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Syrian refugee women's experiences of barriers to mental health services for postpartum depression

Taghreed N. Salameh[1] | Sibel Sakarya[2] | Ceren Acarturk[3] | Lynne A. Hall[4] | Hanan Al-Modallal[5] | Suad S. Jakalat[6]

[1]Koç University School of Nursing, İstanbul, Türkiye

[2]Department of Public Health, Koç University School of Medicine, İstanbul, Türkiye

[3]Department of Psychology, Koç University, İstanbul, Türkiye

[4]University of Louisville School of Nursing, Louisville, Kentucky, USA

[5]The Hashemite University College of Nursing, Zarqa, Jordan

[6]Al-Balqa Applied University School of Nursing, Al-Salt, Jordan

Correspondence
Taghreed N. Salameh, Koc University School of Nursing, Topkapı 34010 İstanbul, Türkiye.
Email: tsalameh@ku.edu.tr

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Abstract

Objective: To describe Syrian refugee women's experiences of the barriers to access mental health services for postpartum depression (PPD).

Design: A descriptive qualitative study was conducted.

Methods: Fifteen purposefully selected Syrian refugee women who scored ≥10 on the Edinburgh Postnatal Depression Scale participated in the semi-structured telephone interviews. Transcripts were coded verbatim and analysed thematically according to the dimensions of Levesque's model of patient-centred access to healthcare. Data were collected between August 2022 and February 2023.

Results: Five themes with 14 subthemes were identified: (1) approachability covered lack of knowledge and misconceptions related to PPD and its treatment, lack of awareness of available psychosocial services and perceived need of mental health treatment; (2) acceptability comprised being a refugee, stigma of mental illness, cultural preferences of healthcare provider and language barrier; (3) availability and accommodation encompassed transportation barrier and location of the centre, no support for childcare and lack of time; (4) affordability included financial difficulties and health insurance coverage; (5) appropriateness comprised no screening for PPD and intermittent services with limited focus on mental health.

Conclusions: The findings of this study reveal that Syrian refugee women experienced multi-faceted complex barriers to access mental health services for PPD. It is important for health professionals, including nurses, and policymakers to address the cultural mental health needs of this population and establish strategies to protect their legal and health rights.

Impact: Our study has important practice and policy implications for establishing strategies designed specifically for refugee mothers to mitigate their perceived barriers to PPD treatment and ultimately improve their mental health.

Reporting Method: The Consolidated Criteria for Reporting Qualitative Research was used.

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Patient or Public Contribution: No patient or public contribution. Participants were Syrian refugee women with PPD symptoms and contributed only to the interviews and member checking.

KEYWORDS
barriers, mental health services, nurses, postpartum depression, refugee women

1 | INTRODUCTION

Postpartum depression (PPD) is a significant public health problem that affects up to 13% of women worldwide (World Health Organization [WHO], 2023). It has devastating health consequences for the mother, child and whole family (Letourneau et al., 2012). Immigrant women, including refugees, are at twice the risk for developing PPD than non-immigrant women (Falah-Hassani et al., 2015). It is critical to investigate the mental health needs of this vulnerable population (Falah-Hassani et al., 2015; O'Mahony & Clark, 2018).

The Syrian conflict has made 6.6 million persons, including 1.2 million women of reproductive age, to flee Syria and settle in the Middle East and Europe, primarily in Türkiye (UN Refugee Agency [UNHCR], 2019; United Nations Population Fund [UNPF], 2016). Refugee women face adversities including gender-based violence (UNPF, 2016), more risk for mental illness than men (Alpak et al., 2015) and limited access to healthcare (WHO, 2018).

2 | BACKGROUND

The United Nations Sustainable Development Goals that influence maternal health in refugees include SDG3 good health and well-being, SDG5 gender equality and SDG10 reduced inequalities (UN General Assembly, 2015). These SDGs can be linked to many social determinants of mental health (Lund et al., 2018) and provide a framework for interventions for refugee women (Herrman, 2019). However, PPD continues to contribute to adverse mental health outcomes in this population due to numerous factors that increase their risk. For instance, refugee women, while being forced to leave their home country for their well-being and safety, may experience social isolation, violence, language difficulties and stigma when resettling in the new country (O'Mahony & Clark, 2018). In addition, resettlement is associated with uncertainty related to social status and identity, as well as unfamiliarity with the rules, regulations and customs of the new country (Ahmed et al., 2017; Hrabok et al., 2020).

Whereas prior research has focused on refugee women's mental health (e.g. posttraumatic stress disorder, depression and anxiety) (Davaki, 2021; Sullivan et al., 2020), there is limited evidence pertaining to PPD (Anderson et al., 2017; Falah-Hassani et al., 2015) and how refugee women with PPD access mental health services (Firth et al., 2022). A focus group of 12 Syrian refugee women in Canada described complex barriers to access mental health services including lack of information about available resources, language barriers, privacy concerns, stigma, absence of culturally sensitive therapists, and their own beliefs and understanding of PPD (Ahmed et al., 2017). In Türkiye, Syrians are registered under the temporary protection regime which grants them the right as refugees to access healthcare services in the province where they are registered (Asylum Information Database, 2023). However, there is no information about Syrian refugee women's experiences of the barriers to accessing mental health services for PPD. It is necessary to understand barriers to mental health services and factors influencing the effectiveness of these services for PPD in Türkiye; hence, policymakers and mental health professionals, including nurses, can find strategies to improve the access rate for mental health services to Syrian refugee women.

3 | THE STUDY

3.1 | Aim

The purpose of this qualitative study was to describe Syrian refugee women's experiences of the barriers to accessing mental health services for PPD in Türkiye.

4 | METHODS

4.1 | Design

The data of this descriptive qualitative study were collected as part of a larger study of Syrian refugee women during the postpartum period. The Consolidated Criteria for Reporting Qualitative Research was used (Tong et al., 2007).

4.2 | Framework

The conceptual model of patient-centred access to healthcare (Levesque et al., 2013) guided the development of the interview guide questions, coding and analysis. We chose this model because it provides a comprehensive conceptualization of access to care and describes broad determinants and dimensions that can influence refugee women's access to mental health services from a multilevel

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approach. This model proposes five dimensions of accessibility of healthcare services corresponding with five dimensions indicating the patient's ability to access the services: (a) approachability/ability to perceive; (b) acceptability/ability to seek; (c) availability and accommodation/ability to reach; (d) affordability/ability to pay; and (e) appropriateness/ability to engage.

4.3 | Participants

Syrian postpartum refugee women were recruited in Istanbul through a referral from a non-governmental organization (NGO). We used criterion sampling, a type of purposive sampling (Sandelowski, 2000), for data collection based on the criterion score on the Edinburgh Postnatal Depression Scale (EPDS) of ≥10 to identify eligible mothers. The EPDS measures postpartum depressive symptoms (Cox et al., 1987). It consists of 10 items rated on a 4-point Likert scale (0–3) according to severity or duration. The total score ranges from 0 to 30 with higher scores indicating increased severity of depression symptoms. An EPDS score of ≥10 was recommended for community screening to identify mothers who are at risk for PPD, with a sensitivity of 65%–96% and a specificity of 76%–96% (Eberhard-Gran et al., 2001). The validated Arabic version of the EPDS was used to screen women for PPD. It has a sensitivity of 91% and specificity of 84% and internal consistency of 0.84 (Ghubash et al., 1997).

Eligibility criteria included: age 18 years or above, having a live birth within the last 12 months, and no current diagnosis of major mental disorder or use of psychiatric medications. From August 2022 to February 2023, an Arab research assistant who is a clinical psychologist and expert in working with refugee populations screened eligible mothers for PPD using structured telephone interviews. Among the 200 Syrian refugee women screened for PPD, 33 scored ≥10 on the EPDS. The first 15 of these were invited and agreed to participate in the in-depth, semi-structured telephone interview; data saturation (Sandelowski, 1995) was reached with the 15 women. In this regard, data saturation was considered reached when the responses of participants started to be redundant and no new information was revealed. Data saturation was determined by the primary researcher and independently checked and confirmed by another researcher when no new themes emerged across interviews during the data analysis. The researchers had consensus on data saturation.

4.4 | Data collection

The first author, who is from the same background as Syrian refugee women and trained in qualitative research, conducted all interviews in Arabic. Before each interview, women were contacted to determine the suitable date and time for the interview to be recorded. The interviewer used an interview guide that included open-ended questions based on the dimensions of the patient-centred access to healthcare model (Levesque et al., 2013; Data S1). An expert panel (2 PhD holders in maternal-child health nursing and 1 PhD holder in clinical psychology) approved the interview guide and assessed its appropriateness to explore themes and subthemes of women's experiences of the barriers in accessing mental health services. The interview guide was pilot tested with two participants to ensure the clarity of its content. As the participants stated that the interview questions were clear and understandable, no changes were made to the interview guide, and the data collected from the two participants were included in the study. Each interview lasted 45–60 min. All interviews were audio-recorded and after each interview, the interviewer wrote field notes to reflect on important issues discussed during the interview. A research assistant transcribed the interviews verbatim; all transcripts were checked for accuracy before the data analysis.

4.5 | Data analysis

All interviews were transcribed verbatim and thematically analysed in Arabic using Dedoose software version 9 (Los Angeles, CA: SocioCultural Research Consultants, LLC). We followed Braun and Clarke's (2006) method in conducting the thematic analysis. Two PhD researchers read the transcripts several times to develop a sense about the experience described. Next, the two researchers independently reviewed each transcript and used line-by-line coding for important statements and concepts. Subsequently, commonalities across codes were identified and grouped together to capture themes and subthemes according to the dimensions of the patient-centred access to healthcare model (Levesque et al., 2013). Finally, both researchers discussed participants' responses and compared derived subthemes and themes to reach full agreement. The translation approach described by Santos Jr et al. (2015) was used in this study. Only quotes selected to support emerged themes/subthemes were translated into English by a professional translator with expertise in health sciences. Another bilingual PhD holder verified the translated quotes for any linguistic issues. Finally, two PhD holders approved the selected quotes.

4.5.1 | Rigour

Different strategies were used to ensure the rigour of the study including peer debriefing, triangulation and member checks (Lincoln & Guba, 1985). For peer debriefings, the primary researcher interacted with the research team to explore the research process and validate the analysis and emerging categories (Lincoln & Guba, 1985). Triangulation occurred when two researchers independently reviewed the transcripts and conducted the analysis, while another two researchers reviewed the themes/subthemes and supporting quotes for validation. Lastly, the derived themes/subthemes were discussed and explained to two participants who agreed that the findings are consistent with their experiences.

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4.6 | Ethical consideration

All participants were informed that their participation in the study is voluntary and they have the right to refuse to participate and withdraw from the study at any time without any effect on the care, services or benefits to which they are entitled. Those who were eligible and agreed to participate in the semi-structured telephone interviews provided verbal consent that was recorded. After the completion of the interview, participants were provided with an electronic voucher ($10) as a compensation for their time. Since the interviews focused on PPD and mental health services that might trigger distressing experiences, participants were provided information about free psychosocial services available for refugee women. This study was approved by the Ethics Committee at Koç University (# 2022.047.IRB3.019, approval date: 1/27/2022).

5 | FINDINGS

We explored 15 Syrian refugee women's experiences of accessing mental health services for PPD. Most participants were aged 18–26 years (66.7%), had less than high school education (86.7%), perceived their income as inadequate (80.0%) and did not plan for their current pregnancies (73.3%). Further, most participants reported that they felt the need for PPD treatment but did not get it (66.7%) (Table 1).

Five themes emerged reflecting barriers to access mental health services for PPD based on the dimensions of Levesque's et al. (2013) model. Table 2 presents themes and subthemes.

TABLE 1 Characteristics of Syrian Refugee Women with Postpartum Depression Symptoms ($N = 15$).

Characteristics	Frequency	Per cent
Age		
18–26	10	66.7
27–35	3	20.0
36–44	2	13.3
Education level		
Less than high school	13	86.7
High school	1	6.7
Some college/college	1	6.7
Employment status		
Unemployed	15	100.0
Marital status		
Married	15	100.0
Financial aid		
Yes	8	53.3
No	7	46.7
Perception of income adequacy		
Not adequate at all	6	40.0
Inadequate	6	40.0
Adequate	5	20.0
Length of stay in Turkey (years)		
1–4	3	20.0
5–8	11	73.3
9 or more	1	6.7
Planned Pregnancy		
Yes	4	26.7
No	11	73.3
High-risk pregnancy		
Yes	8	53.3
No	7	46.7
Para		
Primiparous	3	20.0
Multiparous	12	80.0
Infant's age (months)		
4–6	2	13.3
7–9	5	33.3
10–12	8	53.3
Mode of delivery		
Vaginal delivery	11	73.3
Caesarean section	4	26.7
Number of living children		
1–2	7	46.7
3–4	6	40.0
5 or more	2	13.3
Lifetime diagnosis of depression or anxiety		
Yes	9	60.0

5.1 | Theme 1: Approachability/ability to perceive

This theme relates to Syrian refugee women's recognition of the existence of mental health services and their perceived needs for mental health treatment. Information about PPD, available treatment and outreach activities are some elements that could contribute to the approachability of healthcare services (Levesque et al., 2013).

5.1.1 | Subtheme 1.1: Lack of knowledge and misconception about PPD and its treatment

Syrian refugee women with PPD symptoms lacked knowledge about PPD and its treatment. They expressed not having enough information about PPD, being unable to recognize its symptoms or articulate the role of mental health treatment in alleviating PPD. For example, some women did not understand their depression symptoms nor shared them with others. One participant expressed:

> 'I didn't know because I noticed this thing a year later, one year after I gave birth to my son. I searched for

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TABLE 1 (Continued)

Characteristics	Frequency	Per cent
No	6	40.0
Unmet need for mental health treatment for PPD		
Yes	10	66.7
No	5	33.3

TABLE 2 Themes and Subthemes of Experiences of Syrian Refugee Women with PPD Symptoms of Barriers to Accessing Mental Health Services.

Themes	Subthemes
Approachability (ability to perceive)	Lack of knowledge and misconceptions related to PPD and its treatment
	Lack of awareness of available psychosocial services
	Perceived need of mental health treatment
Acceptability (ability to seek)	Being a refugee (legal status and perceived discrimination)
	Stigma of mental illness exacerbated by language differences
	Cultural preferences of healthcare provider
	Language barrier
Availability and accommodation (ability to reach)	Transportation barrier and location of the centre
	No support for childcare
	Lack of time
Affordability (ability to pay)	Financial difficulties
	Health insurance coverage
Appropriateness (ability to engage)	No screening for postpartum depression
	Services provided are intermittent with limited focus on mental health

Note: Thematic analysis was guided by Levesque's model of patient-centred access to healthcare.

> this, and knew what is the meaning of postpartum depression. I knew that this is me, what I was going through was depression, nothing more. Besides when I was suffering from this thing, no one said it was depression … I did not tell anyone'.
>
> (P# 2)

There was also a misconception related to the treatment of PPD, including psychosocial interventions and medications. One participant expressed that she was not interested in PPD treatment interventions because this could negatively affect her mental health:

> 'I don't care about these things because if we look after these things, they will tire our mental status more'.
>
> (P# 7)

Another participant held misconceptions about the role of professional help for PPD. She reported:

> 'But frankly, I am not convinced of these things. I feel like, "What will the psychiatrist do to me?" I will talk, and he will listen to me, and that's it. What will change? In my reality, it will not change anything… If there were any benefits, they would be temporary, and the depressive state would return'.
>
> (P# 8)

5.1.2 | Subtheme 1.2: Lack of awareness of available psychosocial services

The limited information about available mental health services provided at the Syrian municipality and NGOs impeded women's access to the services. Participants expressed their concern that many Syrian mothers might suffer from PPD because they are alienated from their families, missing the strong social support provided by female relatives after birth, such as traditional customs, childcare and rest. However, they did not have knowledge about available services which might decrease their suffering from PPD.

> 'All the mothers here, I am telling you all the mothers I know, for example, first, they all suffer from postpartum depression because their families are not here. The second thing is that there are no services to be provided to them, as all Syrian mothers will suffer from postpartum depression'.
>
> (P# 10)

Another participant reported:

> 'No, by God, I don't know about the psychological and social support services for postpartum depression, nor I have ever tried them'.
>
> (P# 7)

Some participants requested more information about available mental health services, indicating their right to receive such information.

> '… there should be seminars to invite Syrian women there to. Of course, women must now take care of themselves'.
>
> (P# 1)

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> 'People should be informed about the project that provides care for mothers and children, including psychological support … They need to know that there is a project offered by the refugee organization'.
>
> (P# 9)

5.1.3 | Subtheme 1.3: Perceived need of mental health treatment

Some women struggled to perceive the need for mental health services despite having depression symptoms, and all the challenges and losses they faced because of the war.

> 'No, I didn't think about it before because I feel that I don't need it. I mean, I got used to being alone, at times like this. I mean, it's circumstance after circumstance, so I'm used to it'.
>
> (P# 12)

> 'There is a psychologist at the Syrian municipality, but I did not seek their services because I did not feel the need for it'.
>
> (P# 11)

5.2 | Theme 2: Acceptability/ability to seek

This theme refers to social and cultural factors determining whether Syrian refugee women with PPD can accept mental health treatment (e.g. the sex of healthcare providers, perceived discrimination and the beliefs about healthcare system).

5.2.1 | Subtheme 2.1: Being a refugee (legal status and perceived discrimination)

Some participants asserted that their legal status hindered their ability to seek formal healthcare services as they are not allowed to get benefits from healthcare services provided in Istanbul given that their identification cards were issued in other provinces. Some mothers explained that they had to move to Istanbul after getting married and such a situation affected them negatively as they lost their right to health.

> 'No, I didn't get the benefit of the services available here. We don't get any benefit from these services because our identification card was issued in another province'.
>
> (P# 7)

> 'I wish, I wish, I want that, I mean, but I am telling you that I do not go out or enter. They do not receive me here. For example, if I go to a psychiatrist to tell her about my situation, they do not receive me. For this reason I stay in this house and submit my affairs to God'.
>
> (P# 9)

Furthermore, some participants described being a refugee is the primary barrier to seek mental health treatment for PPD. They perceived discrimination by healthcare providers.

> 'The first obstacle that prevents us from obtaining psychological treatment is that we are refugees. I mean, wherever you go, I hear that you are a stranger, it is not your country, you cannot get something like others, this is because your name is "refugee". This is the obstacle, I mean … There is superiority in treatment, with discomfort'.
>
> (P# 13)

> 'If you go to the clinic, for example, there is no respect. I mean, as a Syrian or a refugee, it feels like you are committing a sin, but in reality, you are not. I am committing a sin only because I am Syrian … No one likes to go there'.
>
> (P# 10)

5.2.2 | Subtheme 2.2: Stigma of mental illness exacerbated by language differences

Some participants reported concerns of stigma related to mental health problems. They were worried about the perception of others when visiting a psychiatrist for PPD.

They further elaborated that because of language differences their need for an interpreter would greatly threaten their privacy due to mistrust issues.

> 'I can't go. If I want to go to a psychiatrist, I need an interpreter. I can't talk in these matters to a stranger. You can't trust anyone. If you talk to any person, people will start talking about you'.
>
> (P# 5)

> 'We need an interpreter for a psychiatric consultation … It is possible that some people go there, but I do not. I swear to God, if my relatives knew about my visit to a psychiatrist, they would gloat over me'.
>
> (P# 12)

5.2.3 | Subtheme 2.3: Cultural preferences of healthcare provider

Participants expressed cultural preferences of female healthcare providers as they feel more comfortable discussing their health

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needs. Participants emphasized the gender role of influencing them in choosing a female healthcare provider as their husbands might not allow them to receive the care provided by male healthcare providers, reflecting their limited autonomy.

> 'My husband refuses my visits to male healthcare providers, including psychiatrists… he refuses'.
>
> (P# 8)

> 'I prefer a female healthcare provider. I think our Syrian community and my husband don't accept male healthcare providers. For sure, the female physician will understand women. When you talk to a male, you don't feel comfortable as if you talk to a female, especially if the physician is stranger'.
>
> (P# 11)

5.2.4 | Subtheme 2.4: Language barrier

Participants reported that language difficulty is the primary barrier to communicate with healthcare providers and to be engaged in healthcare for PPD.

> 'You don't know how to communicate with them… they convey the idea to you in two words. And that's it. It means you do not understand anything about what they are talking about'.
>
> (P# 13)

> 'Not to deal with them. This thing exhausted me. I can't understand what they are talking about. My husband used to translate for me, but when I go alone, I can't understand anything'.
>
> (P# 15)

5.3 | Theme 3: Availability and accommodation/ability to reach

This theme reflects aspects related to the availability of healthcare services including the physical location of the services (e.g., distribution and transportation) as well as the ability of Syrian refugee women to reach mental health services in a timely manner.

5.3.1 | Subtheme 3.1: Transportation barrier and location of the centre

Participants indicated that the geographical location of healthcare centres requires the use of transportation which hinders them from accessing services.

> 'They even used to invite me to visit the clinic, but I didn't go because it is far away from me'.
>
> (P# 6)

> 'The problem here is that I can't go to the refugee organization. It was two or three months since my last visit … I need two buses to reach there and two buses to go back home'.
>
> (P# 10)

Some women reported issues related to using transportation independently due to lack of confidence and limited socialization.

> 'For me, I can't use the bus, I walk. It takes one hour and half. If the place is near me, it is better. I am afraid of getting lost if I use transportation, which means that I do not go out much from the house. If I have to go out, I go out with my husband'.
>
> (P# 6)

> 'I feel afraid to go outside alone… I do not use transportation alone'.
>
> (P# 11)

5.3.2 | Subtheme 3.2: No support for childcare

Participants indicated that the lack of support for childcare led them to take their children with them to healthcare centres and, thus, they sometimes skipped health appointments.

> 'I take my children with me when I go to the center. This thing is like an obstacle for me. I can't leave them alone. There are a lot of outpatient appointments that I couldn't go to because my husband is not with me, or due to the cold weather…There is no one to help me'.
>
> (P# 10)

> 'I have to take my children with me. Where should I place them?… I swear, I have to take them with me. This obligation prevented me from going to the clinic'.
>
> (P# 14)

5.3.3 | Subtheme 3.3: Lack of time

Some participants reported that they did not have enough time to take care of themselves and get the care for PPD.

> 'I have many tasks to complete, for example, cooking for my husband and cleaning the house. I do not

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have time to improve my mental state; I do not have enough time'.

(P# 10)

'In the Syrian municipality, they provided three months of psychological support, that was before the birth, and I didn't complete after it. They called me. But I told them that I don't have time'.

(P# 14)

5.4 | Theme 4: Affordability/ability to pay

This theme describes Syrian refugee women's economic capability to spend time and resources (i.e. income) to use appropriate healthcare services.

5.4.1 | Subtheme 4.1: Financial difficulties

Mothers reported that they were struggling to access mental health services because of financial difficulties.

'… how I can go to the psychiatrist. When I feel sick, my husband could not take me to the doctor because we don't have money. Yes, I want to go to the psychiatrists to talk with them about my mental state or what I am passing through, I used to keep things inside me, I want to go to talk about myself, but I can't because I don't have money'.

(P# 9)

'The financial status is very poor and it is a barrier. If you want to go to a psychiatrist or any physician, you will struggle because you have to pay, and we don't have the money'.

(P# 3)

The cost of transportation and the demand to pay for an interpreter hindered Syrian refugee women to get benefits from available services.

'Yes, the transportation is too expensive. I need to take someone with me… So, it costs a lot of money'.

(P# 10)

This participant also stated:

'There are interpreters, but when you need them, you don't find any of them. There is an interpreter, she takes money … She wants money and there is transportation fees… For this reason, I don't go to the governmental hospitals'.

5.4.2 | Subtheme 4.2: Health insurance coverage

Participants reported that there was no full health insurance coverage which required self-payment for healthcare.

'We don't have full health insurance. I asked for a financial aid and they only offered 230 Turkish Lira, not more than this'.

(P# 4)

'… previously there was a full health insurance, but now they took a percentage. There is nothing free. This will effect on mothers' ability to go to the health center'.

(P# 13)

One mother explained that the legal status as a refugee affects their right to health insurance:

'They don't make these things available because we are Syrians … we talked with the organization about the difference in the identification cards' place of issue. We want health insurance… There is the matter of law. They can't'.

(P# 7)

5.5 | Theme 5: Appropriateness/ability to engage

This theme refers to the fit between healthcare services provided and Syrian refugee women's need, the amount of care required for health assessment and determining the appropriate treatment.

5.5.1 | Subtheme 5.1: No screening for PPD

Despite their vulnerable situation and need of mental health support, participants reported that their healthcare providers did not screen for depression symptoms during and after pregnancy.

'By God, no one asked me… They only asked me about my physical health but did not ask about my mental state. They did not ask'.

(P# 11)

'No, no, no, no one cared, no one asked me, and no one said anything about depression'.

(P# 13)

5.5.2 | Subtheme 5.2: Services provided are intermittent with limited focus on mental health

Some participants reported that there were specific programmes targeting pregnant and postnatal women. However, the main focus

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of these intervention programmes is childcare rather than specifically maternal mental health.

> 'After birth, a woman used to visit me and teach me how to take care of the baby, or if I am under the effect of a psychiatric condition, how I deal with it. After she used to visit me, she no longer does. She visited me the first three months after birth… She didn't advise me about my psychiatric condition … All questions were about the baby'. (P# 6)

> 'A woman visited me to discuss my child care and informed me that she would continue visiting me for the next five years… She inquired about how I take care of my children but did not ask about my mental health. She came for two months, but she no longer visits me'. (P# 8)

6 | DISCUSSION

This study demonstrates that Syrian refugee women experienced multiple barriers to access mental health treatment for PPD. Limited information and misconceptions about PPD and its treatment, as well as lack of awareness of available mental health services, impede Syrian refugee women from navigating the healthcare system effectively in Türkiye. A systematic review also revealed that poor health literacy and lack of awareness about available services are common factors influencing refugee women's help-seeking behaviours for depression during pregnancy and after birth (Firth et al., 2022). Nevertheless, there are various strategies to improve awareness of Syrian refugee women about PPD, its treatment interventions and available free psychosocial resources (Ahmed et al., 2017). For instance, maternal nurses and obstetricians can deliver such information in antenatal and postnatal clinics. In addition, mental and public health nurses can have a role in raising awareness about PPD. Materials in the Arabic language can be displayed through NGOs, community centres and language training centres, while also including information about available resources.

The findings of our study also revealed that the language difference is an important barrier to access and acceptance of mental health services for PPD. Such findings consistently corroborate other studies of refugee women (Firth et al., 2022) and particularly of Syrian refugee women with PPD (Ahmed et al., 2017). This is critical, as while the language barrier limits refugee women from accessing mental health services, research shows that it is associated with higher odds of PPD in migrant women compared to women in the host community (Hamwi et al., 2021). Hence, it is necessary to understand the cultural and social determinants of health when addressing barriers to mental health services in refugee women. Participants in our study also emphasized that stigma and privacy issues are important constraints to accessing mental health services in Türkiye. Specifically, language difficulties affected their privacy as women reported that they would like to share their depression symptoms with a healthcare provider but not in the presence of an interpreter. Consistently, the stigma of mental illness and privacy were reported as major barriers to seek help among Syrian refugee women settled in Canada (Ahmed et al., 2017), reflecting the importance of understanding and addressing the unique needs of the Syrian community. For example, the employment of Syrian health professionals or bilingual health professionals, including nurses, can be considered. They can be trained on how to address issues related to privacy and stigma when providing care for refugee women. These women need to be empowered through learning the Turkish language skills to improve their ability to be engaged in healthcare.

The findings of our study also contributed to our understanding of how gender roles (e.g. decision-making, power and responsibilities) hindered Syrian refugee women's ability to seek mental health services for PPD. These women reported that their main role is childcare while not having the appropriate support to access mental health services. The focus of the available programmes targeting Syrian refugee women was also childcare rather than maternal mental health. Thus, there is a room for improvement through nurses, other health professionals and policymakers to address the cultural mental health needs of refugee women while emphasizing the quality and sustainability of any programme initiatives for PPD. For instance, telehealth care, including psychological counselling using telephone or the use of mobile app or online sessions for PPD interventions (Salameh et al., 2023), may help refugee mothers mitigate barriers to access healthcare such as lack of time, childcare support and transportation. In addition, community engagement activities such as recreational classes and support programmes may help women have social network connections and improve their mental health (Ahmed et al., 2017).

Other barriers reported in our study included perceived discrimination and legal status as a refugee. Regardless of the availability of healthcare services, Syrian refugee women reported protection concerns because of the lack of legal status, especially those whose identification card was not issued in Istanbul. Unfortunately, such issues related to legal identity can lead to living with anxiety and fear of detention among refugee populations (Kang et al., 2019), particularly refugee women (O'Mahony & Donnelly, 2013). Our findings also emphasized that financial difficulties impede women from accessing mental health services due to struggling to pay for transportation, interpreters and healthcare. Healthcare professionals, including nurses, need to understand that Syrian refugee women struggle to access healthcare services due to financial difficulties and issues with health insurance coverage and respond to their needs with empathy and by advocating for their rights. Policymakers need to establish strategies to support these women, especially those who moved from one province to another, and protect their right to health.

Despite the mental health needs of Syrian refugee women, this study showed that mental health was not a priority to screen for and address in the perinatal period, all of which hindered their

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engagement in mental healthcare. Hence, healthcare professionals, including nurses, and policy initiatives need to integrate screening programmes for early detection, appropriate referral and treatment of PPD during antenatal and postnatal healthcare visits.

7 | STRENGTHS AND LIMITATIONS

To the authors' knowledge, this study is the first to identify key barriers to access mental health services for PPD among Syrian refugee women settling in Türkiye. Thus, the findings have important practice and policy implications guiding initiatives to address the cultural sensitive needs of this population of women while protecting their legal and health rights. There are some limitations in this study. First, we recruited Syrian refugee women through referral from one NGO in Istanbul. Most participants in this study had less than high school education; however, this is representative of the level of education of Syrian refugee women in Türkiye (UN Women, 2018). Second, the findings reflect Syrian refugee women's perspectives; hence, it is crucial to conduct interviews with healthcare providers and refugee health experts to better understand barriers to access mental health services in this population. Third, member checking was done with two participants due to limited time; thus, future studies need to consider more robust member checking. Finally, refugee women might feel reluctant to report issues related to accessing mental health services for PPD. However, the first author whose background is the same as the Syrian mothers assured the confidentiality of the information in each individualized interview while providing a safe and comfortable environment to help mothers share their perceptions and experiences of accessing mental health services. Nevertheless, the research team used a theoretical audit process (Lincoln & Guba, 1985; Shenton, 2004) to reflect on data and avoid bias through verbatim transcription, vivid descriptions of the study procedures and validation of themes and subthemes by two researchers.

8 | CONCLUSIONS

Participants of this study reported complex multi-faceted barriers to accessing healthcare services for their mental health needs. Greater efforts are needed to improve health literacy and awareness among Syrian refugee women regarding their mental health needs and available resources and health services in Türkiye. Health services centres can proactively encourage and provide a location for communities of refugee women to come together for mutual and professional support to meet their mental health needs. Mental healthcare tailored according to the cultural needs of Syrian refugees is necessary. Women can be empowered through learning the Turkish language. Policy initiatives to overcome protection barriers and to facilitate insurance coverage and affordable healthcare services are needed for better access to mental health services.

AUTHOR CONTRIBUTIONS

TS, SS, CA, LH, HA, SJ: Made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; TS, SS, CA, LH, HA, SJ: Involved in drafting the manuscript or revising it critically for important intellectual content; TS, SS, CA, LH, HA, SJ: Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; TS, SS, CA, LH, HA, SJ: Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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CONFLICT OF INTEREST STATEMENT

Authors declare that they have no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

Ethical approval was obtained from the Ethics Review Committee of Koç University (# 2022.047.IRB3.019).

ORCID

Taghreed N. Salameh https://orcid.org/0000-0001-9192-1478

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