction and explanation of HCP's responsibilities was also considered necessary, as for example some participants were unaware of the obligation of HCPs to respect patient confidentiality. One participant made a strong argument regarding HCP's prejudices about asylum seekers; they felt that if HCPs assumed how they feel without asking, it hurts the relationship.

"It's me who knows how I feel, not you out of my story."

(Participant 1)

3.3. Use of the RHS-15

'Use of the RHS' gave an overview of the thoughts and opinions participants had on the RHS-15.

3.3.1. Logistics

Six participants preferred the RHS-15 to be taken by their midwife or did not express preference for a specific HCP. Reasons why participants preferred a midwife were that they have many appointments with their

midwife during pregnancy and they only go to a doctor when they are sick.

"Because a doctor, you will call him only when you are sick or only when the midwife will transfer you to him. So, I think the midwife is the first person that she is in contact with, the pregnant lady."

(Participant 2)

Most participants agreed that the RHS-15 could be introduced during their first appointment with an HCP. One participant argued that a mental health disorder can be quite stressful and that screening during the first appointment might help participants and improve their trust in the midwife.

3.3.2. A good start

All participants were satisfied with the RHS-15 as a screening tool and considered it a good way to start talking about mental health. Participants felt comfortable filling in the questionnaire and did not consider the questions too shocking or traumatic. On the contrary, it made them feel heard and supported. It was suggested that the questionnaire could make HCPs understand their patients better because it helped them explain their feelings, made their feelings measurable and helped them to be more specific. The RHS-15 also made participants reflect on their past experiences and mental wellbeing. Filling in the RHS-15 first and then discussing mental health was considered less confrontational than if an HCP would ask about mental health directly.

"Sometimes while you are being really busy in this life, you will forget what you really feel and what you are really feeling from inside. So, this question makes me realize how I really feel. Am I really stressed or not? Can I really handle the stress? Especially in this situation"

(Participant 2)

3.3.3. Suitability of the RHS-15

Participants considered the RHS-15 understandable, and the symptoms asked about in the questionnaire were considered relatable and generalizable. Out of eight participants, five filled out the screening questionnaire on paper. Three participants filled out the questionnaire orally, two because of illiteracy and one because the RHS-15 was not available in Turkish.

"When you read it for me, I understand it. Perfectly."

(Participant 5)

The participants who were interviewed in English did not need an interpreter but suggested that others might need one to fill out the RHS-15. The participants who were interviewed with an interpreter really appreciated the opportunity to ask questions about the questionnaire, even when it was written in their native language.

All participants agreed that the symptoms asked in the RHS-15 related well to their situation. One of the strengths of the RHS-15 mentioned was that the symptoms apply to all asylum seekers. All participants would recommend the RHS-15 to another pregnant asylum seeker.

Q: *"And what do you think about the symptoms asked?"*

A: *"They are real."*

(Participant 1)

During the interview participants were given the opportunity to make suggestions on the RHS-15. They suggested additional questions about traumatic experiences, personal relationships, and their support systems. Adjustments to the timeframe of the questionnaire since they considered scoring their mood over the last month difficult and partner

involvement during the screening were also suggested.

4. Discussion

The aim of this study was to explore the perspectives of pregnant asylum seekers on prenatal screening for mental health disorders using the RHS-15. Overall, participants perceived mental health screening as positive and considered it essential for good care. Participants recognized how their past experiences and seeking asylum during pregnancy rendered them more susceptible to psychiatric disorders. Barriers and facilitators for talking about mental health included a language barrier, cultural differences, family support, practical barriers, the relationship with their HCP and confusion about the Dutch healthcare system. Finally, participants' opinion on the RHS-15 was positive and they considered it a suitable and acceptable method for prenatal mental health screening.

With regards to participant, s positive views towards mental health screening and their willingness to discuss mental health problems with their midwife, our results were in line with previous qualitative studies that interviewed pregnant refugees and immigrants [18,34,35]. A language barrier, cultural differences, and family support were previously described as barriers and facilitators to talking about mental health [16,19,20,36]. Concerning the language barrier, our study and other studies on prenatal mental healthcare for refugees and studies that used the RHS-15 in non-pregnant refugees highlight the importance of the presence of an interpreter during mental health screening [14,18,20,24,25,36–38]. The RHS-15 has already been validated for the refugee population, is advised for clinical use in this population [20,23,24] and a previous study validated the RHS-15 in the pregnant refugee population on the Myanmar–Thai border [26]. However, no study previously assessed the perspectives of pregnant asylum seekers on the RHS-15. In our study, stigma towards mental health in participants' home countries was not considered a barrier to talk about mental health with caregivers in the Netherlands. This is in contrast with previous studies, in which migrants' perceived cultural beliefs and stigma towards mental health disorders as barriers to speaking about their mood [18,34]. This difference between the asylum seekers in our study and migrants in previous research could possibly be explained by the destigmatization of mental health problems in reception centers, which was mentioned by our participants.

Participants also made recommendations to HCPs on how to facilitate a good and trusting relationship with their asylum seeking patients, such as: taking enough time, showing genuine interest, not making assumptions, providing information on the local healthcare system, explaining their role and the duty of confidentiality. Their recommendations were similar to those mentioned in previous studies on mental health of pregnant refugees, which especially highlighted the damaging effect of prejudice and stereotyping on the patient-provider relationship [15,19,20,33,39].

Our results revealed that while asylum seekers were willing to talk about their mental health, HCPs must initiate this conversation. Finally, participants reported limited access to healthcare and prolonged waiting times as systemic barriers to mental healthcare. Recent literature from the Netherlands emphasizes that structural factors and discriminatory policies contribute to adverse healthcare outcomes and hinder access to adequate care for pregnant asylum seekers. The Netherlands enforces restrictive migration policies. Family reunification is tightly regulated, and an extensive list of “safe countries” subjects asylum seekers to accelerated procedures that frequently result in rejection [40,41]. These policies may incentivize the use of unsafe migration routes, thereby increasing the risk of physical and mental health deterioration and

impeding healthcare access during transit [42]. Upon arrival, asylum seekers are commonly accommodated in remote and overcrowded reception centers. They face an average waiting period of 15 months for asylum interviews, contributing to prolonged existential insecurity [43,44]. Furthermore, access to meaningful daytime activities is often limited [45]. Asylum seekers, even when pregnant or in the postpartum period, are frequently relocated [46], leading to a lack of continuity of care and delays in care. Recent articles indicate that pregnant asylum seekers, often receive delayed antenatal care, heightening the risk of complications and emergency interventions [46,47]. These systemic challenges must be critically addressed in discussions on perinatal psychiatric care, given their significant implications for mental health [47].

Strengths of this study included the development process of the topic list and questionnaire, which involved multiple experts with a trans-cultural background to ensure cultural appropriateness. For interviews with participants who were not proficient in English, professional interpreters were present and interview scripts were translated to English by native speakers, so analysis was based on the words of the participants. The main limitation of this study was that we were bound to a convenience sampling of participants because of the low influx of asylum seekers due to the Covid-19 pandemic. Convenience sampling might lead to limited transferability [28]. Furthermore, since this study was conducted during the Covid-19 pandemic, it is possible that the participants had a heightened perceived need of screening for mental health disorders. During the pandemic stressors such as existential insecurity, limited access to healthcare, isolation and poor living conditions were exacerbated; possibly worsening the psychological symptoms [48–51]. Research has also shown that the Covid-19 pandemic has also extended the delays in diagnosis and treatment of mental health disorders in asylum seekers [52]. However, all these factors are not circumstantial to the Covid-19 pandemic only, but unfortunately often inherent to the condition of being an asylum seeker.

Another limitation was that we gave participants who were proficient in English the choice to conduct the interview in English instead of their native language. Although participants who chose to conduct the interview in English were all fluent, they might have had some difficulty expressing themselves. Finally, saturation was reached at a thematic level. Eight interviews provided sufficient data for the objectives of this qualitative study; however, the small number poses a limitation to the transferability of our findings due to the diverse experiences of pregnant asylums seekers.

In conclusion, mental health screening in the perinatal period was considered acceptable and necessary by the pregnant asylum seekers in this study.

Pregnant asylum seekers are a marginalized and underserved population, who often show higher rates of psychiatric disorders [53] and frequently face barriers to access perinatal mental healthcare [54]. Perinatal screening may help detect and treat perinatal psychiatric disorders in this population.

Screening, in the form of the RHS-15, may be performed at the first appointment with a midwife or certified HCP and an interpreter should always be available. Further research should investigate the implementation of the RHS-15 as a standard screening tool for perinatal care in this population.

Consent to participate

Participants received oral and written information, with help of an interpreter and signed an informed consent form before participating in the study.

Consent for publication

Participants gave permission to anonymously publish the results of the study by signing the informed consent form.

Ethics approval

This study was reviewed and approved by the Medical Ethical committee of the University Medical Center Groningen, the Netherlands. The METc reference number is 2020/301.

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Authors' contribution

ES, under direct supervision of AV and IP wrote the research funding request, the research protocol, the semi-structured interview scripts, and

the manuscript. All authors contributed to the study conception and design. The data collection and analysis were performed by ES and AV under the supervision of EF-dJ. Drafts of the manuscript were written by ES and AV and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Declaration of competing interest

The authors declare that they have no conflicts of interest.

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Appendix A. Semi-structured interview script

Introduction question

1. Would you recommend this screening questionnaire to other pregnant women? Why? (Fig. 2)



Fig. 2. Recommending the screening questionnaire to another pregnant asylum seeker. Image description: an illustration in black and white depicting two pregnant persons both wearing a veil. One person is holding a paper and showing it to the other person. Above the paper there is a tick and a cross.

Screening questionnaire

2. What did you think about the screening questionnaire? (Fig. 3)



Fig. 3. evaluation of the screening questionnaire. Image description: an illustration in black and white of a scale going from 1 to 10. Next to the 10 there is a smiley face and a thumb up, next to the one there is a sad face and a thumb down.

3. Could you understand what was asked in the screening questionnaire?
4. Would you need a translator to help you read and understand the questions?
5. How long did it take you to fill in the screening questionnaire?
6. Which healthcare worker would you prefer? Why?
7. Do you think the screening questionnaire is helpful to talk about your past traumas, stress and anxieties? (Fig. 4)



Fig. 4. Talking about mental health with an HCP. Image description: an illustration in black and white of two persons sitting on chairs facing each other. One person is pregnant and wearing a veil and the other has a little cross indicating she is a healthcare professional.

Sharing anxieties, stress, and experiences

8. What do you think about the symptoms (stress, muscle pain, fear...) that were asked about in the screening questionnaire? (Fig. 5)



Fig. 5. Symptoms as asked about in the screening questionnaire. Image description: an illustration in black and white depicting a pregnant person wearing a veil. Around the person different symbols are depicted that indicate: headache, a tearing eye, back pain and joint pain.

9. Has any HCP asked you about these symptoms before?
10. How do women deal with similar symptoms in your country?
11. Could your anxieties and past experiences be discussed in a group with other pregnant asylum seekers? (Fig. 6)



Fig. 6. Talking about mental health in a group. Image description: an illustration in black and white depicting 7 persons sitting on chairs in a circle. Six of them are pregnant and one of them is not and has a little cross indicating she is a healthcare professional.

12. Or do you prefer discussing that alone with a healthcare worker? Why?
13. In what way do you think sharing your anxieties, stress and past experiences with a healthcare worker may help you?
14. How would you feel about being referred to a psychiatrist or psychologist to receive treatment?
15. What would you think we should do differently to talk about trauma, stress, and anxieties with pregnant asylum seekers like you?

Closing question

16. Imagine that you must describe the screening questionnaire to another pregnant woman. How would you do that?

Data availability

Data are available upon reasonable request from the authors.

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