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Manifestation, causes and approach to mental distress among the population of migrant and refugee women in Ecuador and Panama: a qualitative study with key informants

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Abstract

Introduction Human mobility in the Latin American and Caribbean (LAC) region has increased in the last decade, as well as the proportion of women within this population. The difficulties they experience in the country of origin, in their journey and in the receiving country have a negative impact on their mental well-being. In order to gain knowledge about the manifestations of mental distress in the population of migrant women in the region, the causes of such discomfort, the mental health support available to them and proposals for interventions that promote their mental health, we carried out this exploratory qualitative study. The study focused on the towns of Guayaquil and Tulcán in Ecuador and Panama City.

Methods We employed phenomenological qualitative design. Semi-structured interviews were conducted with 37 key informants residing in the three study locations. These were conducted in Spanish in February and March 2021 and recorded in audio. The transcripts of the interviews were analyzed using the thematic analysis methodology.

Results We identified 5 themes and 18 sub-themes from the data. All participants had perceived manifestations of mental distress in migrant women in their communities, citing migratory grief, unmet expectations, uncertainty, violence and discrimination as some of its main causes. Participants cited the family, community, government institutions, international agencies, and civil society organizations as sources of psychoemotional support in the population of study. Several informants agreed on the importance of creating specific care spaces for the migrant women's population, implementing peer support groups, providing educational and informative sessions that promote mental well-being, and providing comprehensive responses to the needs of migrant women, including mental and physical health, but also their causes.

Conclusions This study represents a first step to improve current strategies for the prevention and care of mental distress in the population of migrant women in LAC. Evidence-based interventions such as the one in our study can contribute to reducing inequities based on gender and migration status in mental health and access to mental health services in the region.

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Keywords Ecuador, Mental health, Migrant women, Panama, Qualitative study, Women health.

Spanish abstract

Introducción La movilidad humana en la región de Latinoamérica y el Caribe (LAC) ha aumentado en la última década, así como la proporción de mujeres dentro de esta población. Las dificultades que experimentan en el país de origen, en el camino y en el país receptor impactan negativamente sobre su bienestar mental. Con el objetivo de ganar conocimiento acerca de las manifestaciones de malestar mental en esta población, sus causas, el apoyo a la salud mental disponible y propuestas de intervenciones que la promuevan, llevamos a cabo el presente estudio cualitativo exploratorio. El estudio se centró en las localidades de Guayaquil y Tulcán en Ecuador y Ciudad de Panamá.

Métodos Empleamos un diseño cualitativo fenomenológico. Se realizaron entrevistas semiestructuradas con 37 informantes clave residiendo en las tres localidades de estudio. Estas se realizaron en español en febrero y marzo de 2021 y se registraron en audio. Las transcripciones de las entrevistas se analizaron utilizando la metodología de análisis temático.

Resultados Identificamos 5 temas y 18 subtemas a partir de los datos. Todos los participantes habían percibido manifestaciones de malestar mental en las mujeres migrantes de sus comunidades, alegando al duelo migratorio, las expectativas insatisfechas, la incertidumbre, la violencia y la discriminación como algunas de sus principales causas. Los participantes mencionaron como fuentes de apoyo psicoemocional la familia, la comunidad, las instituciones gubernamentales, las agencias internacionales y las organizaciones de la sociedad civil. Varios informantes coincidieron en la importancia de crear espacios de atención específicos para la población de mujeres migrantes, implementar grupos de apoyo entre pares, impartir sesiones educativas e informativas que promuevan el bienestar mental y dar respuestas integrales a las necesidades de las mujeres migrantes, incluyendo la salud mental y física, pero también sus causas.

Conclusiones Este estudio representa un primer paso para mejorar las actuales estrategias de prevención y atención del malestar mental en la población de mujeres migrantes en LAC. Intervenciones basadas en evidencia como la de nuestro estudio pueden contribuir a reducir las inequidades basadas en género y estatus migratorio en el estado de salud mental y acceso a servicios de salud mental en la región.

Introduction

Human mobility in the Latin American and Caribbean (LAC) region has experienced a great increase in the first two decades of the twenty-first century. According to the United Nations Department of Economic and Social Affairs, the stock of international migrants in the region increased from 24.6 million in 2000 to 42.9 million in 2020 [1]. Migratory profiles are diverse, including asylum seekers, economic migrants, unaccompanied minors, environmental migrants, irregular migrants, victims of human trafficking, and migrants who are stranded due to border closures or asylum bans [2]. Many of these migrations are forced, which leads to situations of greater vulnerability among migrant populations, exacerbated during the COVID-19 pandemic [2]. International migration in the region includes emigration to high-income countries, mainly to the United States (US), immigration from other regions, and intraregional mobility [2].

Considering that the US continues to be one of the main destinations for emigrants from LAC countries, as well as for emigrants from other regions who undertake their journey to the US from LAC, many countries in the region represent transit areas for these migratory flows [3]. In addition, a growing number of migrants (from LAC and other regions) are settling in LAC countries, either intentionally or because they experience interrupted transit on their way to the US, due to the country's migratory restrictions [4, 5]. Migratory flows in LAC over the last decade have been shaped by the forced migration of population from South American countries such as Colombia and Venezuela, Central American countries such as Nicaragua and Honduras, and Caribbean countries such as Cuba or Haiti, because of natural disasters, political and economic conflicts, and violence exercised by organized crime or guerrillas [3, 6].

Changes in migratory flows have also included changes in the demographic characteristics of the migrant population, with an increase in women on the move, the movement of unaccompanied minors with their families, and the movement of these populations in groups known as "migrant caravans" [7, 8]. Many women leave their countries forcibly, due to the gender-based violence they experience [9], the impossibility of covering basic needs such as drinking water, food or housing, or political and organized crime persecution [10, 11]. In addition to these traumatic experiences prior to migration, there

are difficulties on the migratory route and at the place of destination, where the situation of vulnerability related to gender is exacerbated by vulnerabilities related to their mobility situation and, in many cases, irregular migratory status. As a result, migrant women are at greater risk of gender-based violence, labor exploitation or human trafficking than male and non-migrant women [12–14].

The adversities experienced by many migrant women have a negative impact on their mental well-being, resulting in a higher risk of anxiety, depression and post-traumatic stress disorder in migrant and refugee women than migrant and refugee men and in non-migrant and refugee men and women [15, 16]. These differences are even more pronounced in the population of migrant pregnant women, postpartum women, and women belonging to the LGBTQI + community [16]. Poor mental health is one of the leading contributors to functional impairment and can increase women's vulnerability to adversity and potentially traumatic events during and post-migration [16].

Despite the identification of the demographic transition in the migrant population of LAC, categorized as "feminization" of the migratory phenomenon in the region by some authors [7, 8], the evidence on the mental health status of migrant women, its causes and its approach is still minimal in LAC, with some quantitative studies with data disaggregated by gender and/or sex [17–19] and qualitative studies that share specific findings for the female population [20–23]. Considering the lack of updated evidence on the mental health of migrant women in LAC and the need for it expressed by different civil society, government and other actors in the region, we decided to carry out this study.

This research focused on areas of Ecuador (Guayaquil and Tulcán) and Panama (metropolitan area of Panama City), due to the prominent role of these countries in the migratory phenomena of the region and the presence of key allies for the conduct of research in them. Guayaquil (2,746,403 inhabitants in 2022 [24]), a city located on the Pacific coast of Ecuador, is the most populous in the country. Tulcán (92,375 inhabitants in 2022 [24]) is in the Inter-Andean Region of Ecuador, in the mountainous area bordering Colombia. Both cities host migrant and refugee populations, mainly from Venezuela and Colombia, with Tulcán functioning mainly as a transit area and Guayaquil as a destination [25–27]. Panama City is the capital of Panama, and its metropolitan area (2,019,141 inhabitants in 2020) is home to about 50% of the country's population [28]. Panama acts mainly as a transit country for migrants and refugees, although it also represents the destination country for part of these populations [29]. In recent years, the country has reached record numbers of irregular migrant passages, with 248,284 people (mainly from Venezuela, Ecuador and Haiti) crossing Panama in 2022, mostly bound for the US [30]. Ecuador and Panama alone were estimated to be home to 502,000 and 148,000 Venezuelans in the first quarter of 2023, representing the third and seventh countries in LAC with the largest Venezuelan populations respectively [6].

Our qualitative exploratory study aimed to know the perceptions of key stakeholders on the manifestations of mental distress in the migrant women population of Guayaquil, Tulcán and the metropolitan area of Panama City, its causes, the mental health support available to them and proposals for interventions that promote their mental health.

Methods

Study design

The study design is qualitative phenomenological. This approach was used to understand and describe the impressions, values and meanings of the experiences lived by the participants of the study phenomenon [31]. The phenomenological perspective made it possible to obtain knowledge of phenomena of interest free of theoretical presumptions that assign meanings to experiences a priori [32]. The authors adhered to the checklist of 32 elements of the Consolidated Criteria for Qualitative Research Study Reporting (COREQ), which can be found in Additional file 1.

Study setting

Data collection was carried out in Panama City, capital of Panama, and its surrounding peri-urban communities, Guayaquil and Tulcán, in Ecuador. The data collection was carried out in these three localities due to the large influx of migrant population they experience, to represent diverse migration contexts (urban, peri-urban, and transit settings), and due to the presence of the non-governmental organization HIAS, that provides vital services to refugees, asylum seekers and other displaced people. HIAS was one of the participating agencies in the call to expand knowledge of the mental health needs of the migrant women's population and has been a key collaborator in the conduct of this study.

Participants

In-depth semi-structured interviews were conducted with 37 key informants residing in the three study cities recognized by HIAS staff as knowledgeable about the mental health and psychosocial problems affecting migrant women in their community. Participant recruitment was carried out by combining the techniques of non-probabilistic snowball sampling (new key informants were identified through those already known) and purposive (to include a sample of participants with different sociodemographic characteristics and different roles in their community) [33]. The inclusion criteria were: (1)

to be at least 18 years old at the time of the interview; (2) reside in one of the study communities; and (3) to be recognized by HIAS staff as knowledgeable about the psychosocial problems affecting migrant women in their community. Key informants lived with and in many cases served heterogeneous populations of women who were widely referred to as "migrant women," including refugee, migrant, and asylum-seeking women primarily from Colombia and Venezuela in Guayaquil and Tulcán and primarily from Colombia, Cuba, El Salvador, Nicaragua, and Venezuela in the metropolitan area of Panama. Individuals who did not meet the inclusion criteria were excluded from the study.

The original sample needed was estimated at about 20 individuals, according to previous experiences of the research team. However, individuals were recruited until information saturation was reached, when the co-authors considered that adding additional participants resulted in diminishing returns and the data collected were sufficiently rich in diversity and depth considering the study population [34]. An informed consent letter was read and a copy given to all those who were offered to participate, which included detailed information about the study, its objective, its possible benefits and risks, that the interviews would be recorded, how the research team would treat the data provided by the participants and the voluntary nature of participation, without negative consequences for those who decided not to participate. None of the people who were offered the chance to participate refused or dropped out of the study. The following measures were taken to limit potential participants from agreeing to participate in the study for fear that their relationship with HIAS, if any, could be affected if they did not participate. First, the HIAS data collectors were not involved in the provision of services or decision-making in HIAS' interventions and were, instead, part of a multidisciplinary research team with members of different institutions based in different locations. Second, participants were assured that their contributions would be de-identified by the interviewers before being shared with other members of the research team and that only the transcripts of the interviews would be shared and never the audio records, which would be deleted once transcribed. Third, research information, including whether an individual participated in the study, was never shared with other HIAS staff. All this information was detailed in an information sheet provided to potential participants and discussed between the HIAS data collector and participant during the consent process. Participants did not express any doubts or concerns on this point.

Data collection

The interviews were conducted in February and March 2021. Most of them took place in the workplace of the person interviewed. Data collection was carried out by people hired by HIAS in each of the cities included in the study. Research assistants had bachelor's or master's degrees in psychology, anthropology, gender studies, and other areas of the social sciences, as well as experience working with displaced and other vulnerable populations. The interviewers had no previous relationship with the participants.

The interviews lasted between 60 and 90 min and were recorded on audio. In addition, the interviewer took field notes to complement the recordings. The interviews were conducted in Spanish and transcribed using the transcription module within NVivo. Only excerpts selected for publication were translated into English with the collaboration of a native English speaker who was fluent in Spanish. The interviews followed semi-structured interview guides developed by the research team. The guide contained questions addressing the manifestation of mental distress in the migrant women's population (the manifestations of mental distress were asked in general and specifically for the main forms of mental distress previously identified by the migrant women of the study communities themselves in a participatory exercise, these being stress, anxiety and depression [35]), the causes of their mental distress, the support they receive for their mental well-being, and proposals for interventions that promote their mental well-being.

Data analysis

The transcripts were analyzed with the help of the software Dedoose v. 9.2.12 using the thematic analysis methodology defined by Braun and Clarke [36]. Upon initial familiarization with the data, ZA and CG independently coded a subset of interviews. The debate between the two researchers led to a consensus codebook, which was applied to the entire dataset. Once the data were coded, the themes were identified following a deductive-inductive approach, since the themes that emerged from the data were driven by the interview guide. The themes obtained were revised and refined through an iterative process until all co-authors were satisfied with the result. Participants did not provide feedback on the results.

Methodological rigor

To ensure the credibility of the research, the data collectors spent some time in the collection areas before starting the interviews, including the places where participants interacted with the migrant women's population, to have a broad understanding of the study context. The credibility of the study was also strengthened through peer debriefing between collectors and with the rest of the research team, to ensure the validity of the information collected. To ensure reliability of the analysis, a

codebook was used based on the consensus in the coding of several interviews by two of the co-authors.

Dependability and transferability were enhanced through the exhaustive recording of decision-making processes and work context, which are reported in this manuscript.

Confirmability of the analysis was promoted by sharing multiple quotes from participants in the study results, which are consistent with the findings described in the narrative.

The researchers involved in the data collection, analysis and interpretation of the results reflected throughout the study on their assumptions, beliefs and how they interacted with the participants (in the case of the collectors) to ensure that these did not influence the development of the research.

Ethical aspects

All participants provided informed consent to participate. Study procedures were approved by the Institutional Review Boards at Columbia University Irving Medical Center (US), Universidad de Santander (Panama) and Universidad San Francisco de Quito (Ecuador). This study was performed in accordance with the Declaration of Helsinki.

Table 1 Sociodemographic characteristics of the interviewed participants

	N = 37	
	%	***n***
Location		
Panama City	37.8	14
Guayaquil	32.4	12
Tulcán	29.7	11
Gender		
Female	89.2	33
Male	10.8	4
Nationality		
Venezuela	44.8	13
Ecuador	41.4	12
Panama	13.8	4
Position		
Community manager	27.02	10
Program manager in relation to protection	24.32	9
Government official	10.81	4
Psychologist	8.11	3
Non-psychologist health personnel	8.11	3
Other professional activities	8.11	3
Community police officer	5.41	2
Social worker	5.41	2
Human rights activist	2.7	1
Type of organization		
Public sector	37.84	14
Independent worker	32.43	12
Civil society organization	27.03	10
International agency	2.7	1
	Median	**Interquartile Range**
Age	37	32–48

Results

37 people participated in the study (Table 1). Most participants were interviewed in Panama City and its periurban surrounding areas (37.8%), followed by Guayaquil (32.4%) and Tulcán (29.7%). Most interviewees were women (89.2%), with a median age of 37 years. For individuals who disclosed their nationality, this was Venezuelan (44.8%), Ecuadorian (41.4), or Panamanian (13.8). Participants worked primarily in the public sector (37.84%), independently (32.43%), or in civil society organizations (CSOs) (27.03%), with the most common roles being community manager (27.02%), program manager in relation to protection (24.32%), and government official (10.81%).

Based on the data resulting from the interviews, 5 themes and 18 subthemes were identified (Table 2), which are developed below, including illustrative quotes from the participants.

Manifestation of mental distress

Behavior

Several participants shared having observed manifestations of stress and anxiety in the migrant women's population. The main ones were restlessness, erratic movements, a lot of gesticulation, verbiage, difficulty concentrating and demand for immediate solutions. Some participants had also observed compulsive behaviors that they associated with the stress experienced by this population, such as eating a lot, biting their nails or harmful consumption of tobacco and alcohol. According to the interviewees, these behaviors are especially noticeable in newly arrived migrant women:

> *"In these groups of walkers, women were characterized by the quick search for solutions. They are mothers who come with two children, for example, the most complex case I saw was a lady who arrived with a baby in her arms, a two-year-old child, looking for money to get her husband out of jail in Venezuela." (Participant 5, psychologist, Panama City).*

Some participants had also observed manifestations of depression among the female migrant population, the main ones being the lack of cleanliness, sad looks, excessive silence, feeling "gone" or "immersed in their thoughts" and continuous crying. In some cases, they had also observed aggressive, sullen and complaining

Table 2 Themes and sub-themes identified after the analysis

Themes	Sub-themes
Manifestation of mental distress	Behavior
	Mood
	Somatic disorders
Factors at the individual level contributing to mental distress	Migratory grief
	Unmet expectations and uncertainty
	Lack of support network
	Overload of responsibilities
Structural social determinants of mental distress	Economic problems
	Problems linked to the irregular immigration status
	Gender-based violence
	Discrimination
Mental health support	Family and community support
	Support from government institutions and international agencies
	Support from civil society organizations
Recommendations for interventions that promote mental health	Improvement of mental health care
	Informational and educational talks to help prevent, identify, and manage mental distress and its causes
	Recreational activities that promote mental well-being
	Meeting socio-economic needs

behaviors in migrant women that they attributed to their depressive state. One of the participants recounted:

> *"Mistreatment of children, they beat children. It has to do with the fact that they are a lot with that thinking in their head, knowing what direction they are taking, where they are going. Yes, they are a little rude to the children, that is, I have evidenced that they hit the children 'stop crying' and sometimes the children cry from hunger, cold. […] for the very fact that they are going through this ugly depression, the same human mobility then makes them act that way with the little ones." (Participant 5, non-psychologist health personnel, Tulcán).*

Mood

Several interviewees expressed having perceived sadness, negativity, apathy and irritability in some migrant women as emotional manifestations of their depressive state:

> *"Most of the time she feels like crying, she is always sad, any situation affects her and what she expresses most is sadness." (Participant 4, program manager in relation to protection, Panama City).*

Some participants had dealt with migrant women with suicidal thoughts:

> *"There was one who told me that she didn't want to continue living, I got into her spiritually and I managed to get her to talk to these organizations." (Participant 3, program manager in relation to protection, Panama City).*

Several participants mentioned having perceived fear, worry, desire to flee from problems, anger and euphoria in some migrant women, which they identified as emotional manifestations of anxiety and stress.

Somatic disorders

Participants highlighted insomnia, shortness of breath/feeling of tightness in the chest, lack or excess appetite, weakness, sexual difficulties, pain, gastrointestinal problems, and dermatological problems as some of the main somatic symptoms of mental distress reported by migrant women. In all cases, the migrant women had directly reported their discomfort to the participants and had made an explicit association with the mental distress they were suffering from (with a clinical diagnosis issued by a professional or not). In the case of pain:

> *"Her back hurts, her head hurts, there are situations that she no longer tolerates and when she does not tolerate it, she begins to vomit. These situations are stress; she is treated with psychiatry, psychology and the health part. She suffers from the situation of physical and psychological violence." (Participant 12, community manager, Panama City).*

Factors at the individual level contributing to mental distress

Migratory grief

According to the interviewees, one of the main sources of mental distress in the female migrant population is that of leaving behind their relatives, their home, their job, a phenomenon they referred to as "migratory grief" in some cases:

"Grief is for what belonged to you, grief for your partner, to leave family members, children, and it depends on the person's self-regulators. There are people who don't have time to get depressed. What happens with this type of case is that any situation that happens from the loss of a job or a partner, or anything, then all the grief is experienced together." (Participant 5, psychologist, Panama City).

Some of the interviewees mentioned the difficulty that some of the migrant women have in adapting to a new environment, to "a strange country", from aspects such as the climate to differences in bureaucracy, and the impact this has on their psycho-emotional well-being:

"The Venezuelan who migrates from central Venezuela is a person accustomed to chaos, one of the things that shocks him here in Panama is that here the processes are slower than they were used to. The Venezuelan has a lot of grief because things don't go as planned." (Participant 5, psychologist, Panama City).

Unmet expectations and uncertainty

Another cause of mental distress in migrant women expressed by the interviewees is unmet expectations and the situation of uncertainty in the host country:

"When you come from one country to another, you find that everything is new, and you ask yourself 'what am I going to do now?' or 'where do I start?' When I migrated, I came with a plan, I am a systems engineer, and I lasted a year in all the processing of my papers to be able to come well. When I arrived here, I found that all engineering careers were closed to foreigners. Then I went into a state of uncertainty." (Participant 4, program manager in relation to protection, Panama City).

Lack of support network

Many participants reported the lack of friends and family in the new region as a negative contributor to migrant women's mental health:

"Not having someone to talk to, not having a support group or a close group of friends, influences depression, because you have no one to express your feelings or emotions with. It's very hard, as they accumulate all that." (Participant 8, community manager, Panama City).

Overload of responsibilities

Some of the participants shared how the excessive workload represents a source of mental distress for some migrant women, especially when they are the main source of income for the household and are also responsible for domestic and care work. The burden of childcare increased during the COVID-19 pandemic, in which in-person classes were canceled in many schools and children began to study from home. One of the participants recounted:

"We have women heads of household who suffer quite intense situations, because they fulfill that double role, as heads of household and of looking for food and the source of all the needs for their children, so it is all those situations that sometimes they cannot solve and that are put in that negative margin that does not allow them to have that mental tranquility to fully enjoy themselves and their family." (Participant 10, program manager in relation to protection, Tulcán).

According to one participant, the challenging situations faced by migrant women often lead them to put their own interests on the back burner, which negatively impacts their mental well-being:

"Not doing, not having, not being affected. Because when you are a migrant there are priorities, you leave aside 'I want to do this,' 'I have to work,' 'I have to take care of the children,' but not because I want to. This causes a psychological impact that you ask yourself 'how long?', it leads you to a state of nonconformity." (Participant 4, program manager in relation to protection, Panama City).

Structural social determinants of mental distress

Economic problems

Most of the participants agreed that economic problems are one of the main causes of psycho-emotional problems in the migrant women's population, especially for those who have dependents in their care. According to the interviewees, the lack of income is due to the greater difficulties that this population presents in obtaining employment, due to their irregular immigration status in many cases, gender inequities, xenophobia, lack of access to training programs and labor market disruptions caused by the COVID-19 pandemic. One of the participants recounted:

"This emotional part of the fact that I don't have an income, that I don't have anything to feed my son because they sometimes go out to beg, they wait on a corner with a shovel to be taken to work and because of mistrust they don't take them, they look for laundry and out of fear they don't give them. So, that frustration of not getting a job is emotional dam-

age that aggravates them." (Participant 10, program manager in relation to protection, Tulcán).

Several participants agreed that given the challenges experienced by migrants in getting a job, some people are forced to engage in sex work, sometimes without using measures to prevent and control sexually transmitted infections. One of the people interviewed recounted:

"In the situation of migrants, there are many young girls who are looking for an honest job and there are times when they do not get them, there are no sources of work […]. And that I have to send money to my mom in Venezuela, that I have her sick, I'm desperate, I can't get a good job, I don't know what to do, that my mom is calling me that my children are hungry, that I haven't sent them food this week, that's where they come to prostitute themselves because they have no other choice. […] I also don't see that they take care of diseases, it's something we see daily, that we see that there are no condoms, they don't go to the health center to get under control, nothing about that, it's all kind of lightly and that's where the cases of HIV come. We see a lot of cases with HIV here in town, people talk about it being sick, we've seen that people are dying of HIV, it's something we see every day actually." (Participant 12, community manager, Guayaquil).

Problems linked to the irregular immigration status

The lack of regular migratory status in the receiving country was highlighted by the participants as a cause of mental distress in migrant women, due to the institutional barriers and discriminatory treatment that this causes them:

"I have seen many women [irregular migrants] with extreme headaches, another gets gastritis, it hits her in the stomach. They always have that feeling of overwhelm, they are always worried, they cross a barrier then another one comes. One has many obstacles as a migrant." (Participant 9, community manager, Panama City).

Several participants shared how the lack of national documentation leads many migrant women to irregular work, where they are more vulnerable to labor exploitation, as in the case reported by one participant:

"When they are not regular, who is going to give them a job because they have to process their work permit, then they do not have a fixed source of income and many times they are even exploited. They tell us that they prefer to be paid that than to have nothing." (Participant 11, social worker, Panama City).

In other cases, because they are not regularized in the country, they are prevented from accessing public services, such as education or health services, which negatively affects the psychological and physical well-being of migrant women and their families. In some cases, these obstacles violate women's reproductive rights, as in the case set out below:

"This lady tells me that she wanted to have her son vaccinated, however, they told her 'in the health center we have vaccines, but we are going to prioritize only national people, we do not have for Venezuelans right now'. Another risk that they are threatening health is that women want to access contraceptives, but there are none, they say 'they are gone, there are none' or the other thing is giving birth to a child, they are young, they want to have a ligation, however, the same doctor tells them no, that they can have two, three more children. So, as I maintain it, it is a strong reality that they are forcing you to have more children, they are managing your body." (Participant 11, psychologist, Tulcán).

Also, participants shared how the lack of legal status prevents migrant women from formalizing a business or opening a bank account:

"When they go to request alimony for their children, if they do not have their legal status, it is difficult for them to open an account in the bank for the man to deposit them, then until it is regularized." (Participant 11, social worker, Panama City).

According to the interviewees, the irregular migratory situation also leads to abuses by the authorities:

"For the fact of being on the street, the police charge bribes, for being illegal they want to take money from you, or they treat you badly. In my case I have not gone through those bad times, but I have heard friends that especially in the subway stations, the police have given them a hard time, or take them to the police station, so they have to cry to them, and they say 'how much do you have, the money ahead of you'." (Participant 9, community manager, Panama City).

Gender-based violence

Participants shared how migrant women are exposed to different forms of violence with negative effects on their physical and mental health. Most of the expressions of

violence mentioned were gender-based. According to the interviewees, the aggressors are the same partners (intimate partner violence), as well as other migrant men, men from the receiving communities, health sector workers and the authorities.

Participants shared that the sexist and patriarchal culture, the consumption of alcohol and illicit drugs by couples, and the tense situation that many migrant families go through leads to intimate partner violence. In addition, the interviewees had perceived an increase in domestic violence in the migrant and non-migrant population during the confinement in the COVID-19 pandemic. One of the participants mentioned:

> *"Many men choose to consume alcohol or drugs suddenly to forget about the situation they are going through, because of the lack of work and all that situation, that is why a tense environment tends to be generated within that home which already leads to violence and physical aggression many times." (Participant 3, community police officer, Guayaquil).*

According to the interviewees, many of the migrant women who suffer intimate partner violence stay with the abuser due to emotional dependence, economic dependence or fear of losing their children. In addition, the lack of a support network to turn to aggravates the situation of vulnerability of this population. One of the informants recounted:

> *"We look at situations of emotional and especially economic dependence when [migrant women] come with children and say 'what do I do here, I can't stay alone, who is going to take care of me or protect me.' So they endure any type of violence because of this economic and emotional dependence they have. (Participant 9, program manager in relation to protection, Tulcán)*

In addition, the informants shared how the normalization of intimate partner violence, including forced sexual relations, as well as the lack of knowledge of support institutions and local laws or the fear of deportation, contribute to women not reporting the aggressions they suffer to the authorities.

Several participants shared how much of the gender-based violence experienced by migrant women has a sexual component. Interviewees reported cases in which women are asked for sexual favors in exchange for not being reported to immigration authorities, accessing health services, getting a job, or not being fired. One of the interviewees shared:

> *"Workplace harassment goes hand in hand with sexual harassment, that is, I give you a job because you are pretty but if you are pretty you have to sleep with me, then that is the only situation that could ensure you stay at work." (Participant 1, government official, Guayaquil).*

According to the interviewees, women who engage in sex work—often forced by human trafficking organizations—are particularly exposed to sexual assault. One of the participants recounted:

> *"That woman who is paid to be able to support her home, or X reasons she will have, there is also mistreatment of those women, those who prostitute themselves, because they believe that because they are paying for an hour and in that hour you are going to do what I say, then they believe they are authoritarian with women because they are paying." (Participant 2, community manager, Tulcán).*

Discrimination

According to informants, migrant women frequently suffer discrimination from the local population, which negatively affects their emotional state. These acts include the refusal of the local population to rent them housing, to give them jobs or to provide them with access to public services such as health services, as well as verbal aggression. One participant recounted:

> *"They look at us here as something strange, as if we had the plague or were sick and we were going to transmit something to them. This situation obviously increases the situation of emotional discomfort that they have. Because they say, if we approach someone to ask for a job and they hear that we are foreigners: 'no, you are thieves, they are going to come and rob us.'" (Participant 9, program manager in relation to protection, Tulcán).*

Some participants shared how the distrust and rejection of the migrant population is based on the widespread idea that crime rates are higher among this population. This idea is helped by the unjustified attribution of criminal acts to this population, as well as by the greater visibility given to criminal acts committed by the migrant population than to those committed by the local population in the media. One participant recounted:

> *"This xenophobic situation means that also in the media if it is a Venezuelan person who commits a crime, she has about 50 cameras on her, 'those who did this were foreigners', but we go and look at the statistics that the police have and they are minimal*

with respect to the people who participate in criminal acts, in comparison to what is seen in the media. So, I think that this 'marketing with harm' that they do to foreigners makes citizens more afraid to lend a hand, or to look at people on the move as equals." (Participant 9, program manager in relation to protection, Tulcán).

According to several participants, the rejection of migrant women is sometimes based on the generalization of sex work among this population due to gender stereotypes, which is accompanied by aggressions towards migrant women alluding to their alleged sex work.

Also, some interviewees agreed that the rejection of migrant women is sometimes based on the idea that migrants "steal jobs" from the local population. According to the participants, the labor exploitation to which migrant women are subjected due to their irregular situation in the country, can make them more attractive in the labor market than local women, protected by national labor regulations.

Mental health support

Family and community support

Participants shared situations where families are an important point of support for psycho-emotional well-being, either in person or frequently from a distance. One participant recounted:

"Family support with solutions, alternatives or the fact that you are paying attention to it is a great help. There is a difference between families that migrate together and those that migrate separately, because the happiness I feel when I am with my son, with my husband, my mother is not the same as my sister who went alone to Peru." (Participant 7, community manager, Panama City).

However, in many cases women also lack a family support network, either because they are alone, because their only support is the intimate partner who abuses them or because they do not have a good relationship with their families in their countries of origin. Participants also reported that cases are common in which, despite having a family support network, it minimizes mental health problems.

Participants mentioned that for believers, the support of their religious community can have a great impact on emotional well-being. Also, in some cases, migrant communities are organized, with figures such as the "community watchers", mentioned by different participants, who ensures the protection and well-being of migrants, Venezuelans in the case presented by the participants. These "community watchers" refer people with emotional difficulties to the relevant institutions. Other participants shared the figure of "community managers"—some trained by CSOs for the work—mainly migrant women who provide support to the migrant population, including the identification of psycho-emotional distress and referral to relevant services.

Support from government institutions and international agencies

The interviewees mentioned different government institutions that provide psychological support to migrant women or that identify the need and refer them to the relevant care service (in addition to international agencies such as the International Organization for Migration or the United Nations High Commissioner for Refugees [UNHCR]). Even though the main provider of public mental health services, both in Ecuador and Panama, is the Ministry of Health, the participants mentioned other public institutions that have their own psychological care services, especially those that serve women affected by violence. In reference to the work of the Ministry of Health, several participants agreed that there is a tendency to prioritize physical health over mental health and that preventive work is insufficient. In addition, the saturation of the public health system prevents it from meeting all the mental health needs of the population (understood as activities and services that prevent mental distress, including those that promote mental health, and accessible treatment), so they require the support of CSOs. One participant shared:

"Well, sometimes it seems that public institutions require the support of organizations. Well, those with whom we have contact, with health, education, who are the ones with whom we work the most, they have by law to provide all services to mobility people, just as they do with Ecuadorian people. The problem that they tell us is that sometimes the capacity of the services they have to provide is overflowing, not only for people on the move but for Ecuadorians as well, it is not only for Venezuelans, sometimes the capacity overflows and they do not have, for example, the delivery of medicines and this type of more emergent care." (Participant 9, program manager in relation to protection, Tulcán).

Support from civil society organizations

The participants highlighted different CSOs that provide psychological support, in most cases as part of comprehensive care for migrant women, with legal, medical and social work services. Some of these organizations have a shelter (or house of protection in cases of violence) where migrant women can stay temporarily and have access to services such as food and clothing for free. The

CSOs present in the study areas include international and national, religious and non-religious organizations. The mental health services provided by CSOs include identification of mental health needs and accompaniment, psychological containment, psychological care (sometimes in group modality), psychiatric care and preventive actions such as mental health workshops.

Some participants agreed that, due to the mobility situation in which many migrant women find themselves, it is difficult to adhere to long-term psychotherapy, so that sometimes support is limited to psychological containment. One participant recounted:

> *"As it is a population in mobility, it is not that we will see it tomorrow and that we will continue to see it for one or two years, it is impossible, I think that is what affects the most, it is only an intervention in crisis, it is only a decrease in anxiety, of the symptoms that may suddenly have that moment and no more, and that also harms in the long run because it does not have strong containment processes, not much more can be done than that." (Participant 9, program manager in relation to protection, Tulcán).*

Recommendations for interventions that promote mental health

Improvement of mental health care

Some participants mentioned the need to create new spaces of care, both for individual therapy and group therapy, in addition to increasing the staff specialized in psychology and psychiatry in the existing spaces. Group therapy was mentioned by several participants as a promising and still little explored care option in the study regions, with exceptional cases such as the "women's circles", psycho-emotional support groups for women who have suffered violence implemented by a CSO in Tulcán. One participant emphasized the importance of these spaces being able to function as a meeting point with local women:

> *"I think it is super useful to open mental health care centers in which both individual therapy and this type of meeting [group therapy] are given. Because group therapy and experiential therapy, which is what would be the objective, gives many results. I would think about it not only for people in human mobility but for local people as well, that there are these meeting groups." (Participant 11, psychologist, Tulcán).*

On the other hand, some participants emphasized the need for exclusive spaces for migrant women with specialized care, where issues such as migratory grief are discussed, as well as for the underage migrant population. Some actors mentioned the importance of providing mental health care with a family approach, since often other members of the migrant woman's family are experiencing psycho-emotional difficulties.

Informational and educational talks to help prevent, identify, and manage mental distress and its causes

One of the concerns shared by the participants was the lack of information about the mental health services available among migrant women, especially those living in remote areas, far from urban centers. The participants proposed the implementation of dissemination campaigns aimed at migrant communities in marginalized areas where information is provided on the mental health services offered by both public institutions and CSOs, emphasizing free access. These campaigns could include organizing informational talks and distributing written information such as flyers.

In addition, the interviewed actors mentioned the importance of organizing educational talks that cover the following topics: constitutional rights, sexual and reproductive rights, the identification of mental health problems, self-esteem and gender violence. Many participants emphasized the importance of addressing self-esteem in these talks:

> *"I think that first you should work on the self-esteem of these women, teach them and show them how valuable they are and that they don't necessarily depend on someone for them to excel, teach them their value as a person, teach them that they can achieve their goals, especially how valuable they are as human beings." (Participant 3, community police officer, Guayaquil).*

Some participants emphasized the need to include the male population, both migrant and local, in the talks on gender-based violence, as well as to create spaces specifically aimed at the male population as a strategy to prevent violence. One participant commented:

> *"Something that should be rescued and worked on is not only to work with women, why not work with the aggressors? Why not make groups of aggressors? Positive masculinities, why not educate? Because well, okay, in the end we empower women, that's fine, but this aggressor is going to find another woman. So why not also work with the problem, not just with the victims? And be careful, that these aggressors are also victims of other things that they have gone through." (Participant 11, psychologist, Tulcán).*

Recreational activities that promote mental well-being

The participants repeatedly mentioned the need to develop recreational activities aimed at migrant women that promote their mental well-being. One of the participants shared:

> *"Stress gives rise to so many worries about so many things, they have to give fun workshops, that people for an hour or two forget about so many problems they have in their heads, that they laugh, that they have fun." (Participant 9, community manager, Panama City).*

The interviewees mentioned the possibility of organizing physical activities, such as dancing, Zumba, yoga, playing soccer or walking; cultural activities such as a reading club or painting workshops; making crafts, such as sewing or costume jewelry; playing board games, such as puzzles; conducting cooking workshops; or organize self-care sessions, such as skin care. Participants shared that activities that generate products, in addition to contributing to their mental well-being, can represent a source of income.

Meeting socio-economic needs

Most of the participants highlighted the importance of strengthening a comprehensive response to the needs of migrant women to promote their mental well-being, since psycho-emotional distress is often caused by the socioeconomic difficulties experienced by a large part of this population.

The priority areas identified by the participants were legal advice—especially to regularize their immigration status in the country and to be able to respond to violent acts —, support to obtain decent housing and support to obtain a stable and dignified source of income, either working for other people's businesses or their own. On this last point, the interviewees proposed the training of migrant women to improve their employability and entrepreneurial skills, provide them with support to identify job opportunities, the creation of cooperatives or the development of microcredit programs to facilitate entrepreneurship, as well as make childcare services available to mothers while they work. One of the participants shared:

> *"Promote a bank of opportunities or a list of vacancies. To manage jobs for these single mothers and obviously to offer training. Also think about who you are going to leave the small children with if the mommy works. Make small women's cooperatives that set up micro-enterprises. Group them together and through loans tell them that they will all be owners and that they must all contribute and that they have their own business." (Participant 7, non-psychologist health personnel, Guayaquil).*

The participants emphasized the importance of covering basic needs such as regular migratory status, housing and income not only to reduce the burden of concerns of migrant women, but also to promote their autonomy, thus reducing their situation of vulnerability to the different forms of violence to which they are exposed.

Discussion

This study presents new findings about the manifestation of mental distress in the migrant women's population, its causes, the mental health support they receive, and proposals for interventions that promote their mental health. This, on behalf of key actors who live with this population in the cities of Tulcán and Guayaquil in Ecuador and the metropolitan area of Panama City in Panama.

Participants shared manifestations of mental distress mainly due to stress, anxiety and depression, which had been reported to them by migrant women or that they themselves had observed. These three particular conditions had previously been identified in a participatory exercise with migrant women as the main forms of mental distress among this population [35], so interviewers mentioned them explicitly during the introduction to the study. This was to ensure alignment between the information provided by the participants and the main forms of mental distress previously identified by the migrant women's population, as well as to facilitate the identification of manifestations of mental distress by the participants. The mention of these three conditions by the interviewers may have encouraged the association of manifestations of mental distress to specific conditions by the participants, although in most cases they did not have evidence of the existence of a specific clinical diagnosis, the association being subjective. In addition to the bias introduced by researchers in the use of these terms, the use of these terms by both interviewees and migrant women aligns with the widespread use of mental health diagnoses by non-expert populations to describe a set of complex thoughts, feelings and behaviors even though an expert has not issued a diagnosis [37]. This fact contributes to the pathologization of mental distress [38], which is related to stigma towards the affected population, as well as to a negative self-perception, and which can end up leading to the aggravation of symptoms or negatively affect the use of mental health services [38]. Another risk of a reductionist view of mental distress as specific pathological conditions is the omission of the social factors that may be determinants in the occurrence of such distress, as well as the existence of a broader spectrum of thoughts, feelings and behaviors associated with mental distress not limited to those associated with specific

mental health conditions [39]. Therefore, alternative and complementary models to the biomedical one are needed that can integrate the impact of economic and political forces on the health of the population and provide a broader perspective of mental distress [40]. An example of this is the theory of social suffering, whose framework contemplates the exercise of structural violence by socio-economic and socio-political forces against populations with certain characteristics, which translates into asymmetries of power, restricted access to resources and systematic oppression, causing suffering of different kinds in the affected populations [40–43]. This social suffering can manifest itself in the form of specific diseases recognized by Western medicine or not.

Despite the limitations discussed and the resulting bias towards the biomedical model in the identification of manifestations of mental distress, the symptomatology of psycho-emotional distress expressed by the participants coincides with that described in other qualitative studies in LAC in Colombia, Ecuador, Mexico and Chile, expressed both by key actors and by the study population itself [21–23, 44]. Despite the lack of empirical data on the prevalence of mental health conditions in migrant women in the localities where the study was conducted, some of the manifestations expressed by the participants coincide with the symptomatology of anxiety and depression, whose prevalence has been quantified in the population of migrant women in some South American countries. In a study conducted by Médecins Sans Frontières in Colombia, the prevalence of severe depression (using PHQ-9) and anxiety (GAD-7) for the migrant population in general was 15% and 10%, respectively, with no significant differences by sex or gender [19]. In another study carried out on the border between Ecuador and Peru, the prevalence of depression in the migrant population in general was 19% (using PHQ-9), while anxiety was 23% (using GAD-7), both values higher than those of the non-migrant population [17]. In this case, the female migrant population was identified as having a higher risk of depression, with no significant differences for anxiety [17]. Finally, a study conducted in Peru identified a significant difference in the prevalence of self-reported mental health problems between the male and female migrant population (40.1% vs. 59.9%, $p < 0.001$) [18].

The interviewees stated as the main causes of mental discomfort in migrant women a series of factors at the individual level, such as missing what they had left behind in their country, unmet expectations, uncertainty, lack of support network and overload of responsibilities, as well as a series of systemic factors beyond their control, such as economic problems, problems related to the irregular immigration status, gender-based violence and discrimination, that can be categorized as structural social determinants of health. These determinants are represented within the framework of the social determinants of health, initially conceptualized by the Commission on the Social Determinants of Health, and correspond to the forces beyond the individual's control that shape their life context and indirectly impact their health, including their mental well-being [45]. Some of these causes of mental distress affect migrant women before they begin their migratory journey, during the migratory journey, and when they settle in the host community [46]. In the pre-departure period, other studies with Venezuelan migrant adolescents and women have identified parental or partner abandonment and the resulting lack of support structures, as well as experiences of violence at the household and community level, mainly gender-based, as factors with a negative impact on the mental well-being of this population in their country of origin [47, 48]. Violence—especially gender-based—, hopelessness, uncertainty, loss in material and symbolic terms, hostility from the host community, and lack of access to basic services such as housing, health, and food were previously expressed as sources of psycho-emotional distress in the population of migrant women in a situation of mobility or at the place of destination by civil society actors working in LAC [49, 50] and research conducted on Mexico's northern border [20], Colombia [21, 47, 48] and Ecuador [44].

Gender-based violence, one of the main causes of mental distress mentioned in our study, is one of the main scourges of migratory routes in LAC. Violence against women is an endemic problem in the LAC region, where according to the United Nations Population Fund (UNFPA) there are 14 of the 25 countries with the highest number of cases of femicide in the world, understood as the taking of women's lives due to their gender condition [51]. The violence suffered by women in the region is part of a system of inequality that places women in conditions of subordination to men [52–54]. This violence is not isolated individual actions, but rather the systems themselves produce systematic violence against women throughout their life cycle, in a *continuum* that is manifested in the different stages of the migratory journey experienced by migrant women [54]. The experience of violence remains and adds to previous experiences. In addition, this violence occurs in a transversal way, being present in the different spheres of the person's life, as shown in this study, including the family, community, institutional or work spheres; exercised by family members, criminal groups, authorities or co-workers; by acquaintances or strangers [54]. For some women, gender-based violence represents the main reason for emigrating, especially in groups at greater risk such as women in the LGBTIQ + collective, as well as one of the main risk factors for mental distress from the pre-departure period [47, 48, 55–57]. On the journey and destination, a series of factors converge, such as the lack of

institutional support due to irregular migratory status, xenophobia due to the national origin of a foreign country, adverse socioeconomic condition or racism towards racialized people with gender discrimination, increasing vulnerability and exposure and therefore the risk of gender-based violence in the population of migrant women [56, 58]. This fact is reflected in a report published by UNHCR in 2023, according to which on the border between Panama and Colombia one in four migrant, refugee and asylum-seeking women had experienced some type of abuse or harassment on the journey [59].

Participants mentioned different sources of support for the psycho-emotional well-being of migrant women, including family or community support, support from government institutions, international agencies and CSOs. However, there were several actors who considered the current support in the context of the study for the mental health of migrant women to be insufficient, especially from public institutions. This is in line with what has been expressed in other Latin American contexts, such as Mexico and Colombia, where the lack of resources to meet the mental health needs of the population of the public health system leads to this task falling on CSOs and international agencies, whose resources are still insufficient to cover the high demand for these services, both in the local and migrant population [20, 47, 48, 60, 61]. Added to this fact is the medicalization in the response to the mental health needs of the migrant population in various LAC countries, where the medical perspective is prioritized instead of opting for psychosocial models focused on the family or the community with proven effectiveness in contexts of human mobility, underestimating disciplines such as psychology or social work [62]. In addition, as expressed by some of the participants in our study, the lack of mental health services along the migratory routes of the Americas makes it difficult to adhere to long-term therapies or pharmacological treatments [20]. Considering that gender-based violence represents one of the main causes of mental distress among migrant women, the lack of access to service providers for survivors of gender-based violence along the different migratory routes in LAC is worrying. According to the World Bank, only 39% of service providers for survivors of gender-based violence in Central America are accessible within a 1-kilometer radius of the main migrant transit routes [62].

The informants consulted expressed a series of proposals to promote psycho-emotional well-being among the population of migrant women. Some participants agreed on the need to create specific care spaces for this population, with professionals and interventions that can respond to the needs of migrant women. There are precedents in LAC in the provision of mental health services to migrant women with a gender perspective, as is the case of the "Model of Mental Health Care and Crisis Care for Migrant Women" in Mexico [63]. The interventions of this model include group sessions for the promotion of mental health, an approach proposed by various actors in our study and whose feasibility and impact have been demonstrated in other research. An example of this is the "Entre Nosotras" intervention in Ecuador and Panama, which used the evidence obtained in our study in its design [64, 65]. Also noteworthy are the group workshops for the promotion of the mental health of migrant women with an intercultural perspective and a gender approach taught by psychology students in Santiago de Chile, with promising results after their systematization in 2016–2019 [66]. By sharing similar experiences, these spaces not only represent psycho-emotional support, but can also be useful for sharing information and resources that facilitate adaptation to the new environment, considering the lack of a support network that this population often faces [67]. In addition, as suggested by the participants, it has been seen how the creation of mixed groups of migrant and local women facilitates the integration of the former with the host communities [35]. The creation of these spaces for coexistence not only allows for a direct approach to mental health and its causes, but also represents a great opportunity to carry out recreational activities that promote mental well-being and facilitate cohesion among the participants, as suggested by several of the interviewees. Some participants also highlighted the role of migrant women called community watchers or managers, also known as community leaders in other contexts [47], who promote the link between migrant women and the mental health support services available, as well as other protection services they may need.

In addition to the above-mentioned strategies to strengthen mental health care for migrant women, different actors proposed the design and delivery of educational and information sessions that contribute to the prevention, detection and management of mental distress in this population. Several of the topics suggested by the participants were related to the rights of migrant women and their exercise. On many occasions, the irregular immigration status in the country of transit or reception of migrant women dissuades them from seeking support, including mental health, for fear of being reported to the authorities. This fact is related to the lack of knowledge of their rights in the new context, aggravated by the lack of knowledge of the services that allow them to exercise these rights and their location [68, 69]. Some countries in LAC have implemented campaigns to promote awareness of migrant women's rights, including the right to health, not only for this population, but also for public servants and host communities. Recent initiatives promoted by governments, as in the case of Mexico [70], and by international agencies such as UNHCR in the Southern Cone

region [71], which combine the delivery of face-to-face workshops with the dissemination of infographics on paper and through social networks, stand out.

Participants also emphasized the importance of providing comprehensive responses to the needs of migrant women, including mental and physical health, but also their causes. They stressed the importance of providing tools to migrant women so that they can regularize their migratory situation, protect themselves in situations where their rights are violated, enjoy economic autonomy and dignified living conditions, reducing their situation of vulnerability. The inconsistency between laws, public policies, and programs that contemplate migrant women in various LAC countries, including Ecuador and Panama, hinders the implementation of interventions that address the needs of this population effectively and efficiently from public institutions [60, 72, 73]. In addition, the available legal support, economic empowerment and health care programs for migrant women, most of which are funded and implemented by CSOs and international agencies, generally focus on one of the three axes without providing comprehensive care. The lack of well-defined processes of inter-institutional collaboration leads to the loss of opportunities to meet the needs of migrant women when they contact any of the available services, as described in Colombia, Ecuador or Mexico [47, 48, 60, 72, 73]. There are already initiatives in LAC that have favored the integration of protection services between different government actors, international agencies and civil society, although their implementation must continue to be developed to enhance their impact. An example of this is the Interagency Coordination Platform for Refugees and Migrants of Venezuela (R4V), which includes more than 200 organizations and works in 17 countries in the region and performs functions of guiding and monitoring the operational response of the Regional Refugee and Migrant Response Plan [74].

This study represents a first step to improve and tailor current strategies for the prevention and care of mental distress among migrant women who are at risk of suffering mental health problems due to their situations of vulnerability and chronic adversity. The potential impact of the findings is not limited to the three study cities in Ecuador and Panama but can serve as inspiration for other contexts in LAC interested in better characterizing the needs and approach to mental health in migrant women. Evidence-based interventions such as those in our study can contribute to reducing inequities based on gender and immigration status in mental health status and access to mental health services in the region [75].

Finally, it is important to highlight the limitations of our research. The interviewers belonged to HIAS. The fact that some of the interviewed actors had ties to the organization may have led to social desirability bias, especially in questions regarding the provision of care by CSOs in the study area. To reduce this form of bias, identified actors were assured confidentiality and voluntary participation. Another important limitation of the study is the inclusion of a heterogeneous group of actors knowledgeable about the mental health and psychosocial problems of migrant women, who in turn lived/worked with a heterogeneous group of people homogeneously categorized as "migrant women" despite having different nationalities, cultural contexts of origin and migratory conditions (refugees, asylum seekers and migrants). It is important to consider this in interpreting the results, as experiences in terms of access to services, discrimination, and other areas will vary among groups with different sociodemographic characteristics [76, 77]. Another limitation is the fact that data collection was carried out during the COVID-19 pandemic. There is evidence that during the COVID-19 pandemic, the mental health of the migrant population globally was negatively impacted, especially affecting people in precarious housing, with irregular migratory status, the elderly, and women [78]. In addition to aspects such as economic insecurity or fear of contagion that affected the psycho-emotional well-being of the general population, migrants were affected by specific factors such as the tightening of migration policies or greater difficulties in finding accommodation [79]. Also, barriers to access to health services for the migrant population, including mental health services, were exacerbated during the pandemic in the LAC region [80]. The context of the health emergency in which the study was carried out, with especially marked effects on vulnerable populations such as the population of migrant women, may limit the generalizability of our findings to other time periods.

Conclusion

Our study sheds light on the manifestations, causes, and approach to mental distress among migrant women in Ecuador and Panama, thanks to the contributions of key actors knowledgeable about the study population. These findings represent a key input for governments, civil society organizations and international agencies to strengthen their strategies to promote the mental well-being of this population, not only in Ecuador and Panama, but in the Latin American and Caribbean region.

Abbreviations

CSO	Civil Society Organization
GAD	General Anxiety Disorder
LAC	Latin America and the Caribbean
PHQ	Patient Health Questionnaire
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
US	United States

Supplementary Information

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Supplementary Material 1

Author contributions

ZA is the first author of the manuscript. AB and MCG conceptualized the study. AB, MCG, AA, and AAN developed the study methodology, designed the study measures, and supervised data collection. ZA and MCG performed the initial analysis and AB, AA, and AAN participated in the review and refinement of the identified themes. ZA conducted the literature review for the introduction and discussion and led the drafting of the manuscript. All authors participated in the successive stages of writing and approved the final version of the manuscript.

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Data availability

The data presented in this study are available on request from the corresponding author. The data are not publicly available due to privacy and confidentiality.

Declarations

Ethics approval and consent to participate

All participants provided informed consent to participate. Study procedures were approved by the Institutional Review Boards at Columbia University Irving Medical Center (United States), Universidad de Santander (Panama) and Universidad San Francisco de Quito (Ecuador). This study was performed in accordance with the Declaration of Helsinki.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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