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Refugee Mothers' Voices: Exploring Postpartum Emotional and Mental Health Experiences After Resettlement and Childbirth in New Zealand

By
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Abstract

Postpartum psychological distress is a common health concern among women in Aotearoa New Zealand during the first year after childbirth (MOH, 2021). Although refugee mothers are at heightened risk of developing postpartum emotional and mental distress (WHO, 2018), little is known about their experiences in Aotearoa New Zealand. In recent decades, Aotearoa New Zealand has resettled refugee women from diverse conflict-affected regions, including the Middle East, who currently represent approximately one-fifth of the national refugee quota intake (INZ, 2025). This study explored Middle Eastern refugee women's postpartum emotional challenges and the barriers they face in seeking support following resettlement in Aotearoa New Zealand.

A scoping review was first conducted to map international evidence on postpartum mental health among Middle Eastern refugee women in high-income countries. McLeroy's socio-ecological framework (1988) was used to interpret multi-level barriers to help-seeking, including mental health literacy, language constraints, cultural norms and stigma, social isolation, and complex or inequitable healthcare systems. The findings informed the subsequent qualitative study to investigate the individual, interpersonal, cultural, and systemic influences on postpartum wellbeing and help-seeking among Middle Eastern refugee women in Aotearoa New Zealand who had given birth within the past five years.

In the qualitative study, in-depth semi-structured interviews were conducted and were grounded in a constructivist paradigm, which assumes that knowledge and reality are constructed through human experiences and interactions (Guba & Lincoln, 1994; Mann & MacLeod, 2015). The findings were also interpreted using McLeroy's socio-ecological framework (1988) to examine how individual factors, interpersonal relationships, community norms, and broader structural conditions interact to shape women's help-seeking behaviours.

Eight Middle Eastern refugee women (n = 8), originally from Syria and Palestine, participated in the interviews. They had been living in Auckland, Wellington, and Christchurch for between two and nine years. Participants ranged in age from their early twenties to early forties, with the majority having two or more children born in Aotearoa New Zealand. Their youngest children ranged in age from four months to three years.

Data were analysed using reflexive thematic analysis, undertaken through a hybrid inductive-deductive approach. Coding and theme development remained grounded in participants' accounts, and the data were subsequently interpreted through the socio-ecological model.

Four overarching themes were identified, highlighting barriers to seeking informal and formal support: (i) limited awareness and lack of information, (ii) interpersonal challenges, (iii) cultural and gender norms, and (iv) systemic barriers. These themes interacted across multiple socio-ecological levels and constrained women's agency to attend to their needs and access timely support.

Participants recommended increasing the availability of linguistically matched maternity healthcare providers, in-person interpreters, tailored education for husbands, culturally informed communication, transport and childcare support, and more flexible family visa options to enable postpartum support.

Building on these findings, collaboration across government, maternity services, and refugee-led organisations is essential to translate these findings into sustainable, equitable, and culturally safe postpartum care pathways in Aotearoa New Zealand. Future research incorporating appropriate clinical assessment and exploration of digital or community-based supports could further strengthen the evidence base. Evaluating postpartum interventions with refugee women, their families, and service providers, and co-designing culturally responsive care models that include practical supports and early mental health promotion for partners, are needed.

Acknowledgment

I dedicate this thesis to the beloved soul of my father, a professor of Magnetic and Electro-Physics engineering. Although you left us 25 years ago, your devotion to knowledge, research, and hard work has lived on through me, shaping my life and academic journey. Your legacy continues to be a guiding light in all that I do.

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Chapter one: Introduction

This chapter provides an overview of postpartum mental health issues and outlines the motivations underpinning this research study. Postpartum mental health conditions are complex and serious concerns that can have long-term, debilitating effects on refugee women and their families. This chapter introduces the postpartum period in relation to mental health and situates the study within the context of refugee women living in New Zealand, while outlining the study rationale and significance. The chapter also outlines my (researcher's) positionality, the study paradigm and theoretical framework, and the study aims, objectives, and research questions, before concluding with an overview of the subsequent chapters of the thesis.

Background

The postpartum period is one of the most vulnerable phases in a woman's life course, encompassing profound physical, emotional, and social adjustments (Ether et al., 2025; Qutranji et al., 2020; Salameh et al., 2025; WHC, 2021; WHO, 2018). During this time, women experience the dual demands of physical recovery from pregnancy and childbirth while adapting to new maternal roles, shifting family dynamics, and the responsibilities of caring for a newborn (McCarthy et al., 2021). These overlapping changes expose women to increased stressors and heightened susceptibility to mental health difficulties arising from the complex interplay of biological, hormonal, and psychosocial factors (Carlson et al., 2024; NHS, 2022; WHC, 2021). When unaddressed, these challenges can impair maternal wellbeing, disrupt mother–infant bonding, and affect the emotional and developmental outcomes of the child (Agnafors et al., 2013; Ahmed et al., 2017; Signal et al., 2017).

The postpartum (or postnatal) period begins immediately after childbirth and typically continues until physical recovery and psychological adjustment (Fahey & Shenassa, 2013; McCarthy et al., 2021; Sword et al., 2012). Although traditionally described as lasting six weeks, recovery is highly variable; physical healing may take up to 18 months, and emotional adjustment can extend to 12 months or longer depending on individual circumstances and pregnancy complications (Moraes et al., 2017; Siega-Riz et al., 2010; Woolhouse et al., 2012). This transition requires ongoing emotional and social support, as adequate care during

this period is critical to the long-term health and wellbeing of both mother and child (McCarthy et al., 2021; Sendas & Freitas, 2024).

Women's exposure to trauma and environmental stressors can also significantly shape their postpartum mental health outcomes (Angelini et al., 2018). Experiences such as obstetric complications, traumatic birth, or previous histories of violence and displacement increase vulnerability to psychological distress in the postpartum period (Grekin & O'Hara, 2014). Social determinants including poverty, housing insecurity, language barriers, social isolation, and limited access to culturally safe healthcare further compound risks and may hinder recovery or delay help-seeking (Ong et al., 2024; Place et al., 2024). These determinants highlight that postpartum mental health is not solely a product of biological processes but is deeply embedded within wider social, cultural, and structural contexts (Ong et al., 2024; Place et al., 2024).

Maternal Mental Health in the Postpartum Period

The postpartum period presents a time of heightened risk for emotional and psychological difficulties. In terms of diagnostic labelling, the DSM 5 does not have distinct identifiers for postpartum mental illnesses. Rather, broader diagnostic categories (e.g. affective disorders) can be given the specifier of "peripartum onset", and the term perinatal depression is included (Carlson et al., 2025). With these parameters in mind, the broader maternal mental health literature describes a range of mental conditions that may occur during in the postpartum period. These include as postpartum anxiety, depression, psychosis, bipolar disorder, and post-traumatic stress disorder (PTSD) (Sword et al., 2012). Descriptions of the types of postpartum mental disorders women may experience are outlined below:

Postpartum Depression and Anxiety

Postpartum depression (PPD) and postpartum anxiety are among the most common maternal mental health conditions experienced within the first year after childbirth (van der Zee-van et al., 2021). Globally, both conditions are now recognised as highly prevalent, with postpartum anxiety affecting approximately 15% of women worldwide, although rates vary depending on the timing within the postpartum period (Dennis et al., 2017). Postpartum depression affects an estimated 19% of women during the postpartum year, with prevalence varying across age

groups, ethnicities, cultures, and socioeconomic backgrounds (Carlson et al., 2024; Oxley & Fitzgerald, 2010; Signal et al., 2017).

Postpartum depression typically involves persistent feelings of sadness, hopelessness, fatigue, changes in appetite, difficulty bonding with the baby, and, in some cases, thoughts of self-harm (Carlson et al., 2024; Cooper & Murray, 1998; Signal et al., 2017). Postpartum anxiety refers to excessive and persistent worry and is often comorbid with postpartum depression (Carlson et al., 2024). Postpartum depression can become a long-lasting mental health condition and develop at any time within the first year after childbirth (Cooper & Murray, 1998).

Postpartum anxiety refers to excessive and persistent worry or fear, often comorbid with depression (Carlson et al., 2024; Dennis et al., 2017). Postpartum anxiety may also include thoughts of self-harm with an increased risk of parental suicide, which is the second leading cause of maternal mortality in the postpartum period (Carlson et al., 2024; Cooper & Murray, 1998; Signal et al., 2017). Despite being a frequent comorbidity with depression, postpartum anxiety has received limited attention from researchers and health professionals, contributing to its under-recognition in both clinical practice and policy (Dennis et al., 2017).

Risk factors for postpartum depression and postpartum anxiety are multifactorial, encompassing biological, psychological, and social determinants. These include low socioeconomic status; immigrant or refugee background; multiple births; a personal or family history of mental illness; high baseline anxiety; single or LGBTQ+ parenthood; limited social or partner support; cigarette smoking; ethnicity-related stressors; and significant life changes(Beck, 2001; Carlson et al., 2024; Oxley & Fitzgerald, 2010; Salameh et al., 2025; Signal et al., 2017). Women who experience overlapping risk factors are more vulnerable to developing PPD or anxiety (Carlson et al., 2024; Oxley & Fitzgerald, 2010; Salameh et al., 2025). For this reason, it is vital for healthcare providers and all those involved in maternal care to recognise the determinants that may heighten a woman’s risk of developing postpartum depression or anxiety (Beck, 2001; Carlson et al., 2024). Early identification, timely intervention, and culturally appropriate support are essential to improving outcomes for women, their families, and future generations.

More Severe Mental Illnesses

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), mental illnesses encompass a broad spectrum of conditions that differ in terms of symptoms, severity, duration, and impact on daily functioning (APA, 2013). Within the postpartum context, anxiety and depression are often referred to as common postpartum mental conditions due to their high prevalence (Carlson et al., 2024). However, beyond these more frequently encountered conditions, rarer but more severe conditions also affect women in the postpartum period.

At the most severe end of the spectrum is postpartum psychosis, a rare but acute psychiatric emergency. Postpartum psychosis typically develops within 3 to 10 days after childbirth, though onset can occur at any point within the first four weeks postpartum (Carlson et al., 2024). It is characterised by hallucinations, delusions, disorganised thinking, unusual behaviour, and severe mood disturbances, all of which carry substantial risks of suicide or infanticide if left untreated. Although uncommon, postpartum psychosis occurs in approximately 1 to 2 per 1,000 pregnancies (Carlson et al., 2024).

Bipolar disorder (BD) is another significant concern in the postpartum period. Bipolar disorder is a chronic affective mood disorder, and women with a pre-existing diagnosis face a markedly increased risk of relapse following childbirth (Anke et al., 2019). During the postpartum months, symptoms may present as depressive, hypomanic, manic, or mixed episodes, highlighting the particular vulnerability of this group and the necessity for early detection, continuous monitoring, and specialist care (Anke et al., 2019; Rusner et al., 2016). Unlike transient postpartum mood fluctuations, all clinically defined maternal mental health conditions, including postpartum psychosis and bipolar disorder, require professional assessment and timely intervention to protect both maternal wellbeing and infant safety (Carlson et al., 2024).

Post-Traumatic Stress Disorder (PTSD)

Trauma refers to the emotional, physical, and psychological response to distressing event that makes it difficult for a person to cope and function (APA, 2018). Traumatic experiences may be single and acute exposure such as accidents, natural disasters, or assaults, or chronic and cumulative exposure, such as ongoing violence, war conflict and displacement, or abuse

(Feriante & Sharma, 2023). All forms of trauma have the potential to contribute to the development of post-traumatic stress disorder (PTSD) (Feriante & Sharma, 2023).

In the context of maternal health, psychological trauma may stem not only from women's prior life experiences but also from the processes of pregnancy, childbirth, and early parenting, where these experiences can act as co-morbid sources of distress (Liu et al., 2021). Childbirth itself, while often anticipated as a positive and transformative life event, can for some women be experienced as a traumatic stressor (Taylor Miller et al., 2021). Factors such as unexpected medical interventions, emergency caesarean sections, loss of control during labour or experiencing severe pain, inadequate communication from healthcare providers, birth loss, infant health issue, and perceived or actual threats to the life of the mother or infant can all contribute to birth trauma (Beck, 2004; Hollander et al., 2017).

Postpartum PTSD is a psychiatric disorder that develops following exposure to a traumatic event during pregnancy or childbirth and is characterised by symptoms such as disturbing memories, nightmares, hyperarousal, emotional distressing, and avoidance behaviours (Kranenburg et al., 2023; Liu et al., 2021; Taylor Miller et al., 2021).

The prevalence of postpartum PTSD is estimated to range from 1.5% to 6% of women and variation based on the traumatic exposure (Angelini et al., 2018; Beck, 2004; Kranenburg et al., 2023; Signal et al., 2017; Taylor Miller et al., 2021). Similar to all postpartum maternal mental health issues, postpartum PTSD can profoundly affect maternal–infant bonding, partner relationships, breastfeeding, and long-term family wellbeing (Liu et al., 2021; Taylor Miller et al., 2021).

Trauma represents a critical dimension of maternal mental health, and it cannot be considered in isolation from women's broader social, cultural, and personal histories. Survivors of childhood abuse, intimate partner violence, sexual assault, or forced displacement may be particularly vulnerable to re-traumatisation during childbirth leading to postpartum PTSD (Liu et al., 2021; Taylor Miller et al., 2021). This highlights the need for trauma-informed maternity care that recognises the signs of trauma, prioritises safety, fosters trust, and provides culturally safe and compassionate support (Magruder et al., 2017).

Wider Effects of Postpartum Mental Health

The consequences of postpartum emotional and mental health issues extend beyond the mother, affecting partners, children, and family dynamics. Postpartum depression has been shown to increase the risk of depression in partners and to contribute to cognitive, emotional, and behavioural difficulties in children over long term periods (Carlson et al., 2024; Oxley & Fitzgerald, 2010). Some mothers experience persistent self-blame and anxiety over perceived developmental delays or behavioural differences in their children, often attributing these outcomes to their own perceived emotional and mental inadequacies during the postpartum period (Oxley & Fitzgerald, 2010). Such feelings of guilt and worry can reinforce the stigma associated with postpartum mental issues, contributing to greater social isolation and diminished self-esteem among affected mothers (Oxley & Fitzgerald, 2010).

Similarly, although postpartum depression (PPD) is highly prevalent, misconceptions persist that it is less severe than other maternal mental health disorders and that women can recover without intervention, as it is often misattributed solely to hormonal changes associated with pregnancy and childbirth (NHS, 2022; Umboh SJ, 2013). These myths perpetuate under-detection and inadequate treatment, worsening outcomes and, in severe cases, increasing the risk of suicide (NHS, 2022).

Postpartum Mental Health for Refugee Women

While postpartum mental health challenges affect women globally, refugee women often experience additional burdens related to forced migration and displacement, trauma, and cultural adjustment (Ahmed et al., 2017). Migration itself is widely acknowledged as a highly stressful life event that can undermine maternal emotional wellbeing. However, forced migration and displacement introduce additional layers of risk that can exacerbate postpartum mental-health challenges (Heer et al., 2024; Rodríguez-Muñoz & Chrzan-Dętkoś, 2025). The World Health Organization (2018) notes that forcedly displaced women face compounded stressors across multiple stages pre-migration trauma, perilous journeys, and post-migration settlement challenges, all of which heighten the risk of maternal PTSD and other maternal mental health problems.

Among women who have experienced forced migration, the prevalence of postpartum depressive disorders is significantly higher: up to 31% compared with 12–19% in the general

population (Fellmeth et al., 2020). Forced migration not only affects individual health outcomes, but also has broader implications for families, communities, and receiving countries (Murray et al., 2022; Rodríguez-Muñoz & Chrzan-Dętkoś, 2025; Tahir et al., 2022; WHO, 2018). This cumulative impact and the persistence of ongoing intersecting challenges underscore the urgent need for culturally responsive, trauma-informed maternity mental-health care that recognises the unique experiences and needs of displaced mothers (WHC, 2021). In this next section, definitions of refugees and asylum seekers, the context of their settlement in New Zealand, and the health service access challenges they face are outlined.

Definition of Refugees and Asylum Seekers and Middle Eastern

A refugee is a person formally recognised as requiring protection because they have been forced to flee their country of nationality and are unable to return or access its protection due to war, violence, conflict, or persecution (INZ, 2025; UNHCR, 2010). In contrast, an asylum seeker is someone who arrives in a host country and applies for refugee or protected person status after arrival, on the basis of a well-founded fear of persecution in their country of origin or fear of serious harm if returned (UNHCR, 2010). When asylum claims are successful, individuals are granted a refugee status visa in the host country (INZ, 2025).

In this study, the term ‘refugee’ refers to individuals forcibly displaced from their home countries and resettled in Aotearoa New Zealand under legal protection, including those admitted through the Refugee Quota Programme, the Refugee Family Support Category, or approved asylum applications (Immigration New Zealand, 2025). The term ‘Middle Eastern’ refers to individuals originating from countries in the Middle East and North Africa (MENA) region, including Syria, Iraq, Lebanon, Jordan, Egypt, other Arabic-speaking countries, and Iran (StatsNZ, 2024).

Refugee Resettlement in New Zealand

New Zealand has a long-established history of refugee resettlement and plays an active role in international humanitarian efforts aimed at safeguarding individuals forcibly displaced from their countries due to war, persecution, or violence (Brannelly et al., 2024). Aotearoa New Zealand hosts refugee populations from diverse regions, including the Middle East, Africa, and Asia (Immigration New Zealand, 2025). Each year, the country accepts 2,100 refugees; including 1,500 refugees through its Refugee Quota Programme and provides an

additional 600 places through the Refugee Family Support Category, which allows eligible refugees to sponsor family members. Asylum seeker's applications are processed individually based on the merits of their claims, as Aotearoa New Zealand does not operate a formal quota system for this group (Immigration New Zealand, 2025).

Upon arrival, they participate in a residential orientation programme at the Mangere Refugee Resettlement Centre (MRRC) in Auckland, where they receive initial medical screening and treatment. Once resettled in their chosen community, they are enrolled with a general practitioner (GP) and provided with a copy of their medical records (Mortensen, 2011).

The Refugee Resettlement Strategy (RRS) was first introduced in 2012 and updated in 2023 (Immigration New Zealand, 2023). The strategy identifies several key indicators of successful resettlement, including feeling safe and well, developing a sense of belonging, and having opportunities to fully participate in society (Immigration New Zealand, 2023). This strategy is underpinned through five settlement outcomes: (i) participation and inclusion, (ii) health and wellbeing, (iii) housing, (iv) education, training, and English language, and (v) employment and self-sufficiency (Immigration New Zealand, 2023). Within these outcomes, the health and wellbeing outcome includes access to mental health services as one of its success indicators (Brannelly et al., 2024).

However, data from the New Zealand Refugee Resettlement Dashboard shows that engagement with mental health services remains low, with only 45% of refugees attending at least one face-to-face mental health visit in 2018 (Brannelly et al., 2024).
At the time of conducting this study, more recent data were not publicly available, limiting insights into current service engagement trends. This highlights that, while the health needs of refugees are increasingly recognised within the healthcare system, significant barriers remain to help seeking actions and equitable access.

Postpartum Mental Health and Middle Eastern Refugee Women in Aotearoa New Zealand

In 2024, global conflicts reached their highest levels since World War II, intensifying the risks faced by displaced women (Rodríguez-Muñoz & Chrzan-Dętkoś, 2025). Ongoing conflicts in the Middle East since the early 2000s have contributed to a significant increase in

the number of Middle Eastern refugees and asylum seekers resettled in New Zealand. As of 2025, this group accounts for approximately 20% of New Zealand's annual refugee intake (Immigration New Zealand, 2025).

Research on the lived experiences of Middle Eastern refugee mothers in Aotearoa New Zealand remains limited. To date, no studies have specifically investigated postpartum mental health among Middle Eastern refugee women. Existing New Zealand research has largely focused on the mental health of the general refugee population, often treating refugees as a homogenous group and overlooking the distinct experiences of women from different ethnic backgrounds during the postpartum period (Brannelly et al., 2024; Shrestha-Ranjit et al., 2017; Sobrun-Maharaj et al., 2008).

This lack of targeted research overlooks how Middle Eastern refugee women manage early motherhood alongside trauma and resettlement stress, within the context of maternal mental health services in Aotearoa New Zealand. An experiences that may be shaped by culturally specific norms, gender roles, migration histories, and intersecting structural barriers (Brannelly et al., 2024). Evidence indicates that Middle Eastern refugee women often experience disproportionately high rates of postpartum depressive symptoms, frequently co-occurring with anxiety and post-traumatic stress disorder (PTSD)(Ahmed et al., 2017; Salameh et al., 2025; Tahir et al., 2022). However, cultural stigma surrounding mental health may inhibit help-seeking (Salameh et al., 2025), and this is further intensified by intersecting barriers, including language difficulties, systemic inequities, and limited access to culturally responsive and gender-sensitive health services (Ahmed et al., 2017; Mandwee, 2023; Salameh et al., 2025; Tahir et al., 2022). Collectively, these factors contribute to delayed or inadequate postpartum support and increase vulnerability of Middle Eastern to persistent mental health difficulties (Ahmed et al., 2017; Salameh et al., 2025).

These heightened vulnerabilities, combined with the significant gaps in existing research, underscore the need to explore Middle Eastern refugee women's postpartum mental health experiences, their perceptions of support, and the barriers they encounter after childbirth in New Zealand. Greater understanding can inform the development of culturally responsive and trauma-informed maternal mental health services tailored to this population(Brannelly et al., 2024; Kanengoni-Nyatara et al., 2024; Sherif et al., 2022; Shrestha-Ranjit et al., 2017).

Access to Mental Health Care for Refugee Women in New Zealand

Refugees are entitled to the same publicly funded health and disability services as other New Zealand citizens (Abbas, 2022; Brannelly et al., 2024). Refugee mental health services in Aotearoa New Zealand are delivered through statutory agencies and non-governmental organisations (Brannelly et al., 2024). However, persistent resourcing constraints contribute to long wait times, regional inequities, and fragmented care (Brannelly et al., 2024; Shrestha-Ranjit et al., 2017). While support is available in primary care, complex cases are referred to secondary services where delays and limited follow-up hinder timely care (Brannelly et al., 2024).

Although healthcare in Aotearoa New Zealand is publicly funded, refugee women continue to experience inequitable access to mental health support (Brannelly et al., 2024; Sherif et al., 2022; Shrestha-Ranjit et al., 2017; Shrestha-Ranjit et al., 2020). Several Aotearoa New Zealand studies have identified key individual, cultural, and systemic barriers that impede equitable access to mental-health care for refugee populations in general (Brannelly et al., 2024; Cassim, Kidd, et al., 2022; Charania, 2023; Kanengoni-Nyatara et al., 2024; Pepworth & Nash, 2009; Shrestha-Ranjit et al., 2017; Shrestha-Ranjit et al., 2020).

Individual *Barriers:* At the individual level, refugees in Aotearoa New Zealand must navigate the difficulties of adapting to a new language and culture while also managing disrupted educational histories, which in some cases leave them with limited literacy skills even in their first language (Brannelly et al., 2024; Cassim, Kidd, et al., 2022; Kanengoni-Nyatara et al., 2024; Sherif et al., 2022; Shrestha-Ranjit et al., 2020). These studies also highlight that language barriers and communication difficulties, combined with inadequate funding and limited availability of high-quality interpreter services, often hinder refugee women's ability to understand their health conditions, thereby delaying appropriate and timely treatment.

Limited health literacy further compounds the problem, as many refugee women arriving in Aotearoa New Zealand have reduced awareness of mental health and maternal mental health conditions, making it difficult to recognise symptoms, articulate distress, and seek early support (Brannelly et al., 2024; Cassim, Kidd, et al., 2022; Kanengoni-Nyatara et al., 2024; Mortensen, 2011; Sherif et al., 2022; Shrestha-Ranjit et al., 2017; Shrestha-Ranjit et al., 2020). Furthermore, refugee women's limited awareness of available mental health services

in Aotearoa New Zealand adds another layer of difficulty, as it makes navigating the healthcare system even more challenging and restricts access to timely and appropriate care (Shrestha-Ranjit et al., 2017).

Social and Cultural Barriers

Social relationships and cultural challenges also influence how refugee women in Aotearoa New Zealand engage with mental health services (Shrestha-Ranjit et al., 2017; Sobrun-Maharaj et al., 2008). In particular, stigma associated with accessing or utilising mental health care among many refugees communities in Aotearoa New Zealand often discourages attendance at services or meaningful engagement with health professionals (Sobrun-Maharaj et al., 2008). The absence of family awareness about maternal mental health, combined with stigma and fear of community judgment, reinforces a cycle of delayed help-seeking, leaving many refugee women without the support they need during critical periods of mental health vulnerability (Ahmed et al., 2017; Sobrun-Maharaj et al., 2008).

Systemic Barriers

At the systemic level, language and cultural barriers, combined with the dominance of Western biomedical models in Aotearoa New Zealand's health system, create significant obstacles for refugees navigating healthcare (Brannelly et al., 2024). Refugee women often feel that the healthcare providers they encounter in Aotearoa New Zealand lack understanding of their beliefs and cultural traditions surrounding disease, treatment, and health practices, which in turn limits appropriate assessment and increases the risk of misdiagnoses of underlying health issues (Brannelly et al., 2024; Cassim, Kidd, et al., 2022; Kanengoni-Nyatara et al., 2024; Mortensen, 2011).

Cultural insensitivity, a shortage of trained interpreters, and the health system's over-reliance on Western biomedical approaches further constrain its ability to respond effectively to the diverse and complex health needs of women from refugee backgrounds (Brannelly et al., 2024; Kanengoni-Nyatara et al., 2024; Mortensen, 2011; Shrestha-Ranjit et al., 2017). Moreover, New Zealand healthcare providers' reliance on predefined diagnostic criteria risks overlooking the cultural, political, and historical contexts that shape women's experiences of distress, thereby undermining the delivery of appropriate and culturally responsive mental health care (Brannelly et al., 2024).

Collectively, these systemic and structural barriers not only delay timely intervention but also perpetuate inequities in access to mental health services and outcomes for refugee women mental wellbeing in Aotearoa New Zealand (Brannelly et al., 2024; Cassim, Kidd, et al., 2022; Kanengoni-Nyatara et al., 2024; Pepworth & Nash, 2009; Shrestha-Ranjit et al., 2017).

The Study Rationale:

Maternal mental health constitutes a fundamental component of women's overall wellbeing during the postpartum period, which is a time of heightened vulnerability to emotional, psychological, and social challenges (Boyle et al., 2019). These challenges extend beyond the individual woman, exerting influence on infant development, attachment, partner relationships, and broader family systems, with the potential for with potential long-term consequences if left unaddressed (Agnafors et al., 2013; Carlson et al., 2024; Oxley & Fitzgerald, 2010).

Refugee women are at high risk of experiencing postpartum mental health difficulties (O'Mahony & Donnelly, 2010; WHC, 2021; WHO, 2018). This population's vulnerability to postpartum mental health difficulties is shaped by navigating the combined pressures of new motherhood, cultural adjustment, and systemic inequities within an unfamiliar health system (Cameron et al., 2022; Khalil et al., 2024; O'Mahony & Donnelly, 2010).

For refugee women from the Middle East, these challenges are further compounded by recent pre- and post-migration trauma, persistent language barriers, and inadequate access to gender-sensitive and culturally responsive maternal healthcare (Salameh et al., 2025; Vigod et al., 2017). Further the stigma surrounding mental health within some Middle Eastern communities often discourage women from expressing emotional distress or seeking professional help (Salameh et al., 2025). As a result, many women experience delayed diagnosis, unmet support needs, and ongoing psychological strain during the postpartum period (Cameron et al., 2022; Khalil et al., 2024; O'Mahony & Donnelly, 2010).

Despite growing recognition of maternal mental health as a public-health priority, research exploring the postpartum mental health experiences, help-seeking behaviours, and support needs of refugee mothers in New Zealand remains extremely limited (MOH, 2021; Taynton

et al., 2024). Consequently, the specific postpartum mental health needs of Middle Eastern refugee women remain under-researched and insufficiently addressed within the national healthcare system (Abbas, 2022). This gap highlights the urgent need for culturally informed and context-specific research to better understand the lived experiences of Middle Eastern refugee women and to guide the development of equitable, responsive, and trauma-informed maternal mental healthcare services (Abbas, 2022).

Significance of The Study

This study sits at the intersection of maternal mental health, refugee health equity, and culturally responsive healthcare in Aotearoa New Zealand, and is significant for several key reasons. First, it amplifies the voices of refugee women as a marginalised and underrepresented population whose postpartum experiences have been largely overlooked in Aotearoa New Zealand's maternal mental health research and policy development. By centring their perspectives and exploring their emotional and psychological challenges after childbirth, the study responds to ongoing calls within public health and mental health scholarship to inclusive research practices and prioritise the lived experiences of those most affected by systemic inequities (Brannelly et al., 2024; Tahir et al., 2022).

Second, by identifying service gaps and areas of inadequacy, and highlighting the importance of culturally responsive care, this study offers practical recommendations for improving the design and delivery of inclusive postpartum mental health support. The findings have the potential to inform targeted interventions, guide professional training, and support the implementation of policies that are better aligned with the needs of diverse communities in Aotearoa.

Ultimately, this research contributes to reducing the maternal mental health burden among refugee women and enhancing the wellbeing of mothers and their infants. It also enriches the broader literature on refugee health in resettlement contexts by bridging theoretical understanding, lived experience, and applied healthcare practice. In doing so, the study supports the advancement of a more equitable and culturally competent maternal mental healthcare system in New Zealand.

Researcher Positionality and Motivation

This research has been shaped by my own lived experience as a Middle Eastern migrant woman who moved to Aotearoa New Zealand ten years ago and became a mother of three children in a new country without the support of extended family. While my migration to New Zealand was a personal choice made through the skilled migrant pathway, I am acutely aware that many women have been forced to leave their home countries and families due to conflict or displacement.

Through my own journey of motherhood, I experienced the emotional complexities of postpartum adjustment in a new cultural environment, particularly after the birth of my youngest child, who was only one year old when I decided to pursue postgraduate studies in public health. This experience deepened my understanding of the intersecting challenges mothers face when navigating both motherhood and adaptation to a new society. Also, my professional background as a former dentist from Jordan, a region deeply affected by the forced displacement of neighbouring populations, has strengthened my understanding of the layered and intersecting challenges faced by refugee women. It also inspired my interest in exploring how refugee mothers, who face additional pressures of forced displacement and family separation, experience and emotionally cope with the postpartum period while striving to care for their children and adjust to unfamiliar western health systems and social environments.

Furthermore, through my current work as a cancer screening support and health promoter, I have witnessed the challenges refugee women in Aotearoa New Zealand face when feeling overwhelmed or struggling to access appropriate care within an unfamiliar healthcare system. Many of these women face inequitable treatment, sometimes due to health providers limited cultural understanding or unconscious bias. Likewise, I have observed healthcare professionals struggling with how to provide appropriate, culturally responsive care for women from refugee backgrounds. These observations have motivated me to undertake this study to enhance opportunities for improving maternal mental health by exploring the perspectives of refugee women during the postpartum period.

A recent study by Brannelly et al. (2024) examined the mental health needs of the general refugee population in New Zealand to identify community-based recommendations for

developing targeted interventions and policies that address the underlying social, political, and economic determinants of refugee wellbeing. Although that study focused on the general refugee population and broader mental health concerns, it highlighted critical service gaps and emphasised the need for culturally sensitive, community-led approaches to co-design and deliver mental health services in partnership with refugee communities. The findings of this study (Brannelly et al., 2024) underscored the importance of moving beyond Western-centric models to more inclusive, equity-oriented practices.

Drawing on the work of Brannelly et al. (2024) and my own personal and professional experiences, this study reflects my deep commitment to ensuring that the voices of women from minority populations are genuinely heard, respected, and used to shape more responsive and culturally inclusive maternal mental healthcare systems. The voices of Middle Eastern refugee women are particularly significant, as their experiences are shaped by forced migration, prolonged insecurity, and exposure to violence, factors that distinguish them from other migrant populations, and they also face substantial linguistic, cultural, and socioeconomic barriers that complicate help-seeking and limit access to appropriate mental health support (Rodríguez-Muñoz & Chrzan-Dętkoś, 2025).

Study Paradigm and Framework

This study adopts an approach that recognises the complexity of postpartum mental health among refugee women as a socially constructed and context-dependent phenomenon. To capture this complexity, the study is underpinned by a constructivist paradigm, which emphasises the co-creation of meaning between researcher and participants (Guba & Lincoln, 1994), and by the Socio-Ecological Model (SEM), which provides a multi-layered framework for examining the interplay between individual, relational, community, and structural influences on health (McLeroy et al., 1988). Together, these frameworks offer a coherent foundation for exploring how social, cultural, and systemic contexts shape Middle Eastern refugee women's postpartum mental health experiences in Aotearoa New Zealand.

Constructivist Paradigm

This study is grounded in a constructivist paradigm, which assumes that knowledge and reality are constructed through human experiences and interactions with phenomena (Mann

& MacLeod, 2015). Constructivism in research recognises that findings are produced as subjective truths rather than objective facts, which is shaped by context, culture, and perspective (Mills et al., 2006; Mohajan & Mohajan, 2022).

Within this paradigm, qualitative methods such as interviews are particularly valuable because they allow the researcher, in close engagement with participants, to explore how individuals interpret and give meaning to their lived experiences (Mills et al., 2006). This approach privileges a diversity of perspectives, recognising that multiple realities may coexist, and seeks to illuminate these variations rather than reduce them to a single dominant narrative (Mann & MacLeod, 2015; Mills et al., 2006; Mohajan & Mohajan, 2022).

In the present study, postpartum mental health is therefore not conceptualised as a static or objective condition. Instead, it is understood as being intricately shaped by the voices of Middle Eastern refugee women, whose experiences are embedded within cultural traditions, social environments, migration histories, and interactions with healthcare systems. By privileging participants' meanings, this study aims to surface insights that might otherwise remain marginalised within mainstream discourses on maternal mental health.

Socio-Ecological Model (SEM)

This study is guided by the Socio-Ecological Model (SEM), an interpretive framework originally developed by Bronfenbrenner (1994) to explain human development. The model conceptualises health and behaviour as the outcome of continuous and dynamic interactions between individuals and the multiple environments in which they are embedded. In public health, McLeroy et al. (1988) extended the model to articulate how health outcomes are influenced not only by individual attributes but also by interpersonal and community relationships, and broader system structures (Henderson & Baffour, 2015; Kilanowski, 2017; Mecano, 2016).

Applied to this research, the Socio-Ecological Model (SEM) offers a comprehensive lens through which to examine the postpartum mental health of Middle Eastern refugee women in New Zealand. It recognises that mental wellbeing is shaped by the intersection of multiple, interdependent layers of influence ranging from individual factors, interpersonal and

community relationships , and broader systemic or societal structure (Ahmed et al., 2017; Mecano, 2016; Thaivalappil et al., 2024).

By employing the Socio-Ecological Model as a conceptual foundation, this study situates postpartum mental health within a broader framework of health determinants. It illustrates how this multi-level influences interact to shape the wellbeing of Middle Eastern refugee women during the postpartum period. The framework strengthens the study's capacity to inform contextually grounded and culturally responsive interventions, and to guide policymakers and healthcare providers in developing maternal mental health services that promote equity, inclusion, and meaningful support for refugee women in Aotearoa New Zealand.

Study Aim and Objectives:

The overall aim of this research is to explore the postpartum mental health experiences, needs, and help-seeking behaviours of Middle Eastern refugee women resettled in New Zealand, and to assess the nature and adequacy of support and knowledge provided by maternity healthcare services. The study seeks to generate insights that can inform the development of culturally responsive, gender-sensitive, and trauma-informed maternal mental health support within New Zealand's healthcare system.

To achieve these aims, the study is structured in two stages:
Stage One involved a scoping review of international literature to identify and synthesise existing knowledge about postpartum mental health among Middle Eastern refugee women living in high-income countries. Given the absence of research specifically addressing this topic within the New Zealand context, the scoping review aimed to map the existing evidence base and highlight key factors influencing Middle Eastern refugee women's mental health during the postpartum period.

Stage Two builds upon the findings of the scoping review through a qualitative study that explored the lived experiences of Middle Eastern refugee women in New Zealand during the postpartum period. This stage focused on understanding women's emotional wellbeing and cultural expectations surrounding motherhood. It also identified the barriers that influence their help-seeking behaviours and access to maternal mental health support. Furthermore, the

qualitative study assessed the nature and adequacy of support and knowledge provided by maternity healthcare services in addressing postpartum mental health needs among Middle Eastern refugee women. Finally, it sought participants' recommendations to guide the development of maternity mental healthcare policies and practices aimed at improving culturally responsive, equitable, and trauma-informed support for refugee women in New Zealand.

Research questions

The study aims to answer the following research questions:

1. How do Middle Eastern refugee women resettled in Aotearoa New Zealand describe their emotional and mental wellbeing during the postpartum period?
2. What barriers do Middle Eastern refugee women encounter when seeking formal and informal support for postpartum emotional and mental health needs?
3. What recommendations do Middle Eastern refugee women propose for improving postpartum emotional and mental health support in Aotearoa New Zealand?

Summary

This chapter has introduced the background and context of the study, outlining key issues related to postpartum mental health and the unique challenges faced by refugee women. It also presented the rationale for focusing on Middle Eastern refugee women in Aotearoa New Zealand, establishing why this topic is significant and under-researched. By framing the research problem and situating it within both global and local contexts, the chapter provides a foundation for understanding the aims, significance, and direction of the study.

The next chapter, Chapter Two, presents a scoping review of international literature on postpartum mental health among Middle Eastern refugee women in high-income countries. Chapter Three describes the qualitative research methodology, including the theoretical and philosophical frameworks, study design, participant recruitment, data collection, and analysis procedures. Chapter Four presents the findings of the qualitative study, exploring participants lived experiences and the factors shaping their postpartum mental health and wellbeing. Finally, Chapter Five discusses these findings in light of the scoping review and the wider literature review, and concludes the thesis by outlining the recommendations, the study's limitations, and directions for future research.

Chapter Two: Literature Scoping Review

This chapter presents the findings of a scoping review conducted to map existing evidence on the postpartum mental health experiences of Middle Eastern refugee women resettled in high-income host countries. The review aimed to identify key factors influencing these women's postpartum mental and emotional wellbeing during the first year after birth, as well as the barriers they face in seeking maternal mental health care and support. By synthesising current international literature, this chapter provides an overview of the factors shaping postpartum wellbeing within intersecting individual, interpersonal, community, and systemic contexts. The insights gained from this review also inform the subsequent qualitative stage of the study, which explores these issues within the unique context of Aotearoa New Zealand.

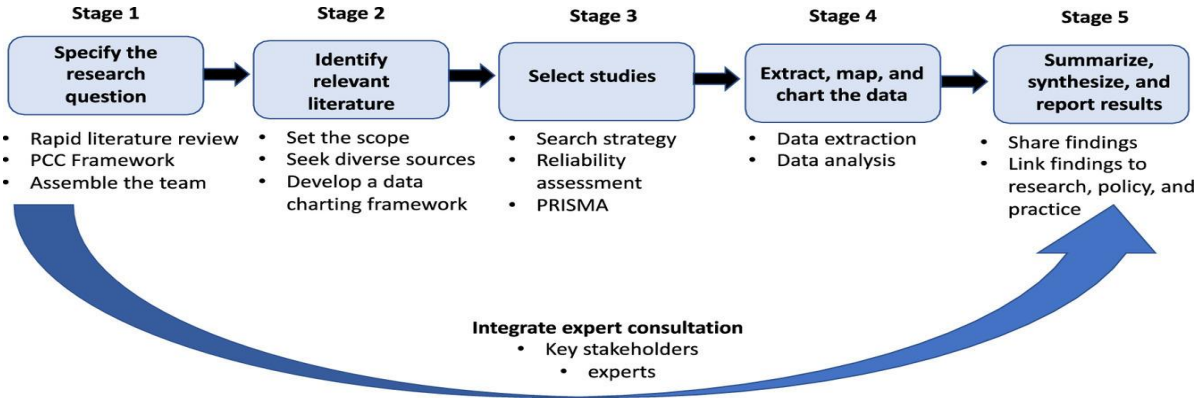
Rationale for Scoping Review

This study adopted a scoping review approach, which is widely recommended for mapping the extent, range, and nature of research activity on the topic of interest (Arksey & O'Malley, 2005). Scoping reviews are particularly useful for investigating broad topics, summarizing existing evidence, and identifying gaps in the literature (Arksey & O'Malley, 2005; Levac et al., 2010). This approach was well suited to the aims of the current study, which sought to examine the existing evidence on postpartum emotional and mental health challenges, and the barriers to help-seeking faced by Middle Eastern refugee mothers resettled in high-income host countries. Given the absence of research in the New Zealand context, the findings of this review will help to identify priority areas for further investigation and will directly inform the development of the subsequent qualitative study.

Scoping Review Framework

This review was conducted using the framework proposed by Arksey and O'Malley (2005) for scoping review studies (Westphaln et al., 2021). This widely used framework consists of six stages as shown in Figure 1: (1) identifying the research question, (2) identifying the relevant literature, (3) selecting studies, (4) data charting, (5) synthesizing and reporting the results, and (6) consultation (Arksey & O'Malley, 2005; Daudt et al., 2013; Levac et al., 2010). Arksey and O'Malley (2005) suggest that the consultation stage is optional and may be included depending on the purpose of the review.

Figure 1: Arksey and O'Malley (2005) framework. Source: Westphaln et al. (2021)



Stakeholder consultation was not undertaken in this review. Instead, the preliminary findings from this review informed the question guide for the subsequent qualitative study that sought to investigate similar issues in the Aotearoa New Zealand context.

Stage 1: The Research Question

According to Arksey and O'Malley (2005), the question for a scoping review should be broad in nature, as the aim is to capture the breadth of evidence available in the literature. This process involves clearly defining the concept, target population, and health outcomes of interest to refine the focus of the review and establish an effective search strategy. In this review, the concept of interest is postpartum emotional and mental health challenges and help-seeking barriers during the first 12 months after birth. The target population is Middle Eastern refugee mothers who have given birth in high-income host countries. The outcomes of interest include the factors that influence postpartum emotional and mental wellbeing, as well as the barriers that affect help-seeking and access to maternal healthcare and mental health support services.

Accordingly, this scoping review was designed to address the following research question: What is known about the postpartum emotional and mental health challenges of Middle Eastern refugee women resettled in high-income countries, and what barriers affect their help-seeking and access to maternal mental health services?

Stage 2: Identify the Relevant Literature

Information Sources and Databases:

The study population of interest was Middle Eastern women who were identified as refugees. Refugees are individuals who have been forcibly displaced due to war, violence, conflict, or persecution and have crossed an international border to seek safety in another country, whereas asylum seekers are individuals who have sought international protection by applying for asylum and are granted refugee status visa (Betts et al., 2013). No restrictions were applied regarding participants' age, specific country of origin within the Middle East, or length of time since resettlement.

The electronic databases searched were PubMed, Scopus, PsycINFO, and the Cochrane Library. In addition, manual searches were conducted using Google Scholar and the Massey University Library to identify additional relevant studies. The search included English-language publications published between 1 January 2000 and 15 July 2025.

Search Terms:

The search strategy was developed in collaboration with my supervisors and a health sciences research librarian. A combination of controlled vocabulary (e.g. MeSH terms) and relevant keywords was used, alongside Boolean operators, to capture a comprehensive range of literature. The core search terms included:
("refugee" OR "forced migrant" OR "forced migration" OR "asylum seeker") AND ("perinatal" OR "postnatal" OR "postpartum") AND ("mental health" OR "depression" OR "anxiety" OR "mental disorder" OR "psychological distress" OR "post-traumatic stress disorder" OR "bipolar" OR "psychosis").

The initial search was intentionally broad to capture all studies involving refugee participants that examined postpartum psychological health, irrespective of country of origin or study setting. In the screening stage, records were refined according to predefined inclusion criteria to identify studies specifically involving refugees from the Middle East and North Africa (MENA) region resettled in high-income countries.

Stage 3: Studies Selection

Inclusion Criteria:

Inclusion criteria were predefined and comprised peer-reviewed studies published in English, conducted in high-income host countries, that examined maternal emotional or mental health and included refugee women from the Middle East and North Africa (MENA) region, including but not limited to Syria, Iraq, Lebanon, Jordan, Egypt, other Arabic-speaking countries, and Iran (StatsNZ, 2024). Both qualitative and quantitative studies were eligible for inclusion.

Search strategy:

All literature identified through the search strategy was uploaded to Covidence, an online review management platform. Article titles and abstracts were screened against the predefined inclusion criteria (see above). Initial screening was conducted independently by two blinded reviewers: I (as the primary researcher) and my primary supervisor (LM). Articles marked as "maybe" were further reviewed and discussed by both reviewers.

Following title and abstract screening, full-text articles of potentially eligible studies were assessed for inclusion. Studies were excluded if they did not address postpartum emotional or mental health, did not focus on Middle Eastern refugee populations, or were review articles, systematic reviews, editorials, commentaries, grey literature, or book chapters. Articles that met the eligibility criteria following full-text assessment were included in the final scoping review and proceeded to data extraction.

Reliability Assessment:

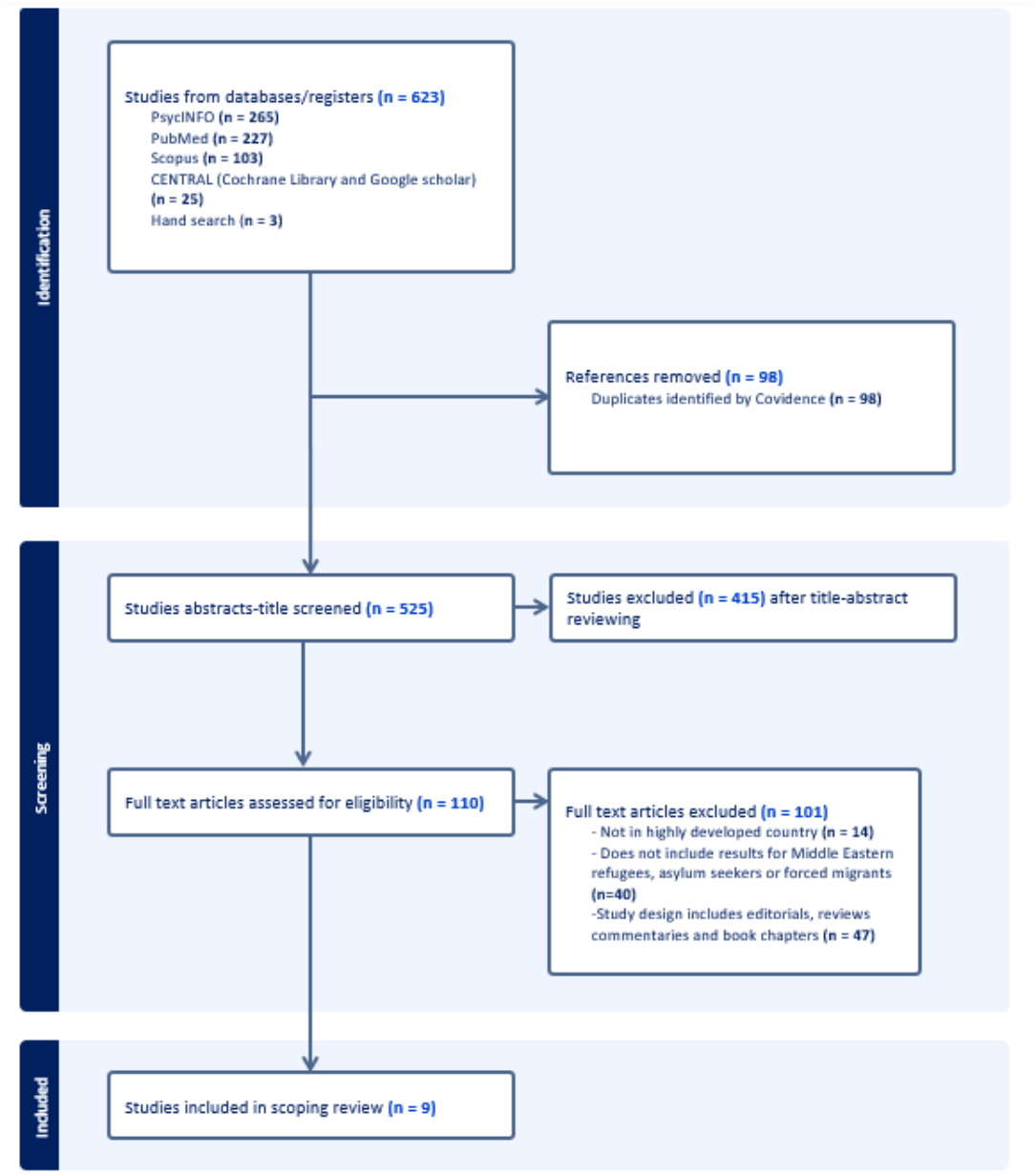
In accordance with the Joanna Briggs Institute (JBI) Manual for Evidence Synthesis critical appraisal is not mandatory for scoping reviews (Peters et al., 2020). As the primary aim of this scoping review was to map the extent and nature of existing evidence rather than to assess the quality or strength of individual studies, no formal quality appraisal was undertaken.

PRISMA:

Figure 2 summarises the findings of the study selection process in a PRISMA flow chart generated using Covidence software. A total of 623 records were retrieved from database

searches, with a further three identified through hand searching. Following the removal of 98 duplicates, 525 records were screened by title and abstract, resulting in 110 full-text articles assessed for eligibility. Of these, 101 were excluded based on country context, population relevance, or study design. Nine studies met the inclusion criteria and were included in the final scoping review.

Figure 2: Covidence PRISMA Flowchart



Stage 4: Charting the Data

Data were extracted using Covidence with a predefined, self-designed data extraction coding template. For all included studies, the following items were extracted: study demographics (author, year, country of study); study aim and design (as stated by the authors); participant characteristics (sample size, number, and ethnicity of Middle Eastern refugees); and study findings and intervention summaries (see Appendix F).

Preliminary synthesis was undertaken by reading the included papers multiple times to extract data relevant to the coding template within Covidence. Data extraction was then completed manually. Extracted data for the nine articles were then exported into MS Excel (see Appendix F). The data were subsequently re-checked and discussed with the supervisors to ensure consistency and a shared understanding. Links between the codes were then developed and categorized into overarching themes.

Stage 5: Collating, Summarising, and Reporting the Results

Study Characteristics:

The scoping review identified nine studies that examined the maternal emotional and mental health experiences of refugee women from the Middle East who resettled in high-income countries, including Australia, Canada, the United States, and Turkey (Table 1). The sample size and composition of Middle Eastern and Arabic refugee participants varied across studies. Some studies exclusively explore postpartum experiences of refugee mothers from the Middle East (Cameron et al., 2022; Salameh et al., 2025; Stirling Cameron et al., 2021), while others include additional data on prenatal mental health, non-refugee participants, or non-Middle Eastern refugee mothers (Ahmed et al., 2017; Alsamman et al., 2025; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Vigod et al., 2017).

All studies identified barriers experienced by refugee mothers from the Middle East which negatively impacted help seeking for postnatal maternal mental healthcare, the efficiency of the provided healthcare and support services, and, in some cases, addressed potential interventions. Two studies specifically investigated how pre-existing challenges faced by Middle Eastern refugee mothers during the postpartum period were intensified by the public health restrictions imposed during the COVID-19 pandemic (Hearn et al., 2024; Stirling Cameron et al., 2021).

Table 1: Scoping Review Studies Summary

Title	Authors	Publishing Date	Study Country	MENA Sample Size (N)	Participants' country of origin
Perceptions and Experiences of Inequity for Women of Refugee Background Having a Baby during the COVID-19 Pandemic in Melbourne, Australia.	Hearn, F., Brown, S. J., Szwarc, J., Toke, S., Alqas Alias, M., Essa, M., ... & Riggs, E.	2024	Australia	8	Syria, Iraq Sudan
"COVID affected us all:" the birth and postnatal health experiences of resettled Syrian refugee women during COVID-19 in Canada.	Stirling Cameron, E., Ramos, H., Aston, M., Kuri, M., & Jackson, L.	2021	Canada	8	Syria
Barriers to postpartum health and opinions on a postpartum peer navigator program amongst refugee women resettled in California.	Alsamman, S., Tadesse, R. T., Sarferaz, K., Mohamed, A. S., & Mody, S. K.	2025	United state	14	Sudan Syria
Refugee women's well-being, needs and challenges: implications for health policymakers.	Qutranji, L., SilahlÄ±, N. Y., Baris, H. E., & Boran, P. E. R. R. A. N.	2020	Turkey	47	Syria
The postnatal experiences of resettled Syrian refugee women: Access to healthcare and social support in Nova Scotia, Canada.	Cameron, E. S., Aston, M., Ramos, H., Kuri, M., & Jackson, L.	2022	Canada	11	Syria
Maternal stressors and maternal bonding among immigrant and Refugee Arab Americans resettled in the United States.	Khalil, D., George, Z., Dannawey, E., Hijawi, J., ElFishawy, S., & Jenuwine, E.	2024	United state	44	Syria, Palestine Lebanon Yemen Iraq
Postpartum mental health of immigrant mothers by region of origin, time since immigration, and refugee status: a population-based study	Vigod, S. N., Bagadia, A. J., Hussain-Shamsy, N., Fung, K., Sultana, A., & Dennis, C. L. E.	2017	Canada	3,588	From all Middle Eastern and North Africa (MENA)-Arabs
Maternal depression in Syrian refugee women recently moved to Canada: A preliminary study	Ahmed, A., Bowen, A., & Feng, C. X.	2017	Canada	12	Syria
Syrian refugee women's experiences of barriers to mental health services for postpartum depression	Salameh, T. N., Sakarya, S., Acarturk, C., Hall, L. A., Alâ Modallal, H., & Jakalat, S. S.	2025	Turkey	15	Syria

Regarding studies design, four studies employed qualitative methods for data collection, such as individual semi-structured interviews and focus groups. Three studies adopted a mixed-methods approach, combining qualitative data with quantitative measures obtained through questionnaires or administrative databases (Ahmed et al., 2017; Qutranji et al., 2020; Salameh et al., 2025). One study utilized a population-based cohort design (Vigod et al., 2017), while Khalil et al. (2024) applied a cross-sectional design (Appendix F).

Thematic Synthesis of Findings

In this scoping review, data were analysed using a descriptive thematic analysis approach (Graneheim et al., 2017). Findings from the included studies were compared to identify recurring phenomena and grouped inductively into broad categories. This process generated themes describing factors influencing postpartum emotional and mental health among Middle Eastern refugee women, including social isolation, language barriers, systemic barriers, cultural beliefs and stigma, and reported interventions and recommendations.

For structured presentation, these themes were mapped onto the socio-ecological framework, which conceptualises health as shaped by interacting factors at individual, interpersonal, community, and health system or societal levels. The framework served as an organising lens rather than an analytic tool to illustrate how multilevel barriers influence postpartum mental health and help-seeking. This inductive analysis aimed to summarise existing evidence without engaging in interpretive synthesis or theory generation, consistent with the scope of a scoping review (Elo & Kyngäs, 2008; Graneheim et al., 2017).

Individual barriers

Lack of Health Literacy:

The included studies indicated that many Middle Eastern refugee women have low educational attainment and limited health literacy, affecting their ability to understand postpartum information and follow care plans (Salameh et al., 2025; Khalil et al., 2024; Qutranji et al., 2020). In the United State study, nearly half of the participants had not completed high school and 83% were unemployed, reflecting significant socioeconomic disadvantage (Khalil et al., 2024). Similarly, in Turkey studies, Syrian refugee women reported a median of six years of schooling and high unemployment, limiting autonomy and navigation of health services (Qutranji et al., 2020).

Limited awareness of postpartum depression (PPD), difficulty recognising symptoms, and uncertainty about treatment were also reported, contributing to delayed help-seeking (Khalil et al., 2024; Salameh et al., 2025). Middle Eastern refugee mothers in California described receiving inadequate or unclear postpartum information and often relied on informal sources, including family, friends, or online materials in their native language, sometimes leading to misinformation (Salameh et al., 2025).

Limited Knowledge of Maternal Care Services:

Many Middle Eastern refugee women reported not knowing where to go or how to book and attend postpartum or mental health appointments, particularly soon after arrival (Cameron et al., 2022; Qutranji et al., 2020). This gap spanned the maternity pathway and included confusion about booking systems, clinic locations, interpreter access, costs, documentation, referrals, and when symptoms required urgent care (Cameron et al., 2022). Due to language barriers, many relied on informal networks for guidance, which sometimes led to misinformation, missed appointments, or delayed care (Alsamman et al., 2025; Cameron et al., 2022; Qutranji et al., 2020).

The gap widened during COVID-19, when services shifted to telehealth, home visits were suspended, and visitor rules changed without clear, language-concordant communication (Stirling Cameron et al., 2021). Inconsistent information and limited translated materials further increased confusion, isolation, and disconnection from the health system (Hearn et al., 2024).

Language and Interpreter-Related Challenges:

Across studies conducted in Australia, Canada, Turkey, and the United States, language barriers were consistently identified as a primary obstacle for Middle Eastern refugee women during the postpartum period (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021; Vigod et al., 2017). In Canadian and Turkish studies, women were described as having limited host-country language proficiency and relying heavily on interpreters (Ahmed et al., 2017; Qutranji et al., 2020). Research from Canada and Turkey further reported that interpreter services were often difficult to organise and inconsistent,

particularly during sensitive discussions (Cameron et al., 2022; Salameh et al., 2025) (Cameron et al., 2022; Salameh et al., 2025). In the Australian context, Hearn et al. (2024) noted challenges related to telephone-based interpretation, including delays and dialect mismatches.

During the COVID-19 pandemic, studies from Australia and Canada reported that the transition of postpartum services to telehealth added further complexity to interpreter use, particularly when interpretation was conducted by telephone only (Cameron et al., 2022; Hearn et al., 2024). In related findings, research undertaken in Canada, the United States, and Turkey described ongoing delays in securing interpreters and discomfort with male interpreters, which were reported as affecting women's willingness to discuss sensitive concerns (Alsamman et al., 2025; Cameron et al., 2022; Salameh et al., 2025). Across several studies, especially those from Canada and the United States, women indicated a preference for female and culturally trained interpreters to enable more open communication (Alsamman et al., 2025; Cameron et al., 2022; Stirling Cameron et al., 2021). Overall, the evidence from these national contexts suggests that interpreter-related challenges influence women's experiences of postpartum and mental health care (Alsamman et al., 2025; Cameron et al., 2022).

Interpersonal Barriers:

Social Isolation:

Social isolation was a recurrent theme across studies conducted in Australia, Canada, Turkey, and the United States, reflecting the loss of traditional postpartum support systems following resettlement (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021). Participants commonly described separation from extended family members, particularly mothers, sisters, and aunts, who would traditionally provide childcare, meals, and emotional care. This disruption of cultural postpartum practices was associated with loneliness, exhaustion, and emotional distress (Ahmed et al., 2017; Cameron et al., 2022). Women frequently described early motherhood in a new country as overwhelming and lacking culturally familiar guidance (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021).

Some women reported forming informal “chosen family” networks with friends, neighbours, or other refugee families, which provided emotional reassurance and occasional practical support. However, hesitation to seek help was also described, as many feared burdening others facing similar resettlement challenges (Alsamman et al., 2025; Qutranji et al., 2020; Stirling Cameron et al., 2021).

Studies from Australia and Canada further reported that social isolation intensified during the COVID-19 pandemic (Hearn et al., 2024; Stirling Cameron et al., 2021). Both Hearn et al. (2024) and Stirling Cameron et al. (2021) emphasised that during national or global crises, resettled Middle Eastern refugee women face greater risks of negative postpartum mental health outcomes than non-refugee women. These risks arise from compounding factors such as prolonged isolation, lack of culturally familiar support, and reduced access to in-person health services, conditions that reinforce and widen existing health inequities for marginalised populations (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021).

Cultural Barriers

Social Influence and Stigma:

Stigma around mental health was reported across Middle Eastern individual, familial, and community levels in studies conducted in Canada, Turkey, the United States, and Australia, which found related to the reluctance to seek professional support (Ahmed et al., 2017; Qutranji et al., 2020; Salameh et al., 2025; Vigod et al., 2017)., Middle Eastern Refugee women describing shame, fear of being labelled “mentally unstable,” and concerns about damaging family reputation if raised their need to mentalhealth support(Ahmed et al., 2017; Alsamman et al., 2025; Hearn et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Vigod et al., 2017).

Studies from the United States and Canada further describe persistent fears among Middle Eastern refugee women that seeking mental health support could result in family rupture or other negative consequences. These fears contributed to some women concealing their symptoms during health assessments (Alsamman et al., 2025; Ahmed et al., 2017; Cameron

et al., 2022). For example Middle Eastern refugee women in the United States often avoided counselling or psychiatric care despite experiencing depressive symptoms due to fear of being judged incapable of caring for their children (Alsamman et al., 2025). Some other women expressed distrust toward the healthcare system, believing that disclosure of mental health concerns could lead to intervention from child protection services or even loss of custody. Similarly, Ahmed et al. (2017) and Cameron et al. (2022) noted that many Syrian refugee women deliberately concealed symptoms of distress during health assessments to avoid such scrutiny.

These cultural and structural fears often led to significant delays in seeking help or complete avoidance of mental health services, even among women showing severe depressive or anxiety symptoms (Ahmed et al., 2017; Alsamman et al., 2025). In several studies, religious interpretations of mental illness played a role in shaping these attitudes. For example, some women attributed emotional suffering to weakness of faith or inadequate prayer, viewing spiritual devotion as the appropriate remedy rather than professional care. Thus, emotional distress was normalised as part of motherhood, rather than recognised as a legitimate health concern warranting intervention (Ahmed et al., 2017; Alsamman et al., 2025; Khalil et al., 2024; Qutranji et al., 2020).

Another key factor reinforcing stigma was privacy and confidentiality concerns, particularly related to the use of interpreters from the same ethnic or linguistic community. Both Ahmed et al. (2017) and Salameh et al. (2025) reported that women feared their private experiences might be disclosed to others in their community if discussed in the presence of interpreters from same ethnicity. The combination of internalised shame, spiritual interpretations of suffering, and privacy concerns creates a powerful barrier to early identification and intervention (Ahmed et al., 2017; Alsamman et al., 2025). Overall, stigma, cultural norms, and fear of social or institutional repercussions were described as shaping women's postpartum mental health experiences and service use (Ahmed et al., 2017; Alsamman et al., 2025; Hearn et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Vigod et al., 2017).

Systemic Barriers

Complex Healthcare Systems:

Complex healthcare systems were described as a significant barrier across studies conducted in Australia, Canada, Turkey, and the United States (Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Qutranji et al., 2020; Stirling Cameron et al., 2021). Across these studies, Women reported that inflexible service structures, limited language proficiency, and lack of social support made navigating maternity and mental health services challenging, including locating providers, booking appointments, and understanding referral pathways.

In the United States, Middle Eastern refugee women reported unclear care pathways, technological barriers, and complex administrative procedures as obstacles to postpartum mental health access (Alsamman et al., 2025). Middle Eastern refugee women in this study also perceived the Western biomedical model of care as rigid and overly complex, often describing it as misaligned with their cultural values and expectations. Consequently, many women minimised or normalised their postpartum emotional struggles, rationalising that seeking care from a system they viewed as unhelpful or impersonal would be futile.

Hearn et al. (2024) noted in their study that even when midwives, nurses, or general practitioners observed potential signs of distress, referral pathways in Australia to mental health services were often unclear, and follow-up procedures were poorly defined, particularly for women with limited health literacy or language barriers.

In the same vein, Salameh et al. (2025) highlighted that the routine postpartum depression (PPD) screening in Turkey was reported as inconsistent and opportunistic, with substantial variation across clinical settings and providers. Similarly in Canada, some participants in Ahmed et al. (2017) and Vigod et al. (2017) study's noted that mental health questions, when asked, felt rushed or superficial, with little opportunity to elaborate due to short appointment times, limited interpreter availability, or the presence of other family members. They also emphasised that in hospital and maternity settings, screening tools were not always culturally adapted or linguistically validated, resulting in under-recognition of depressive symptoms or misinterpretation of culturally normative expressions of distress (Ahmed et al., 2017; Vigod et al., 2017). In several instances, clinicians relied on informal observation rather than standardised instruments, further reducing diagnostic accuracy.

Middle Eastern refugee women in Turkey and Canada consistently perceived postnatal services as baby-centred rather than mother-centred, with clinical encounters focusing primarily on infant feeding, immunisation, and growth tracking, rather than the mother's emotional wellbeing (Cameron et al., 2022; Salameh et al., 2025). Moreover, Cameron et al. (2022) and Hearn et al. (2024) addressed that in Canada and Australia, once formal maternity care ended, typically around six weeks postpartum, women often lost contact with healthcare providers, leaving them unsupported during the subsequent months when the risk of postpartum depression peaks. These systemic discontinuities, combined with structural inequities and a lack of culturally responsive care, perpetuate gaps in detection, follow-up, and treatment of postpartum mental health issues among Middle Eastern refugee women.

Inequity*:*

Across multiple studies in Australia, Canada, and Turkey, Middle Eastern refugee women frequently described being perceived as "outsiders" or "strangers" within host-country healthcare systems, a perception that was both socially and institutionally reinforced (Ahmed et al., 2017; Cameron et al., 2022; Salameh et al., 2025). Many women described feeling marginalised due to their legal status as refugees or their visible religious identity, particularly Muslim women who wore the hijab (Ahmed et al., 2017; Cameron et al., 2022). From their perspectives, these visible markers of identity often triggered implicit bias and stereotyping by healthcare professionals, leading them to feel perceived as culturally "incompatible" or "too different." Such experiences contributed to feelings of dismissal and, at times, paternalistic treatment within healthcare settings (Ahmed et al., 2017; Cameron et al., 2022; Hearn et al., 2024; Salameh et al., 2025; Vigod et al., 2017).

This was emphasised by Vigod et al. (2017) who found that refugee women in Canada, including Middle Eastern refugees, were significantly more likely to experience acute mental health issues leading to emergency department visits than non-refugee women. This pattern suggested a systemic failure of equal and inclusive outpatient and preventive care, which often overlooked the trauma histories and contextual vulnerabilities of refugee populations (Vigod et al., 2017).

Furthermore, Cameron et al. (2022) found that perceived and experienced discrimination directly contributed to poorer postpartum health outcomes among Syrian refugee women in Canada. Compared with Canadian-born women, these refugees were more likely to report inequitable access to care, limited awareness of available mental health services, and a lack of culturally appropriate supports during the postpartum period.

Cultural incompetence of healthcare providers was a recurring dimension of this inequity across multiple studies in Australia, Canada, and Turkey (Ahmed et al., 2017; Cameron et al., 2022; Hearn et al., 2024; Salameh et al., 2025; Vigod et al., 2017). Providers' lack of cultural sensitivity contributed to power imbalances, leaving women feeling dismissed or misunderstood. In Canada and Turkey, Middle Eastern refugees women expressed deep distrust toward the Western healthcare model, fearing that clinicians might overreact, misinterpret culturally bound expressions of distress, or impose unwanted medical interventions (Ahmed et al., 2017; Cameron et al., 2022; Hearn et al., 2024; Salameh et al., 2025)

The intensity of these inequities was more evident during the COVID-19 pandemic. For example in Australia and Canada, the rapid policy shifts and the transition to virtual healthcare, including "one-size-fits-all" restrictions on support persons and interpreter services, disproportionately affected Middle Eastern refugee women with limited English proficiency. (Hearn et al., 2024; Stirling Cameron et al., 2021). Hearn et al. (2024) emphasised that such restrictions reinforced existing inequities, making refugee women feel invisible and disempowered within healthcare systems.

The failure to provide accessible and gender-appropriate interpreter services in Canada and Turkey was also described as a form of systemic discrimination, leaving Middle Eastern refugee mothers hesitant to discuss intimate concerns and vulnerable to misunderstanding, misdiagnosis, and inadequate support (Ahmed et al., 2017; Cameron et al., 2022; Salameh et al., 2025).

Collectively, a dominant Western-centric, one-size-fits-all health system design was described as contributing to culturally unresponsive maternal mental health care for Middle Eastern refugee women, intersecting with persistent discrimination and linguistically limited services,

and reinforcing exclusion and emotional vulnerability within this population (Ahmed et al., 2017; Cameron et al., 2022; Hearn et al., 2024; Salameh et al., 2025).

Socioeconomic Determinants:

Socioeconomic disadvantage emerged as a significant determinant influencing help-seeking behaviours and access to postpartum mental health services among Middle Eastern refugee women in Australia, Canada, Turkey and United state (Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Vigod et al., 2017). These studies reported that financial hardship, unemployment, transportation, lack of childcare subsidies, and unstable housing collectively constrained women's ability to engage with and sustain participation in mental health or social support programs.

In Turkey, Middle Eastern refugees women identified financial hardship as a direct obstacle to accessing mental health care that forced them to choose between essential needs and healthcare costs (Qutranji et al., 2020; Salameh et al., 2025). This was similarly addressed by Middle Eastern refugees in Canada and the United States as employment discrimination and systemic exclusion from the labour market further intensified the financial hardship of refugee families, intensifying distress and increasing the risk of depressive symptoms for mothers of affected families (Cameron et al., 2022; Khalil et al., 2024; Vigod et al., 2017)

Hearn et al. (2024) further reported that socioeconomic inequities intensified during the COVID-19 pandemic, as lockdowns disrupted employment, limited access to welfare supports, and increased household stress. Overall, findings across the included studies indicate that socioeconomic marginalisation, manifesting through poverty, unemployment, housing instability, and caregiving burdens, was a compounding barrier to mental health care engagement among Middle Eastern refugee women (Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025).

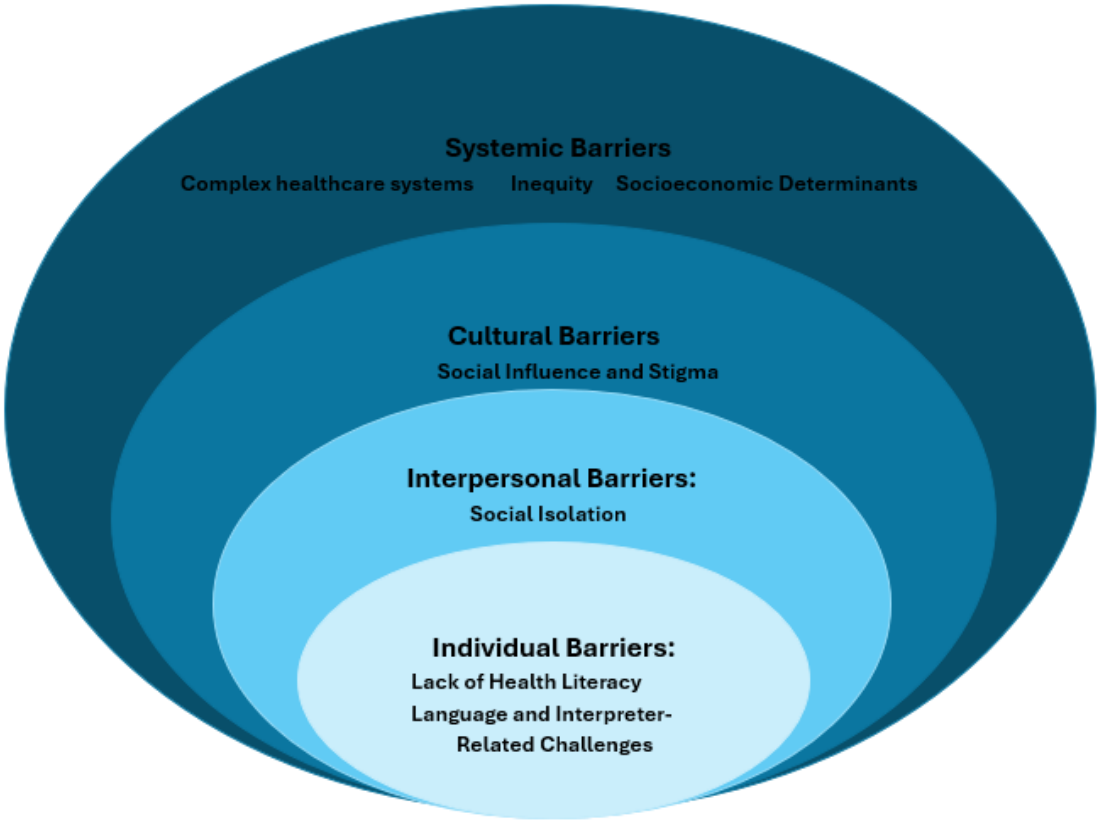
Discussion

This scoping review presented the existing literature on postpartum mental health experiences among Middle Eastern refugee women resettled in high-income host countries. The included studies represented women from diverse Middle Eastern and North African backgrounds,

including Syrian, Sudanese, Palestinian, Iraqi, Assyrian, Lebanese, Yemeni, and other Arab communities, with Syrian refugee women most frequently represented.

The review highlights a range of reported barriers to help-seeking and access to maternal mental health care. Across the included studies, four broad themes were identified, reflecting barriers operating at different socio-ecological levels: individual-level barriers, interpersonal barriers, cultural barriers, and systemic barriers (Figure 3). These themes suggest that barriers to postpartum mental health support are shaped by interacting influences across individual, interpersonal, community, and systemic contexts (McLeroy et al., 1988; Mecano, 2016).

Figure 3: Socio-Ecological Diagram of Help-Seeking Barriers Among Middle Eastern Refugee Women in High Income countries. Adapted from McLeroy et al. (1988)



Individual Barriers:

The reviewed studies suggest that Middle Eastern refugee women may experience limited health literacy and insufficient awareness of available postpartum healthcare and support services in resettlement contexts, which can contribute to difficulties navigating unfamiliar health systems (Alsamman et al., 2025; Khalil et al., 2024; Qutranji et al., 2020). This finding

indicates that lower health literacy among refugee women is associated with delayed help-seeking and poorer postpartum mental health outcomes (Brannelly et al., 2024; Cassim, Kidd, et al., 2022; McKeary & Newbold, 2010; Sherif et al., 2022; Shrestha-Ranjit et al., 2020).

The review reported language barriers as a significant challenge during the postpartum period, limiting women's understanding of health information and their ability to communicate effectively with healthcare providers (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021; Vigod et al., 2017). Communication difficulties, compounded by negative experiences with interpreter services, including reliance on telephone interpreting, mismatched dialects, and the use of male interpreters, also constrained Middle Eastern refugee women's ability to disclose sensitive symptoms of depression, anxiety, or trauma-related distress, potentially contributing to delays in recognising and addressing postpartum mental health concerns (Ahmed et al., 2017; Cameron et al., 2022; Hearn et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021).

Language difficulties and the provision of health information in unfamiliar or inaccessible formats are considered persistent barriers to timely and appropriate postpartum mental health care (Brannelly et al., 2024; Cassim, Kidd, et al., 2022; McKeary & Newbold, 2010; Sherif et al., 2022; Shrestha-Ranjit et al., 2020). Limited health literacy, when combined with low digital literacy, may further reduce refugee women's capacity to access online health information and services (Floyd & Sakellariou, 2017)

Interpersonal Barriers:

The scoping review also highlighted the substantial role of social isolation and the loss of traditional family support, which are central interpersonal determinants of postpartum wellbeing for many Middle Eastern mothers (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021). In many Middle Eastern countries, extended family networks play a key role in providing emotional support and shared caregiving during the postpartum period. The absence of these networks following resettlement was frequently associated with emotional exhaustion, loneliness, and increased symptoms of anxiety or

depression (Ahmed et al., 2017; Alsamman et al., 2025; Khalil et al., 2024; Salameh et al., 2025).

Similar patterns have been reported in the wider literature on refugee mothers, which emphasises that refugee mothers often experience reduced social networks, limited connection with co-ethnic communities, and fewer opportunities for informal support in host countries (Firth et al., 2022; Merry et al., 2021; O'Mahony et al., 2012; O'Mahony, 2011). Notably, the scoping review further suggests that these challenges may be intensified during public health crises due to restrictive policies, such as COVID-19 lockdown measures (Hearn et al., 2024; Stirling Cameron et al., 2021).

Cultural Barriers:

The scoping review further reported that social and cultural beliefs, stigma, and privacy concerns were prominent influences discouraging open discussion of emotional difficulties, delaying engagement with mental health support, and shaping Middle Eastern refugee women's help-seeking behaviours (Ahmed et al., 2017; Cameron et al., 2022; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021; Vigod et al., 2017). Several studies exploring help-seeking barriers among refugee women similarly highlighted that stigma within some refugee communities may normalise postpartum suffering, discourage emotional expression, and limit open conversations about mental health (Almeida et al., 2016; Kanengoni-Nyatara et al., 2024; Sherif et al., 2022).

The review also explained that privacy concerns emerged as a barrier to help-seeking, particularly when disclosing sensitive or mental health–related concerns involved interpreters from the same cultural, family, or community background (Alsamman et al., 2025). Reliance on family members, friends, or community-based interpreters was found to raise concerns among refugee women more broadly regarding confidentiality, accuracy, and comfort in sharing personal information (Boyle et al., 2019; Shrestha-Ranjit et al., 2020). Thus, stigma and privacy concerns operate not only at the individual level but are reinforced through broader cultural norms and community expectations.

Systemic Barriers:

Finally, at the systemic level, the scoping review reported that Western biomedical healthcare models in high-income countries were frequently described as lacking the cultural responsiveness, continuity of care, and structural supports required to adequately meet the needs of Middle Eastern refugee women (Alsamman et al., 2025; Boyle et al., 2019; Cameron et al., 2022; Hearn et al., 2024; O'Mahony et al., 2012; Sherif et al., 2022). Middle Eastern refugee women reported difficulties navigating inflexible and complex healthcare systems, and standardised postpartum mental health screening tools were often described as culturally or linguistically inappropriate (Alsamman et al., 2025; Cameron et al., 2022; Qutranji et al., 2020; Salameh et al., 2025; Vigod et al., 2017). The review further suggested that during public health crises, such as COVID-19, existing inequities may have been exacerbated by "one-size-fits-all" approaches that did not adequately consider Middle Eastern refugee women's needs and barriers (Hearn et al., 2024; Stirling Cameron et al., 2021).

The scoping review also highlighted the intersection between systemic barriers and socioeconomic disadvantage. Studies reported that economic hardship, unemployment, transport constraints, and unstable housing collectively compounding existing vulnerabilities Middle Eastern refugee women's, and limited their ability to access, engage with, and sustain postpartum mental health care (Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025).

Consistent with these findings, broader research on diverse refugee populations has identified complex Western healthcare systems as a significant resettlement challenge contributing to prolonged maternal mental and emotional suffering (Hearn et al., 2023; Murray et al., 2022; Rodríguez-Muñoz & Chrzan-Dętkoś, 2025; Tahir et al., 2022). Reliance on screening tools that are not translated or transculturally validated, together with limited availability of culturally competent and trauma-informed services, may reduce opportunities for early identification and support, particularly when healthcare providers feel underprepared to address trauma histories and migration-related stressors (Roia A & Barber B, 2025; Verschuuren et al., 2025; Willey et al., 2024). Moreover, inequitable access to financial and social supports further shapes engagement with and continuity of postpartum care among refugee women from lower socioeconomic contexts (Hawkins et al., 2021; Heer et al., 2024).

Interventions and Recommendations

The literature review highlighted several interventions to address postnatal mental health needs among Middle Eastern refugee mothers who resettled in developed countries. The review found that the available interpreter services and female health providers play an essential role in overcoming language barriers, though the presence of interpreters from the same community sometimes discouraged disclosure due to privacy concerns. Therefore, there was a consistent recommendation across all studies for culturally and linguistically appropriate support through the use of trained interpreters with confidentiality assurances and, where possible, bilingual healthcare providers to foster trust and engagement (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021; Vigod et al., 2017).

Another set of interventions focused on cultural competence in the healthcare system. Integrating culturally tailored healthcare services through peer navigators, culturally competent health workers, and Arabic-language health information resources were suggested as a way to bridge gaps between Middle Eastern refugee mothers and health service (Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Vigod et al., 2017). Group-based supports, such as educational sessions for women and peer support circles delivered in Arabic, were also recommended to reduce stigma and build social connections (Khalil et al., 2024).

Early identification and fast referral pathways were identified as potential ways to overcome some of the aforementioned barriers. This would involve implementing and prioritising routine screening for depression for refugees mothers, using validated tools in Arabic and other relevant languages both during pregnancy and after birth to ensure timely detection of distress and linkage to care (Ahmed et al., 2017; Stirling Cameron et al., 2021). Addressing practical barriers such as transport, childcare, and financial limitations was also noted as necessary to improve uptake of mental health services (Alsamman et al., 2025; Salameh et al., 2025).

In addition, several studies highlighted the need to strengthen outpatient and community-based supports to prevent escalation of untreated depression into emergency or inpatient care (Vigod et al., 2017). Ensuring home visits by public health nurses, particularly for newly

arrived refugee mothers, and prioritising refugee women for follow-up care were described as effective strategies (Cameron et al., 2022; Vigod et al., 2017). Overall, the evidence from the literature review underscores the value of culturally safe, language-concordant, community-embedded supports, alongside systematic screening and tailored follow-up, as key approaches to improving postnatal mental health outcomes among refugee women.

Implications For the Next Qualitative stage of this Study

The review highlights persistent challenges such as language barriers, social isolation, stigma, and difficulties navigating unfamiliar health systems. Therefore, improving maternal mental-health outcomes for refugee women requires approaches that are culturally responsive, trauma-informed, and grounded in women lived realities. These insights reinforce the need for deeper, context-specific exploration to understand how such barriers are experienced within different health and settlement environments (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021; Vigod et al., 2017).

In Aotearoa New Zealand, refugees have access to publicly funded healthcare, interpreter services, and government-supported settlement programmes; however, there is little research examining whether these provisions effectively support postpartum mental health for Middle Eastern women (Cassim, Ali, et al., 2022; Mortensen, 2011; Reem Abbas, 2022). Because most existing evidence is drawn from overseas contexts with different postpartum maternity service structures, it cannot be assumed that international findings fully reflect the New Zealand experience (Table 2).

For this reason, the next stage of this study will explore the perspectives of Middle Eastern refugee women resettled in Aotearoa New Zealand. The aim is to examine whether known barriers are reproduced or transformed in the Aotearoa New Zealand context, and to identify any help-seek challenges unique to the New Zealand postpartum maternity system. Generating this knowledge is essential for informing culturally safe, equitable, and context-appropriate maternal mental-health support that meets the needs of refugee mothers in New Zealand.

Table 2. Comparison of Postpartum Maternity Care Structures Across High Income Countries

Country	*Postpartum Care Model*	*Funding & Cost to Patients*	*Service Scope and Duration*
United States (USA)*	Postpartum care typically physician-led, with one follow-up visit around 6 weeks after birth: limited community or home-based support.	Coverage varies by insurance; Medicaid covers 60 days postpartum for low-income women; private insurance terms differ.	Hospital discharge usually within 24–48 hours; limited structured home-visiting or midwifery support; mental-health screening inconsistent.
Canada*	Midwife- or physician-led postnatal care depending on province; strong home-visit framework for midwifery clients.	Fully publicly funded under provincial health insurance; no cost for essential postpartum services.	Home or clinic visits for up to 6 weeks; newborn checks, breastfeeding support, and mental-health screening included.
Australia*	Public system provides midwife-led follow-up through hospitals and community health services, shared care with GPs.	Covered by Medicare; small or no co-payments for public services; private options available.	Routine home or clinic visits by midwives or child-health nurses for up to 6 weeks; extended support via parenting centres.
Turkey**	Family-health-centre model under Ministry of Health; nurses and family doctors provide home visits.	Free under the General Health Insurance (GHI) scheme; fully state funded.	At least two home visits in first 15 days; follow-ups on maternal recovery, infant care, and vaccination; public-health focus.
New Zealand***	Midwife-led continuity of care through Lead Maternity Carer (LMC) system; transition to Plunket/Well Child services after 4–6 weeks.	Entirely publicly funded; no charge for maternity or postnatal services for eligible women.	Regular home or clinic visits until 6 weeks postpartum; ongoing Well Child follow-ups to age 5; mental-health screening and lactation support integrated.

(Cheng et al., 2006; Saldanha et al., 2023), **(Dol et al., 2022), ***(Brodribb et al., 2016), *(Turan & Derya, 2021), *****(Dawson et al., 2021; MOH, 2021; Roia A & Barber B, 2025)**

Limitations and Conclusion

This scoping review demonstrates that Middle Eastern refugee women face a constellation of barriers to recognising, disclosing, and seeking support for postpartum mental health concerns. These barriers are shaped by intersecting individual, interpersonal, cultural, and systemic influences that collectively constrain Middle Eastern refugee women's access to appropriate and timely care in high-income host countries. However, several limitations of the review must be acknowledged.

The included studies featured women from a variety of Middle Eastern backgrounds; however, Syrian refugees were heavily over-represented, which may limit the transferability of findings to other Middle Eastern subgroups with differing cultural norms, migration trajectories, and resettlement experiences. Also, most of the included literature focused predominantly on postpartum depression, giving comparatively limited attention to the broader emotional and mental wellbeing during postpartum period, resulting in a narrower

conceptualisation of postpartum mental health. Finally, the review included only peer-reviewed studies published in English, excluding research in other languages that may have provided additional cultural perspectives or community-based insights.

Despite these limitations, the review provides important evidence that Middle Eastern refugee women continue to encounter substantial and multi-layered barriers to postpartum mental-health support. While the international literature offers valuable insights, the absence of research from New Zealand highlights a significant gap in knowledge. New Zealand shares several similarities with other high-income countries in its maternal healthcare framework; however, it remains unclear how such similarities and differences influence refugee women's postpartum mental-health experiences in practice. The findings of this review therefore reinforce the need for the next stage of this research, which will explore the lived experiences of Middle Eastern refugee women in New Zealand. Generating this local, context-specific evidence is essential for informing culturally responsive, trauma-informed, and equitable maternal mental-health services that reflect the needs, values, and realities of refugee mothers in Aotearoa New Zealand. The following chapter outlines the methodological framework and research design for the qualitative study.

Chapter Three: Qualitative Study Methodology

This study is grounded in a constructivist paradigm (Mann & MacLeod, 2015) and is guided by the Socio-Ecological Model of health (McLeroy et al., 1988), which together provided the conceptual foundation for the chosen research design and analytical approach. This chapter outlines the research design and methods used to explore the postpartum mental health experiences of Middle Eastern refugee women in Aotearoa New Zealand. The chapter explains the procedures followed for participant recruitment, data collection, and analysis, and describes the ethical considerations and strategies used to ensure rigour, credibility, and trustworthiness throughout the research process.

Study Design

This study employed a qualitative research design, to explore participants' lived experiences and perspectives in depth (Austin & Sutton, 2014; Renjith et al., 2021). Qualitative approaches are particularly valuable for capturing rich, contextualised accounts in participants own words, enabling a deeper understanding of complex and sensitive topics (Adeoye-Olatunde & Olenik, 2021; Austin & Sutton, 2014; Renjith et al., 2021).

Semi-structured interviews were selected for data collection because they are a widely used and well-established approach that enables open-ended responses and two-way communication, allowing for both depth and richness in the data collected (Adams, 2015; Adeoye-Olatunde & Olenik, 2021; Evans & Lewis, 2018). This stage was informed by the findings of the scoping review, which identified what is known globally, while the interviews generated new, context-specific insights into the experiences of refugee and asylum-seeking mothers in New Zealand.

By asking the "what" and "how" questions of the phenomenon, the study sought to explore postpartum emotional and mental health experience among Middle Eastern refugee mothers in New Zealand and how such experiences were shaped by cultural, social, and systemic contexts. It examined barriers to help-seeking, interactions with maternity healthcare providers, and participants' recommendations for strengthening culturally responsive and accessible support within the New Zealand context. This orientation recognises the existence

of multiple and varied realities, privileging participants' voices and situating their experiences within their own lived environments (Adams, 2015; Evans & Lewis, 2018).

Ethical Considerations for The Qualitative Study

Ethical approval for the qualitative study was obtained from the Massey University Human Ethics Committee (OM1 25/17) (See Appendix A), in accordance with the Massey University Code of Ethical Conduct for Research, Teaching, and Evaluation Involving Human Participants (Massey, 2017).

Conducting research with refugee women required careful attention to ethical principles, particularly respect for participants' cultures, minimising harm, and balancing benefits and risks (Kolarcik et al., 2022; Munford et al., 2008). Working with vulnerable populations requires researchers to be knowledgeable about the community, anticipate recruitment and retention issues, develop strategies for addressing research-related challenges, and draw on relevant evidence from previous studies (Beattie & VandenBosch, 2007; Harley & Wazefadost, 2023).

My own personal and professional background supported the ethical integrity of this study (Harley & Wazefadost, 2023). I am from Jordan in the Middle East, where I worked as a dentist and treated many refugees from Syria, Iraq, Palestine, and Yemen. In my current work in Aotearoa New Zealand as a Middle Eastern community health promoter, I continue to support this population and have developed detailed knowledge of their cultural values, beliefs, and health needs, as well as the barriers they face in engaging with health services.

To ensure that safe and supportive spaces were established for participants, the Harley and Wazefadost (2023) guidelines for co-produced research with refugees and other people with lived experience of displacement were reviewed and adopted, and additional input was sought from an expert advisory group. The advisory group meeting was held on 30 July 2025 to inform the participant engagement strategy. The group included Dr Bronwyn Sweeney, clinical psychologist and honorary research associate at the sleep/wake research centre; Dr Yara Jarallah, senior lecturer in population studies at the university of Waikato; and Jannine Nock, manager of migrant wellbeing at refugee trauma recovery, New Zealand red cross.

The discussion focused on strategies to build trust and encourage participation among Middle Eastern refugee mothers, and potential challenges where the interviewer shares a Middle Eastern background. The group provided valuable guidance on approaching mental health discussions in a culturally sensitive and broad manner, recommending the use of terms such as “emotional challenges” rather than “mental health issues” to reduce stigma. They emphasised the importance of broadening the focus beyond postpartum depression to include anxiety and trauma, and ensuring emotional safety through flexible pacing, culturally responsive communication, and clear referral pathways. Their input significantly shaped the interview approach and question guide, which is discussed further later in this chapter.

Their expertise was instrumental in anticipating potential ethical risks, particularly the likelihood that discussions of sensitive emotional topics could evoke distressing memories or trigger difficult emotions for participants (NEAC, 2019). These processes ensured the study not only minimised potential harm but also to fostered an environment of trust, respect, and cultural safety, enabling participants to share their experiences with confidence and dignity (Harley & Wazefadost, 2023; NEAC, 2019).

Before any interviews were conducted, it was ensured that participants understood their participation was entirely voluntary. They were informed that withdrawal was possible during the interview or up to two weeks afterwards. It was clearly explained that no obligation existed to answer any questions they found uncomfortable and that breaks could be requested at any time during the interview. To further safeguard their wellbeing, contact information for counselling services was provided in the information sheet (Appendix B) and confirmed verbally before each interview, so participants were aware of where support could be accessed if distress was experienced.

To ensure informed consent, both the study information sheet (Appendix B) and the consent form (Appendix C) were provided in Arabic and English, based on the participants’ preferred language. These were shared electronically in advance, allowing participants time to read, reflect, and make an informed decision. Consent was given by signing either a hard copy or a digital form.

Data Management and Confidentiality

All necessary steps were also taken to guarantee anonymity, privacy, and confidentiality. Before each interview, participants were informed that all identifying information would be removed from the data. It was explained to them that transcripts and audio recordings will be coded numerically and stored securely on my password-protected computer. After data collection and analysis were complete, all files were transferred to a secure, password protected shared Massey drive, which only my supervisor and I could access using a unique passcode. Hard copies of consent forms were scanned into electronic copies, and along with the other electronic consent forms were stored separately in a secure folder on the Massey shared drive, and the hard copies were shredded immediately after scanning. Participants were assured that final reports will not contain any identifying details, and in line with ethical requirements, all data will be securely destroyed five years after the completion of the study.

By being consistently compliant with these measures throughout the research, this study was conducted in accordance with the highest standards of ethical and cultural integrity (NEAC, 2019). Indeed, many women reflected afterwards that the opportunity to talk openly was appreciated, with several stating that the interviews made them feel better because they could share their feelings in their own language without fear of judgement. This feedback reinforced that this study not only met ethical requirements but also provided a respectful and empowering space for participants to voice their experiences (Harley & Wazefadost, 2023; NEAC, 2019).

Participants and Recruitment

Purposive sampling was used to recruit participants for the interviews. This sampling method is commonly employed in qualitative research to select participants who are knowledgeable about, or have direct experience with, a particular phenomenon of interest, thereby maximising the richness of the collected data (Ahmad & Wilkins, 2024; Palinkas et al., 2015; Suri, 2011).

Building on this approach and the purpose of the study, the recruitment eligibility criteria required participants to be Middle Eastern women from refugee backgrounds who had given birth in Aotearoa New Zealand. The timing of childbirth was considered as a criterion for inclusion as the population was very specific. Women who had given birth in the past five

years but were willing to talk about their experience of the postpartum period were included. In this study, the postpartum period was defined as the first twelve months following childbirth, a timeframe commonly adopted in maternal health research to capture both immediate and longer-term emotional and psychological changes (Goodman, 2004; Meyling et al., 2023). Women's memories of their childbirth and related emotional experiences remain clear and salient well beyond the immediate postpartum period and they generally can recall these memories accurately for at least five years after giving birth (Altuntuğ et al., 2024; Nahaee et al., 2024). Such recollections are strongly associated with longer-term outcomes, so women who experienced negative emotions often reported an intensification of these emotions over time and yet were still able to recall their experiences consistently. Conversely, women with positive emotions tended to remember their overall childbirth experience in a stable manner (Altuntuğ et al., 2024). Consequently, for this study, eligible participants were Middle Eastern refugee women who had given birth in Aotearoa New Zealand within the last five years.

Once eligibility was defined, recruitment and data collection for this study occurred between August 2025 and September 2025. Recruitment was conducted through advertisements posted in Arabic and English languages on WhatsApp and Facebook groups for Middle Eastern refugees and migrant communities (Appendix D). Approval was sought from group administrators, and they were provided with information about the study, participant recruitment process, and assurances of confidentiality. From these advertisements, three women expressed interest through the Facebook group, four through WhatsApp groups, and three were referred via their personal networks. In total, ten prospective participants expressed interest.

Following expressions of interest, I personally contacted all prospective participants by phone to briefly explain the study, the nature of the interviews, the types of questions, and the confidentiality procedures, as well as to confirm their eligibility. After this initial conversation, a text message was sent to confirm participants' willingness to take part in the study and to obtain their preferences regarding the interview method (online or in person), as well as their available times and days. Eight prospective participants responded and confirmed their availability, while two did not respond further. In total, eight Middle Eastern refugee women participated in the data collection interviews. Of these, five resided in

Auckland, two in Wellington, and one in Christchurch, reflecting a small but geographically diverse sample across New Zealand.

Interview Guide Development

Semi-structured interviews were selected to allow open-ended responses and facilitate two-way communication with the participants, enabling both depth and richness in the data collected (Adeoye-Olatunde & Olenik, 2021; Evans & Lewis, 2018; Islam & Aldaihani, 2022). Open-ended interview questions were used to encourage participants to describe their experiences in their own words (Islam & Aldaihani, 2022). Pre-prepared open-ended questions served as prompts to elicit narratives that provided rich and descriptive context (Adeoye-Olatunde & Olenik, 2021; Kahlke et al., 2025), ensuring that both I, as the researcher, and the participants remained aligned with the study's aims, while retaining flexibility to explore emerging topics in depth (Islam & Aldaihani, 2022).

The development of the interview questions followed multiple stages of refinement and was influenced by the results of my scoping review. First, an initial draft of the interview questions was created in English. This draft included five demographic questions and ten open-ended questions. The five demographic questions were designed to gather information about participants' country of origin, number of children, number of children born in New Zealand, age of the youngest child born in New Zealand, and type of delivery. Although previous literature has associated postnatal mental health disorders with delivery complications (Grundström et al., 2022; Logue et al., 2022; Xayyabouapha et al., 2022), this relationship was not reported in this study due to the small number of participants.

The semi-structured interview guide consisted of ten open-ended questions designed to elicit detailed accounts of participants' postpartum mental health and wellbeing experiences. The questions were informed by the overall study aim and refined using insights from the scoping review, while remaining flexible to allow participants to introduce issues of personal importance.

The open-ended interview questions focused on women's emotional experiences following childbirth. Participants were invited to describe their experiences with pregnancy and postpartum period, as well as the social and practical circumstances shaping their wellbeing.

Several questions explored perceptions of support from partners, family members, and wider social networks, and how these relationships influenced women's ability to cope and seek help. It should be noted that this was an open-ended qualitative interview designed to give voice to participant experiences. Therefore, no psychometric screening tools or formal language around mental health diagnoses was included, as this would be inconsistent with the study approach.

The interview guide also included questions examining women's interactions with maternity and postnatal healthcare services in Aotearoa New Zealand, including experiences with midwives, Plunket nurses, and other healthcare providers. These questions explored participants' understanding of the maternity system, the clarity and usefulness of information provided, and the extent to which emotional and mental health needs were acknowledged during care encounters. Barriers to discussing emotional concerns with healthcare providers were explored, including language challenges, the use of interpreters, time-limited consultations, and perceived lack of cultural understanding.

In addition, a specific question explored postpartum sleep experiences, recognising sleep disturbance as a critical factor influencing emotional wellbeing. Participants were asked to describe their sleep patterns following childbirth, the impact of sleep disruption on their mental and emotional health, and any information or support received to manage sleep-related challenges. This focus reflects evidence linking disrupted postpartum sleep with increased risks of depression, anxiety, and emotional dysregulation (Bhati & Richards, 2015; Maghami et al., 2021). For refugee women, sleep disruption may be compounded by pre-migration trauma, resettlement stress, cultural adjustment, and limited family support, increasing vulnerability to postpartum mental health difficulties (Gessesse et al., 2022; Lies, Jones, et al., 2019). This makes sleep an important area of investigation for this study.

As a concluding question, participants were invited to suggest service improvements and supports that could strengthen their confidence in discussing postpartum emotional needs with maternity and postnatal healthcare providers.

The initial draft of the questions was reviewed by the research supervisors, who provided feedback and recommendations. Based on their input, the questions were refined and a second draft was developed. This draft was then discussed with the advisory group, where

additional input was sought from expert members. Their expertise was instrumental in identifying potential ethical risks in the wording, particularly the possibility that direct references to “mental” issues might cause discomfort. As a result, terminology was revised, replacing “mental” with “emotional” to reduce the risk of triggering distress. A final draft was subsequently developed, reviewed by the supervisors, and translated into Arabic using AI tools such as Google Translate, ChatGPT, and Grammarly. I then personally reviewed the translation to ensure accuracy and cultural appropriateness.

To further ensure clarity and cultural appropriateness, a pilot interview was conducted with a volunteer refugee woman from my network who was fluent in both Arabic and English. During this pilot, each question was asked twice; once in Arabic and once in English; to confirm that the meaning was consistent across both languages and that each question elicited the intended type of data.

Following the pilot, the draft questions were refined again in both languages, and the English version was reviewed and approved by the supervisors. After their approval, a final review of the Arabic version was undertaken by a senior research advisor fluent in Arabic and English, who voluntarily conducted an additional language check to confirm the accuracy and quality of the Arabic questions.

To maintain consistency across all interviews, a comprehensive interview guide was developed (Appendix E). This guide included the final agreed draft of the interview questions in both Arabic and English, along with pre-interview and post-interview checklists to ensure a standardised process across participants.

Data Collection

In this study, participants included refugee women residing both within and beyond Auckland, the use of online interviews conducted via Zoom or Teams has been shown to be beneficial, as participants often feel more comfortable and willing to disclose sensitive information when speaking from a familiar and private setting (Lobe et al., 2022; Oliffe et al., 2021). Furthermore, conducting interviews in a home environment often allows participants to feel more at ease, resulting in deeper narratives and enhanced data richness (Boland et al., 2022). This aspect was especially beneficial when exploring sensitive topics such as

postpartum emotional wellbeing, where creating a safe space for honest reflection was critical (Lobe et al., 2022). For refugee women, who may experience heightened stress when navigating unfamiliar environments, the opportunity to participate from the comfort and safety of their own homes was particularly important in fostering trust and openness.

Practical considerations also reinforced the appropriateness of the online option. Online interviews significantly reduced costs related to travel and venue booking, thereby making it possible to extend recruitment reach and enhance inclusivity (Wakelin et al., 2024). This cost-effectiveness enabled interviewing participants living outside Auckland, ensuring that geographic distance did not limit our sample, thus increasing our study geographical access. Taken together, the benefit of interviews occurring in a comfortable environment, and the reduction in costs and logistical barriers, made online interviews an effective option for conducting the qualitative interviews in this research.

Participants residing in Auckland were offered the choice of either in-person or online interviews, with the time and location determined by the participants themselves. Of the five Auckland participants, four chose to take part in face-to-face interviews, while one preferred an online format. For the three participants living outside Auckland, in Wellington and Christchurch, interviews were conducted exclusively online via Zoom or Teams, according to each participant's preferred platform, day, and time. All interviews were audio recorded using Teams and Zoom recording function and instant transcription was utilized during the interview. All interviews were conducted by me in Arabic, which was the preferred language for all participants, and no interpreter was required as I am fluent in Arabic.

At the beginning of each interview, the information sheet was reviewed with participants, the project was explained again, questions were answered, and the consent form was discussed. Confidentiality, voluntary participation, and the right to withdraw up to two weeks after transcript review were assured. Consent was obtained from all participants prior to the commencement of interviews. For in-person interviews, both electronic and hard copy consent forms were made available, while for online interviews, electronic consent forms were provided.

The interviews lasted between 40 and 60 minutes, with the duration determined by the richness and depth of the conversation. Participants were informed that they were not obliged

to answer any questions they found uncomfortable. Because refugee women could potentially disclose sensitive or distressing matters, contact details for refugee mental health counselling services were provided (Appendix B). In addition, the contact details of Dr. Bronwyn Sweeney, a Clinical Psychologist and Honorary Fellow at the Sleep/Wake Research Centre, was available in case I experienced distress because of sensitive topics raised by participants. At the conclusion of each interview, participants were given a $40 Prezzy visa gift card as a gesture of appreciation for their participation. For in-person interviews, the visa gift card was handed directly to participants, while for online interviews, the card was delivered to their preferred address.

This study employed a homogeneous sample, as all participants shared comparable characteristics and experiences as Middle Eastern refugee or asylum-seeking women who had given birth in New Zealand (Bekele & Ago, 2022; Hennink & Kaiser, 2022; Sim et al., 2018). In qualitative research, there is no universally prescribed minimum sample size for homogeneous groups; rather, adequacy is guided by the study's aim, scope, theoretical orientation, and the depth of data required (Hennink & Kaiser, 2022; Sim et al., 2018; Squire et al., 2024).

Conceptual models of sample adequacy emphasise that when participants possess shared experiences and the research focus is narrow and well-defined, fewer interviews are often sufficient (Bekele & Ago, 2022; Braun & Clarke, 2021; Sim et al., 2018). Literature suggest that between five and eight interviews can generate rich and nuanced insights into a specific phenomenon(Bekele & Ago, 2022; Hennink & Kaiser, 2022). Guided by these principles and considering the study's focused scope and the richness of the narratives anticipated, a total of eight participants were recruited.

All transcripts were initially produced in Arabic using Zoom's and Teams instant transcript function and accuracy was ensured by reviewing transcripts against the original audio. The use of video-call platform instant transcription was appropriate as it provided an immediate, automated record of the interviews, saving time compared with manual transcription (Keen et al., 2022).

After completing the eight interviews, the transcripts were reviewed to remove any identifiable data, then coded and translated into English using AI-based tools. The use of

these tools was deemed appropriate as they offered efficiency, consistency, and accuracy in processing substantial volumes of text, while also maintaining confidentiality and cost-effectiveness (Herdiyanti, 2024). To ensure fidelity to participants' original meanings, I carefully reviewed and refined all translated texts, as I am fluent in Arabic and English. This process ensured that the translations preserved the authenticity and cultural nuances of participants' narratives while making the data accessible for rigorous qualitative analysis (Herdiyanti, 2024).

Data Analysis

Data analysis followed Braun and Clarke's (2022) six-phase model of reflexive thematic analysis: familiarisation, coding, generating initial themes, reviewing themes, defining and naming themes, and reporting/writing up. This flexible and interpretive approach supports the identification of patterned meanings across a dataset (Braun & Clarke, 2022).

Familiarisation began through repeated, active reading of the transcripts, accompanied by note-taking to capture initial observations. Coding was conducted manually without the use of qualitative data analysis software. I read through the transcripts to highlight and identify meaningful features and patterns across the data. As the interviews were conducted in Arabic and later translated into English, initial codes were generated inductively, focusing on capturing patterns of meaning within participants' narratives rather than relying solely on specific terminology or word frequency. Emerging codes were reviewed and discussed with my supervisors to enhance reflexivity and ensure clarity and consistency. Codes were refined, merged, or redefined where necessary before being organised for subsequent theme development.

During the theme development stage, related codes were grouped into preliminary themes that reflected broader patterns of meaning relevant to the research questions. In the reviewing stage, themes were examined iteratively by moving back and forth between coded extracts and the full dataset to ensure coherence and accurate representation of participants' accounts. Themes were also considered in relation to findings from the scoping review to strengthen interpretive depth and analytical rigour.

In the defining and naming stage, themes were further refined through merging, splitting, or discarding where appropriate. Theme names were revised with my supervisors to ensure they clearly reflected their underlying meanings and were appropriately supported by illustrative quotations. Finally, in the writing-up stage, findings were presented by outlining the developed themes with supporting data extracts (Chapter 4) and interpreting them in relation to the scoping review and wider literature (Chapter 5).

Recruited Participants

The findings of this study are based on in-depth interviews with eight Middle Eastern refugee women residing in Auckland, Wellington, and Christchurch. The sample demonstrated diversity in age, educational background, country of origin, length of residence in New Zealand, total number of children, number of children born in Aotearoa New Zealand, and the age of the youngest child (Table 2). This variation in participant characteristics enhanced the depth and richness of the data and strengthened the contextual relevance and transferability of the findings across different resettlement experiences within Aotearoa New Zealand.

Table 2: Participant Characteristics Summary Table (N = 8*)*

Participant	Age	Education	Country of Origin	Years in NZ	No. of Children	No. of Children Born in NZ	Age of Youngest Child
P1	28	University	Palestine (Gaza)	2	3	2	1 year
P2	20	School	Syria	4	2	2	1.5 years
P3	34	University	Palestine	4.5	2	2	1.5 years
P4	38	University	Syria	6	4	1	3.5 years
P5	28	School	Palestinian (born in Syria)	8	3	3	4 months
P6	40	School	Syria	4	6	2	1 year
P7	30	School	Syria	9.5	4	2	1 year
P8	40	University	Palestine	6	2	2	3 years

Participants ranged in age from their early twenties to early forties and had been living in Aotearoa New Zealand between two and nine years. Most were mothers of multiple children, with the majority having two or more children born in Aotearoa New Zealand. Educational backgrounds varied, with half holding a university degree and half having completed school-level education. Their youngest children ranged from four months to three years old. Collectively, these characteristics reflect a diverse sample of resettled Middle Eastern refugee mothers navigating early motherhood in a new cultural and health-care environment.

Summary

This chapter has outlined the qualitative study methodology underpinning this research. Guided by a constructivist paradigm (Guba & Lincoln, 1994) , the study employed a semi-structured interview approach to capture rich, experiential data from participants regarding their postpartum period. It examined how these experiences are socially constructed and shaped through interactions at individual, interpersonal, cultural, and systemic levels within Aotearoa New Zealand. The Socio-Ecological Model (SEM) (McLeroy et al., 1988) provided a comprehensive, multi-layered framework to interpret these data, enabling analysis across interconnected levels of influence.

Purposive sampling was adopted to recruit Middle Eastern refugee women who had given birth in New Zealand and experienced their postpartum period within this context, ensuring that participants had direct and relevant lived experience to inform the findings. Data were analysed using reflexive thematic analysis, as outlined by Braun and Clarke (2022) allowing for iterative, interpretive, and reflexive engagement with participants' narratives while acknowledging the researcher's role in knowledge construction.

Ethical research practices were rigorously maintained to ensure confidentiality safeguards and careful attention to cultural considerations throughout data collection. This was achieved by adhering to formal research ethics approval requirements, consulting with a highly experienced advisory group prior to commencing the study and maintaining regular consultation and reporting with supervisors to ensure methodological integrity and cultural responsiveness.

Overall, this qualitative methodological approach was designed to generate rich, contextually grounded, and evidence-informed data while upholding strong ethical standards. Grounded in a coherent theoretical paradigm, it provided a robust foundation for exploring how individual, social, cultural, and systemic contexts shape Middle Eastern refugee women's postpartum mental health experiences in Aotearoa New Zealand. The following chapter presents the findings derived from this analytical process.

Chapter Four: Qualitative Study Results

This chapter presents Middle Eastern refugee women's perspectives on the factors influencing postpartum emotional distress and mental wellbeing following childbirth in Aotearoa New Zealand. Individuals use their own cultural frameworks to interpret, organise, and cope with illness experiences (Kleinman, 2020). Grounded in a constructivist approach, the meanings and values embedded within the lived experiences of Middle Eastern refugee women provided important insights into how they constructed their understanding of postpartum emotional and mental health. In addition, the findings revealed what women considered as barriers to care, and how these beliefs influence their attitudes and behaviours toward seeking support. Participant's perceived barriers to help-seeking are also explored across individual, interpersonal, cultural, and systemic levels, reflecting the complex and interconnected influences shaping their postpartum experiences.

Findings

In the following sections, the findings of the reflexive thematic analysis, based on Braun and Clarke (2022), are presented. The analysis first outlines women's perspectives on their postpartum emotional and mental wellbeing, from which two themes were constructed to capture the broader meanings of their experiences*: "*crying and overwhelmed" and "sleepless and tired".

Subsequently, the analysis identified the barriers Middle Eastern refugee women encountered when seeking both formal and informal support during resettlement in Aotearoa New Zealand. A further eight themes were constructed to represent these barriers across individual, interpersonal, cultural, and systemic levels: limited awareness and lack of information; language barriers and challenges with interpreters; loss of traditional support and social isolation; limited partner support and awareness; cultural and gender norms; challenges in navigating midwifery services; limited postpartum health focus and support; and experiences of marginalised and unresponsive care.

Postpartum Emotional and Mental Wellbeing Experiences

Women from diverse cultural backgrounds may conceptualise and experience postpartum mental and emotional wellbeing in distinct ways (Haque & Malebranche, 2020). Therefore, how Middle Eastern refugee women define postpartum emotional and mental stressors may differ substantially from Western biomedical understandings. Their help-seeking behaviours are likely to be shaped by access to social support networks, cultural values, and familiarity with mental-health care systems.

The participant's accounts revealed a deep emotional journey during the postpartum period, one that combined joy, exhaustion, vulnerability, and resilience. Their emotional wellbeing fluctuated across time, shaped by the physical demands of caring for a newborn, the loneliness of resettlement, and the strain of constant tiredness. While each woman's experience was unique, a shared pattern of emotional exhaustion, sadness, and longing emerged. The following themes illustrate the participants' experiences.

Crying and Overwhelmed:

Many participants described the early months after birth as emotionally overwhelming. Feelings of sadness, emptiness, and mental fatigue were common and were often expressed through crying, restlessness, and difficulty feeling connected to daily life. Several women characterised their postpartum experience as "very difficult" (Participant 1) and described the first six months after birth as "very draining emotionally" (Participant 3). One participant reflected on the added pressure of migration, explaining that "during the first 12 months after birth, I felt a lot of pressure, especially because I'm far from my family in a new country" (Participant 4).

Ongoing emotional distress was frequently described through persistent crying and exhaustion. One woman shared that she "cried constantly, especially in the first few months postpartum, and it lasted for a long time" (Participant 5), while another described feeling "extremely tired, cried a lot, and often felt suffocated" (Participant 1). These accounts illustrate how emotional distress was closely intertwined with physical exhaustion during the postpartum period.

Despite these emotional strains, there were also moments of emotional recovery and peace, particularly, when they experienced emotional connection with their babies, a sense of joy and gratitude emerged “I had him after ten years of his sister birth, cuddling him was the happiness and the relief for my tiredness.” (participant 6)

Over time, as they became more settled in Aotearoa New Zealand, several women reported feeling calmer, stronger, and more capable in their roles as mothers, particularly when they gave birth a few years after resettlement. Participant 1 reflected “Things were very different with my third child…. I learnt from my previous pregnancy, and I felt I know the after-birth services much better.” Similarly participant 7 stated “Alhamdulillah, my most recent birth was very easy, and I was more familiar with the heath system… I was happy”

Sleepless and Tired:

Sleep deprivation was identified as a major contributor to emotional distress among participants. One woman explained “After my second baby, I hardly slept at all. I had a two-year-old and a newborn. The babies cried a lot, and no one helped me, not the midwife, not anyone else” (Participant 1).

Disturbed sleep, exhaustion, and long nights with crying babies were repeatedly described as triggers for sadness, irritability, and emotional burnout. Participant 2 shared her struggle: “He cried a lot and barely slept. It drained me emotionally and physically.” Participant 3 further explained her experience: “Sleep was the biggest challenge. I had severe sleep deprivation. The baby woke multiple times a night.”

The lack of sleep was compounded by the absence of family support or affordable childcare options, particularly for mothers caring for more than one young child under the age of five. As Participant 3 noted, “I couldn’t even nap during the day because the older one didn’t take naps and there was no one to take care of him except me.” Some women described chronic tiredness, disrupted sleep patterns, and overwhelming childcare responsibilities, which left them physically drained and emotionally unstable. Participant 8 reflected, “All the time I was extremely exhausted, because when the baby napped, I needed to spend time with my older daughter.”

Several women described episodes of tearfulness and heightened sensitivity triggered primarily by exhaustion and sleep deprivation. Participant 6 explained, “Lack of sleep clearly affected my mood. I became easily exhausted and upset and sometimes cried for no clear reason.” Similarly, Participant 2 described her struggle: “I needed rest but couldn’t get any, which made me constantly tired and irritable.”

Although some participants described how their husbands occasionally provided assistance, most women felt that the primary responsibility for night waking and infant care rested entirely on them. Without consistent shared responsibilities or accessible external support, many participants felt trapped in a cycle of fatigue and emotional decline. For example, Participant 3 elaborated “Sometimes my husband would take the baby so I could nap, but not consistently. With two children less than two years apart, it became even harder.”

A few participants who managed to get consistent rest described improvements in mood, emotional stability, and capacity to care for their children. As Participant 4 noted, “Getting an unbroken night’s sleep had a huge positive effect on my mood.” These accounts emphasised the importance of adequate sleep for recovery and overall wellbeing:

> When my mother came to stay with me, everything was much better. She helped care for my other children … allowed me to sleep…. and calmed me whenever I felt down. (Participant 1)

In contrast, participants consistently noted that midwives and nurses paid little attention to their sleep or emotional wellbeing, focusing primarily on the baby’s physical health:

> I received no support or guidance from the midwife or Plunket nurse about sleep; they were only concerned about the baby’s feeding and weight. No one explained strategies to help me rest, it was all my own trial and error. (Participant 6)

Several women also reported that when they raised concerns about exhaustion or coping, these were dismissed or met only with generalised advice. As Participant 2 noted, “The information from the midwife and nurse was very general, just English pamphlets.”

In contrast, when healthcare professionals showed genuine interest in mothers’ rest and wellbeing, women described a noticeable difference in how supported and valued they felt. Participant 5 explained, “During follow-ups, they regularly asked if I was sleeping and if I felt rested, and I noticed a positive difference from that attention.”

Overall, sleep deprivation emerged as both a physical and emotional burden that compounded existing stressors, including limited family support. The findings suggest that insufficient professional attention to mothers’ rest and emotional wellbeing left many women struggling alone, reinforcing feelings of exhaustion, frustration, and emotional instability throughout the postpartum period.

Barriers for Seeking Formal and Informal Help

The scoping review highlighted that both formal and informal support systems are central to women’s ability to cope with postpartum emotional and mental health challenges (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021). In this study, formal support refers to postpartum assistance received from maternal healthcare providers, mainly midwives and Well Child Tamariki Ora nurses (including Plunket services).

Informal support encompasses help from family, friends, community members, and social networks. For many Middle Eastern women, such informal support is traditionally abundant and readily available in their countries of origin. However, after resettlement in Aotearoa New Zealand, most participants reported that these familiar layers of care were significantly reduced due to geographical separation from extended family, limited social relationships, and feelings of isolation. This diminished support, both emotional and informational, created a challenging environment for navigating postpartum mental and emotional distress. Participants expressed diverse perspectives on the difficulties they encountered when seeking appropriate help. The following section presents their reflections and experiences in greater depth.

Limited Awareness and Lack of Information:

Across the interviews, women consistently described their limited awareness of postpartum emotional wellbeing, which they attributed to minimal communication and information provided during pregnancy and after childbirth. None recalled receiving structured, clear, or culturally tailored information about postpartum mood changes, warning signs, or available help-seeking options. As one participant explained, “The midwife never raised the topic. She never opened a conversation about mental health or explained the emotional changes that can happen after birth” (Participant 4). This lack of discussion left women uncertain about what emotional experiences were normal and when support might be needed.

Emotional care was often perceived as secondary to routine physical checks. One participant reflected, “No one explained emotional changes after birth. I didn’t know what was normal or what needed help… I did not feel they prepared me emotionally” (Participant 6). Others similarly described feeling overlooked, with one noting that “as she knows I was a nurse, the midwife treated me as if I already knew everything… she did not ask about my emotions or mental health” (Participant 1).

Participants also highlighted that partners were rarely included in education about maternal health, which further contributed to feelings of isolation. As one woman explained, “My husband was not given any guidance to help him understand what I was going through” (Participant 1), while another suggested that partner-focused education could have improved support: “If there had been sessions for husbands during pregnancy, he could have supported me better” (Participant 5).

A recurring concern was uncertainty about where to seek help when emotional distress arose. Many women reported a lack of clear signposting or guidance, reinforcing perceptions that support services were inaccessible or not intended for them. As one participant explained, “No one told me where to go or who to contact if I felt emotionally unstable, they assumed as I am a nurse I know everything” (Participant 1). Another similarly reflected, “No one gave me a number or explained who to contact… it made me feel alone” (Participant 6). For some women, this lack of information meant that available services remained entirely unknown, as

one participant noted, “I never heard that such services exist; this is the first time I’m hearing about them” (Participant 5).

Language Barriers and Interpreters:

Language barriers further widened interpersonal communication and knowledge gaps. Participants explained that information booklets were provided only in English and were rarely discussed or clarified. Even when pamphlets were offered, women reported that they lacked explanation, were exhausting to translate, or were inaccessible to those with limited literacy. As one participant noted, “They only gave me booklets without checking if I understood them” (Participant 2). Another explained:

> Everything was in English, and my language was not strong. It took a long time to translate and understand, and I was too tired… I really needed someone to explain it in Arabic. (Participant 4).

A particularly important perspective emerged from Participant 7, who articulated not only her own challenges but also the broader reality facing many Middle Eastern refugee mothers with disrupted education. She highlighted that some women are unable to read in Arabic as well, underscoring a critical literacy gap that limits the usefulness of written materials in improving health literacy:

> Often the booklets were only in English, and many mothers cannot read or understand them. I try to translate what’s important, but some women cannot read at all, there are women who are illiterate or stopped schooling because of the war. Even if information exists on paper, many won’t grasp what it means. There should be someone to explain it clearly and simply. (Participant 7)

In addition to written communication barriers, interpreting challenges further weakened communication around mental and emotional concerns. Women described how telephone interpreters often failed to capture tone, emotion, or nuance, while dialect differences created additional confusion. Some participants also noted limited attention to non-verbal

communication by midwives and Plunket nurses. As one woman shared, “The phone translation was emotionless. It didn’t show how I really felt” (Participant 1). Another explained, “Even when there was an interpreter, dialect differences made it hard; Syrian, Iraqi, Egyptian Arabic are not the same” (Participant 6).

Overall, these accounts reveal persistently ineffective communication and limited promotion of mental health awareness across both the antenatal and postpartum periods. This was reflected in reduced mental health literacy, poor awareness of available services among Middle Eastern refugee mothers and their partners, and a clear absence of culturally and linguistically accessible information.

Loss of Traditional Support and Social Isolation:

Many resettled refugee families in New Zealand are separated from their extended relatives. As a result, many Middle Eastern refugee women experience the postpartum period without the close family interpersonal networks they would traditionally rely on after childbirth. This loss of traditional support left participants feeling isolated, exhausted, and unprepared for the demands of motherhood in a new and unfamiliar environment. One participant reflected, “With my first daughter, it was different. I did not have friends here yet and was not integrated into the community. My language was weak, I didn’t go out much, and I felt isolated” (Participant 7). Over time, this isolation was sometimes accompanied by emotional withdrawal, with another woman describing how she “developed social anxiety” and began “preferring to stay home” (Participant 2).

Most participants described a strong sense of loneliness and emotional strain after childbirth, which they linked directly to separation from family and the absence of familiar postpartum support systems. As one woman shared, “Emotionally, with my first daughter, I was more anxious. I cried a lot and missed my family deeply” (Participant 6).

For many Middle Eastern women, the early postpartum period is traditionally supported by mothers, sisters, and extended female relatives who provide emotional reassurance and practical assistance. Participants mourned the absence of this support, noting that nothing could fully replace the comfort and understanding offered by close female relatives:

> I cried a lot and missed my family deeply. I felt a strong need for my mother or sister, especially during birth, because they understood me and could comfort me. (Participant 7).

The contrast between births experienced without family support and those where relatives were later present was striking. Participants who were able to receive support from mothers or close relatives described noticeable improvements in emotional wellbeing and recovery. Participant 1 described a significant change when her mother was able to join her during her third, unplanned pregnancy:

> When I gave birth in 2024, everything was much better. Having my mother with me was such a great support…. she helped care for my other two children, allowed me to sleep and rest when the baby was sleeping, and calmed and comforted me whenever I felt down. (Participant 1)

She further reflected that her mother's presence substantially reduced her emotional burden, explaining that "the difference between the two experiences was enormous… the third birth was much easier and emotionally lighter because my mother was there" (Participant 1).

A small number of participants described forming limited social connections with neighbours or friends, which provided some emotional relief. However, this support was often perceived as temporary or constrained. As one woman noted, "There are things you cannot always ask friends to do, no matter how close they are, because their help is limited to visits or occasional gestures" (Participant 4). Others described meaningful but time-limited support, such as food provision and regular visits, which helped ease early postpartum demands. One participant shared, "For almost a month I did not cook; my friends brought food to my home every day. I felt a lot of love and support, which really eased things" (Participant 7).

Even among women who adjusted relatively well, longing for family remained a persistent emotional undercurrent. Being physically distant from familiar networks intensified homesickness and magnified the everyday challenges of motherhood. As one participant reflected, "For my second birth, it was a very stressful and emotional time for me as well. I had no family to support or celebrate this blessing baby" (Participant 8).

Overall, women's narratives highlight how the loss of traditional family and community care created a profound gap in both emotional and practical support during the postpartum period, contributing to feelings of isolation, emotional distress, and vulnerability.

Limited Partner Support and Awareness:

As a result of social isolation and separation from family members, many women relied primarily on their partners or husbands as their first and often only source of close kin support. As one participant explained, "I had no one to help me except my husband" (Participant 1), while another noted, "My husband tried his best to help" (Participant 8).

Across participants, limited partner support emerged as a notable contributor to emotional distress during the postpartum period. Although partners were often willing to assist, women described support as inconsistent or dependent on explicit guidance:

> He tried to help, but it was limited and only when I guided him. It wasn't something that came naturally to him… as a Middle Eastern man, he had very little awareness of what I was going through emotionally. (Participant 1).

Another similarly shared, "With my first birth, my husband was not as supportive as I expected" (Participant 3).

While participants acknowledged their husbands' efforts to adjust to life in New Zealand, many described limited emotional awareness and practical involvement during the postpartum period. Several women explained that partners had little understanding of the emotional and psychological changes associated with childbirth, which left them feeling unseen and isolated:

> Honestly, the biggest barrier was my husband's lack of awareness. After birth, mothers are exhausted and emotionally and hormonally affected, especially with a first baby, and need a lot of care and support, but he had no understanding of that (Participant 4).

Resettlement-related pressures further constrained partners' ability to provide consistent support. Participants described their husbands as emotionally distant not out of neglect, but because of competing demands related to employment, financial insecurity, and concern for family members in conflict-affected regions. One woman explained, "He was still adjusting to life here, trying to find a job, while I was anxious and stressed, which made him more stressed too" (Participant 1). Another shared, "After we moved to Auckland, my husband started a new job standing all day. He came home very tired, and I did not want to add to his stress" (Participant 2). Similarly, Participant 8 reflected, "Even though we were safe here, we still worried about our families back home. My husband carried a lot of stress, and I did not want to add to it."

Structural barriers, particularly inflexible workplaces and limited parental leave entitlements for fathers, further restricted partner involvement during the postpartum period. Several women explained that their husbands' ability to help was constrained by hourly or casual employment, financial insecurity, and unsupportive employers:

> when I gave birth to my second child, my husband was struggling with his job. He wanted to maintain a good impression with his manager, so taking leave just to help with the baby was impossible. (Participant 1)

Another explained:

> One important thing that prevented him from being strongly supportive is that he was hourly paid. If he stayed home, he wouldn't be paid, and that would cause financial burden. (Participant 4).

For families relying on a single income, even brief absences from work generated anxiety about meeting basic needs. Women described how this economic vulnerability reduced partners' availability and emotional presence during the early postpartum weeks. As one

participant noted, “His manager was not cooperative, and the workplace didn’t offer any support for dads to help mothers with new infants” (Participant 8).

Overall, these accounts highlight that even when partners were emotionally willing to be more involved, limited awareness, resettlement stressors, and structural constraints often restricted their capacity to provide consistent support. The combination of economic pressure, inflexible employment conditions, and lack of paternal leave contributed to women’s sense of carrying the postpartum burden largely alone during a period of heightened emotional vulnerability.

Cultural and Gender Norms:

Understanding the social and cultural processes that shape stigma in women’s lives is essential for interpreting their postpartum emotional experiences and help-seeking behaviours. While cultural beliefs sometimes functioned as sources of strength by offering familiar traditions, expectations, and a sense of continuity, they also created barriers when they reinforced stigma around mental health or positioned childbearing and postpartum recovery as exclusively female responsibilities.

For many participants, ingrained gender norms from their countries of origin shaped their postpartum experiences. Participants reflected that postpartum care was traditionally viewed as a woman’s responsibility, shaped by long-standing social expectations. As one participant explained, “Husband helping with the house or baby wasn’t part of our traditions” (Participant 4). Another noted, “It may be due to lack of awareness, traditions, and the influence of the men around him. None of them help their wives at home” (Participant 6). These expectations often contributed to emotional silence within relationships.

Fear of stigma and cultural misunderstanding around mental health further discouraged women from expressing their emotional needs. Several participants avoided discussing distress with their husbands due to concerns about judgement, rejection, or being labelled as “mentally ill”:

> In our culture, there isn't much space to recognise that a woman might need psychological or emotional support after giving birth. It's seen as something normal that women should simply handle on their own. (Participant 1).

Another described feeling expected to cope independently, stating, "He relied on me to manage without offering real emotional support. It's this idea that the mother should just manage on her own" (Participant 3).

Others described how stigma within families and communities reinforced silence, with emotional exhaustion sometimes interpreted as weakness rather than a legitimate need for support. As one participant shared, "I couldn't explain my mental state because I was afraid, he would say I was mentally ill. In our culture, that's seen as shameful" (Participant 2).

Despite these challenges, many women described gradual shifts in their partners' attitudes over time, particularly as families became more settled in New Zealand and were exposed to more egalitarian parenting norms. Observing other men participate in childcare helped some partners reconsider their roles. As one participant shared, "Over time, my husband became more understanding and started helping more, especially after we settled here and he saw how men help their wives" (Participant 5). Others described small but meaningful changes that signalled growing awareness and empathy, such as partners stepping in during daily tasks or childcare:

> Before, even if the baby cried while I was washing dishes, he wouldn't help. But lately he has started to change a little; if he sees me working, he steps in and helps. It's a small change, but important to me. (Participant 6)

Participant 4 offered a particularly insightful reflection on how resettlement enabled new forms of partnership. Distance from community scrutiny created space for her husband to engage in caregiving in ways that would have been discouraged in their country of origin. She explained that "being abroad became an opportunity to drop some constraints from our original communities," adding that "here, no one is watching or judging, so he began to enjoy

sharing and helping because he truly believed in it" (Participant 4). Observing local parenting practices further normalised this shift, as she noted, "We saw men cooking for their wives or staying with the kids. That normalised the idea for us too" (Participant 4).

Overall, cultural and gender norms remained key contextual factors shaping the extent and quality of partner support during the postpartum period. However, women's accounts also suggest that resettlement in New Zealand, characterised by different gender norms and reduced community surveillance, created opportunities for more supportive and equitable partnerships to develop over time.

Challenges in Navigating Midwife Services:

At systematic level, many participants reported unfamiliarity with navigating New Zealand's maternity care system, particularly the process of selecting and maintaining continuity with a midwife. Most women were unfamiliar with the concept of self-selecting a Lead Maternity Carer (LMC), which differs substantially from maternity care systems in their countries of origin. As one participant explained, "At first, understanding the New Zealand health system was hard. Back home we usually go to a private doctor; here it's different" (Participant 7).

Selecting a midwife often required multiple phone calls, emails, and language-based communication, which participants described as confusing, time-consuming, and emotionally draining. Several women reported receiving little guidance, resulting in inconsistent care or late connection with services:

> I didn't know how to register or choose a midwife, and no one guided me through the process. The hospital assigned me a midwife, but she kept changing, so there wasn't consistent follow-up. (Participant 3)

The lack of accessible information in participants' own language further complicated decision-making. Many relied on friends, community members, or general practitioners to connect them with midwives. For women with limited English proficiency, navigating online directories or communicating by phone was particularly challenging. As one woman noted,

“There were no clear Arabic resources explaining how to choose a midwife or what my rights were. I relied on friends’ experiences” (Participant 7).

Several participants perceived reluctance from midwives to accept them as clients once interpreter needs or limited English proficiency were disclosed. Women interpreted this as a form of exclusion, which left them feeling marginalised and anxious. As one participant explained, “After you mention interpreter needs, they all claim they are fully booked” (Participant 4). This often-forced women to accept whichever midwife was available, sometimes requiring long travel distances that increased fatigue and stress during pregnancy.

A lack of continuity of care further undermined trust in maternity services. Seeing different hospital midwives across pregnancy, birth, and postnatal visits led to inconsistent communication and limited emotional connection. One participant reflected, “Every visit I had to remind them of my health details, and they would go read previous notes” (Participant 8). In some cases, poor communication regarding serious health concerns left women feeling unsafe, prompting them to disengage from services.

Despite these challenges, some participants described improved experiences once they became more familiar with the maternity system or were able to choose a midwife through personal recommendations. One woman shared, “By my second pregnancy, I knew the system better. I asked a friend, and she recommended a kind, understanding midwife” (Participant 7).

Limited Postpartum Health Focus and Support:

At the system level, maternity healthcare practices presented a further challenge, particularly through a limited focus on postpartum emotional wellbeing. Women commonly perceived postpartum care as highly task-oriented and baby-centred, with limited attention to maternal emotional wellbeing. Many participants reported that emotional check-ins were absent or superficial in the regular maternity health check-ups, with care focused primarily on the infant’s needs. As one participant explained, “The midwife only came to check the baby briefly, then left. She didn’t ask about me” (Participant 1). Others similarly noted that visits prioritised physical checks rather than emotional wellbeing. One woman reflected, “The

focus was more on the baby than on me, and my own checks were always quick" (Participant 3).

Instead of discussing mood, anxiety, or exhaustion, many women reported that providers prioritised family-violence screening, which some experienced as uncomfortable or misplaced. This narrow focus left several participants feeling misunderstood or stereotyped:

> Healthcare providers focused only on looking for signs of domestic violence instead of supporting me emotionally or giving clear information. That made me lose trust and fear that what I said might be used against me or my husband. (Participant 1)

Another explained, "Some nurses thought all Arab men are violent, so they always asked about that" (Participant 7). Similarly, Participant 8 noted, "They focused on asking whether my husband was abusive instead of checking my mental state," reinforcing feelings of being judged rather than supported. As another participant reflected, "I felt they wanted to prove my husband was violent rather than support me as a mother" (Participant 5).

In contrast, the few women who experienced warm, person-centred conversations with healthcare professionals described these interactions as meaningful and supportive. One participant recalled, "The Plunket nurse always said, 'When you're well, the baby is well.' That made me feel seen" (Participant 4). Another noted that respectful communication from a social worker was "the only time I felt truly supported" (Participant 2). Some women also reported improved experiences in subsequent pregnancies, with more consistent emotional check-ins and follow-up, as one explained: "With my second child, there was a clear difference. They asked me regularly, 'Are you okay? Are you comfortable? How are you doing?'" (Participant 5).

Overall, participants described postpartum care framework as fragmented, with maternal emotional wellbeing often neglected. This approach left many women feeling invisible and unsupported during a period of heightened emotional vulnerability.

Marginalised and Unresponsive Care:

Within maternity care services, experiences of marginalisation and unresponsive care represented a further layer of challenge. Some participants described their midwives or Plunket nurses as unresponsive or minimally engaged. One woman explained that the only meaningful support she received came from a social worker, stating:

> The only person who truly supported me after birth was the social worker… The midwife and Plunket nurse didn't provide any practical information. They often made excuses or said, 'We'll get back to you,' but they never followed up. I felt their visits were pointless. (Participant 2).

Repeated experiences of brief, inconsistent, or task-focused interactions eroded trust in maternity care providers and reduced the perceived value of professional support. As a result, many women described withdrawing from services and relying instead on self-coping strategies or informal support. One participant shared, "I faced everything alone by reading, praying, and comparing myself with family back home" (Participant 1), while another explained, "No follow-up, no real answers… I began to avoid appointments because they added no value" (Participant 2).

Several participants also described feeling judged or stereotyped, believing that their refugee background or ethnicity shaped how they were treated by healthcare professionals. One woman reflected, "I also wanted to feel genuine care and support, not like I was being interrogated" (Participant 5). Another noted differential treatment, stating, "I noticed how warmly they greeted other women, smiling and chatting, but with me they were quick and distant. I deserve the same respect" (Participant 8).

Others described a lack of cultural understanding, with one participant explaining, "They didn't know our culture or ask questions that would help them understand my life" (Participant 4), while another felt that interactions were superficial, adding, "It felt like they were checking a box, not really listening" (Participant 3).

Overall, participants' accounts suggest that trust and emotional safety were not adequately established within maternity care encounters. Limited responsiveness and perceived stereotyping reinforced the belief that women's emotional wellbeing was peripheral to the system's priorities, leaving many feelings dissatisfied with their care.

Consequently, several women reported turning to informal support networks rather than professional services. As one participant noted, "I used to call my family back home or search online for solutions" (Participant 1), while another shared, "My neighbour and friend gave me practical help" (Participant 3). Others described disengaging entirely from maternity services, explaining, "I started cancelling appointments because I saw no benefit from midwife visits" (Participant 2) and "I didn't expect much support from my midwife, and I didn't ask for a lot" (Participant 3).

Participants' Recommendations for Improving Postpartum Emotional Wellbeing

Across interviews, women identified several forms of support that they believed would strengthen their confidence to express emotional needs and improve their overall postpartum experiences. Participants consistently emphasised that maternity healthcare providers should have a better understanding of Middle Eastern cultural norms, religious expressions, and family dynamics. As one participant explained, "Healthcare providers need to understand our culture properly" (Participant 6). This view was echoed by another participant, who stated, "Healthcare staff need to better know Middle Eastern cultures… not every Arab man is abusive" (Participant 7).

Women also expressed a strong preference for Arabic-speaking staff or, at minimum, access to skilled in-person interpreters. Many women believed that having Arabic-speaking midwives or social workers would foster trust and allow them to speak more openly about emotional distress. As one participant explained, "It's very important to have Arabic-speaking interpreters or midwives… it would make it easier to express feelings without fear of being misunderstood" (Participant 1).

Participants also highlighted the importance of education sessions for husbands, suggesting that partners should receive direct, culturally tailored information from healthcare providers. As one participant noted, “If the midwife had explained things to him, he would have understood my needs much better” (Participant 6). Another emphasised that information delivered by healthcare professionals carried greater authority, stating, “Sometimes he won’t take it seriously from me, but he would from the midwife” (Participant 3).

Clear, centralised, and multilingual information provided early in pregnancy was another recurring recommendation. Women described existing information as scattered, inaccessible, or unavailable in their preferred language. One participant reflected, “I needed clear and centralised information about services. Instead, everything was scattered” (Participant 1), while another added, “All the materials were in English… I didn’t know what services even existed” (Participant 3).

Practical support was also identified as a significant unmet need. Participants suggested that access to childcare or babysitting support during the postpartum period would substantially reduce stress. Several participants proposed a model similar to free early childhood education hours, with one noting that “even 10 hours per week in the first postpartum year would reduce stress” (Participant 6).

Finally, women emphasised the emotional importance of family support and recommended more flexible visa options to allow family members to visit during the postpartum period. Participants explained, “If my mother could have come for even a few months, it would have reduced so much psychological pressure” (Participant 4). Another participant shared, “having them here would make a much bigger difference” (Participant 6).

Together, these recommendations illustrate women’s desire for a maternity care system that acknowledges cultural context, actively engages partners, reduces practical barriers, and recognises the profound value of family presence in supporting postpartum emotional wellbeing.

Summary

This study explored Middle Eastern refugee women lived experiences of postpartum emotional wellbeing after resettlement in Aotearoa New Zealand. The findings show that the postpartum period was emotionally intense, and that help-seeking behaviour was shaped by interacting individual, interpersonal, cultural and systemic influences
(Figure 3).

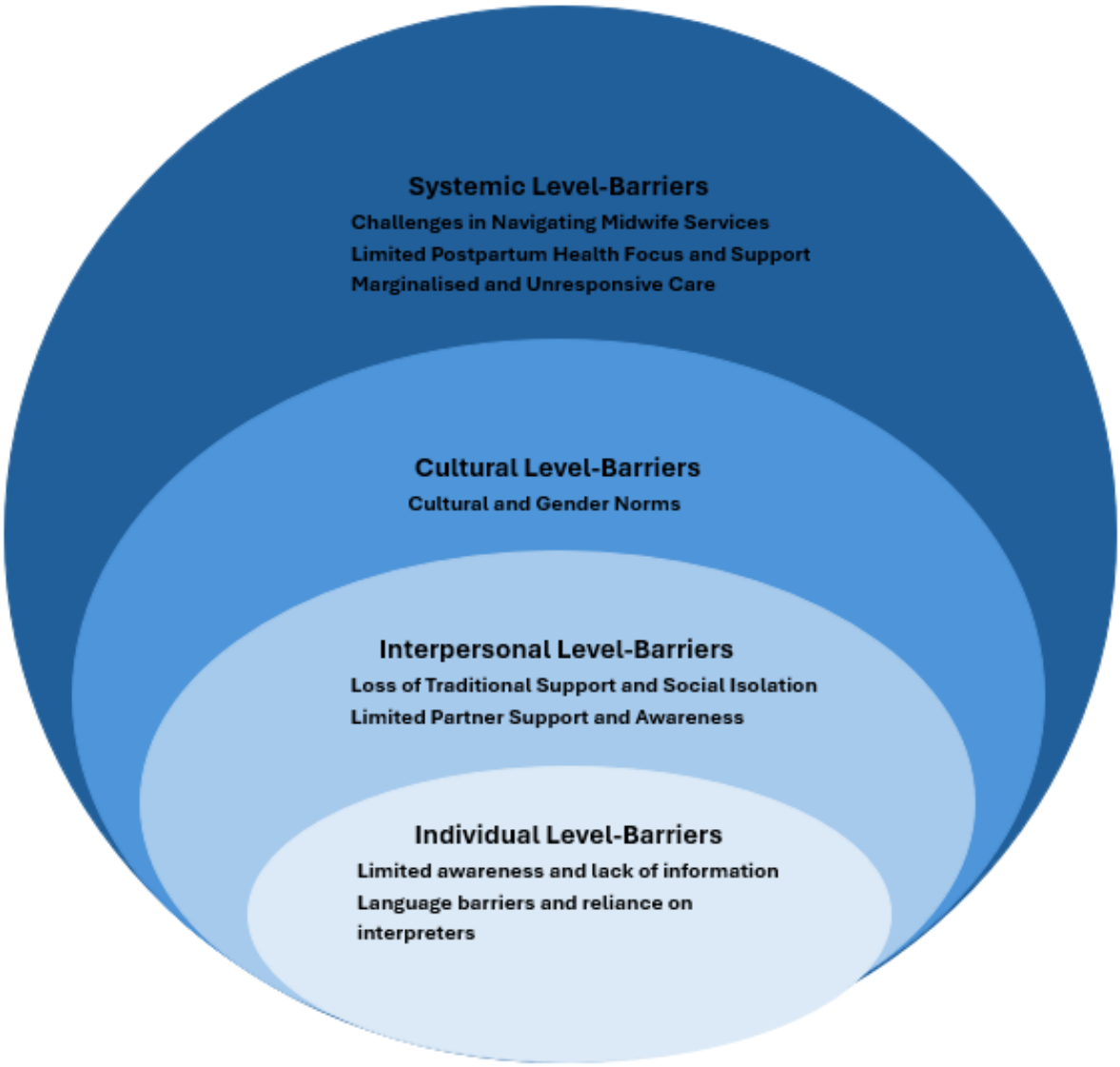
Sleep disruption emerged as a major contributor to emotional distress. Several participants linked tearfulness, irritability and low mood to prolonged periods of poor sleep. In contrast, they felt more emotionally stable, capable and valued when infants slept for longer stretches or when partners or mothers assisted at night. These accounts highlight sleep as a central determinant of postpartum mental wellbeing.

Barriers to seeking both formal and informal help were evident across all socio-ecological levels (Figure 3). At the individual level, women described significant gaps in mental-health literacy and limited information about available services. Also, communication and network Language and interpreter barriers further restricted access to care. These communication gaps limited women's mental-health literacy and contributed to reliance on self-learning, online searches, prayer or advice from peers rather than formal services.

At the interpersonal level, the loss of traditional family support left many women without the postpartum care typically provided by mothers, sisters and extended relatives. With family absent, husbands became the primary potential source of help. However, most women reported limited partner awareness of postpartum emotional needs.

At the cultural level, stigma surrounding emotional distress discouraged open discussion, as many women feared community judgement and damage to family reputation. Gender norms positioning childcare as women's responsibility further influenced the extent of partner involvement in supporting mothers during the postpartum period. However, some participants described gradual improvements in partner engagement over time, as families adapted to New Zealand's parenting norms and felt less constrained by traditional community expectations.

Figure 4: Socio-Ecological Framework of Help-Seeking Barriers Among Middle Eastern Refugee Women adapted from McLeroy et al. (1988)



At the systemic level, women reported structural barriers within maternity and postnatal services. These included difficulties navigating the Lead Maternity Carer system, limited focus on maternal emotional health after birth, and interactions perceived as marginalising or unresponsive. Emotional wellbeing screening was frequently described as checklist-driven and heavily focused on family violence rather than holistic mental health. Such experiences led some women to disengage from formal services and rely on informal networks or personal coping strategies.

Overall, the results show that Middle Eastern refugee women's postpartum mental-health experiences in New Zealand were shaped by sleep disruption, the loss of traditional support, limited partner awareness, cultural expectations, communication barriers and systemic gaps in maternity care. These intersecting factors often left women carrying the emotional burden of postpartum adjustment largely alone, underscoring the need for culturally responsive, linguistically accessible and family-focused approaches within refugee and maternal health services. The following chapter discusses the qualitative findings in light of the scoping review and the wider literature on refugee postpartum mental health.

Chapter Five: Discussion and Conclusion

In line with the qualitative design intended to foreground participants' own narratives and lived experiences, this study captures Middle Eastern refugee women's accounts of their postpartum emotional and mental-health experiences following resettlement in Aotearoa New Zealand, as well as their perspectives on the factors shaping help-seeking for both formal and informal support. Specifically, the study addressed three research questions: (1) how Middle Eastern refugee women describe their emotional and mental wellbeing during the postpartum period; (2) the barriers they encounter when seeking support; and (3) their recommendations for improving postpartum emotional and mental-health support in New Zealand.

The scoping review employed descriptive thematic synthesis to identify and categorise reported international evidence on postpartum mental health experiences among Middle Eastern refugee women in high-income countries, as well as the barriers influencing their help-seeking. These findings informed the focus and design of the subsequent qualitative phase. The semi-structured interviews then explored Middle Eastern refugee women lived postpartum experiences in Aotearoa New Zealand, examining barriers across individual, interpersonal, cultural, and systemic levels, and generating recommendations grounded in their resettlement realities.

This chapter discusses the qualitative findings in relation to the scoping review literature, highlights areas of convergence and divergence, and interprets the results through the socio-ecological model. The findings reveal a complex intersection of individual emotional challenges, disrupted social support, cultural norms, and systemic constraints within the maternity care system in Aotearoa New Zealand. Together, these factors shaped Middle Eastern refugee women's postpartum emotional wellbeing and their capacity to seek and receive appropriate support.

Middle Eastern Refugees Women Postpartum Emotional and Mental Wellbeing Experience

Across interviews, women described the postpartum period as one of intense emotional fluctuation, combining joy at the arrival of a baby with fatigue, sadness, anxiety, and feelings

of being overwhelmed. Many linked frequent crying, irritability, and heightened pressure and loneliness to sustained periods of poor sleep and the absence of family support, particularly during the first months following childbirth. Participants' descriptions of their postpartum emotional and mental health struggles were consistent with the experiences reported in the scoping review. Middle Eastern refugee women resettled in Australia, Canada, Turkey, and the United States were similarly found to experience intense emotional strain, anxiety, and depressive symptoms during the first postpartum year (Ahmed et al., 2017; Alsamman et al., 2025; Khalil et al., 2024; Salameh et al., 2025). Such emotionally rich accounts are valuable, as they reflect how women themselves make meaning of postpartum experiences that are deeply shaped by relational and contextual factors (Simkin, 1991).

In contrast, some participants described feeling calmer and more capable during the postpartum period when subsequent births occurred after a longer period of settlement in Aotearoa New Zealand. The scoping review similarly indicated that longer duration in the host country can modestly improve women's ability to navigate health systems and access support (Cameron et al., 2022; Qutranji et al., 2020). These accounts illustrate how postpartum experiences may differ substantially between births for the same woman, depending on the timing of resettlement, familiarity with services, and availability of support (Dennis & Chung-Lee, 2006; Firth et al., 2022).

The central role of sleep in shaping postpartum emotional distress emerged strongly in this study. Evidence shows that mothers who experience poor, disrupted, or insufficient sleep are significantly more likely to develop postpartum depression than those with adequate sleep (Goyal et al., 2007; Iranpour et al., 2016; Ladyman et al., 2021; Sivertsen et al., 2015). This was echoed by participants, who repeatedly described how prolonged sleep deprivation intensified irritability, sadness, and emotional fragility. For many, sleep loss was intertwined with caring for multiple young children and the absence of extended family support. In contrast, women who were able to rest, whether through partner or maternal support or improved infant sleep patterns, reported feeling more emotionally stable, hopeful, and responsive to their children.

The disruption to sleep was not explicitly explored within the scoping review literature. This highlights a clear gap, as sleep is recognised as a core determinant strongly associated with increased risk of postpartum depression and emotional distress among women (Ladyman et

al., 2021; Leistikow & Smith, 2024). This is particularly the case for refugee women, as it is further intensified by pre-migration trauma, resettlement stressors, caregiving demands, and the loss of traditional family-based support structures that would normally protect maternal rest (Carlson et al., 2024; Cooper & Murray, 1998; Ladyman et al., 2021; Lies, Jones, et al., 2019).

Although effective postpartum sleep interventions exist, persistent barriers to access, help-seeking, and recognition of need leave many women without timely or preventative support (Ladyman et al., 2022) . For refugee women, these barriers are likely amplified by language challenges, limited health literacy, and difficulties navigating complex health systems (Gessesse et al., 2022; Goyal et al., 2007; Ladyman et al., 2022; Lies, Mellor, et al., 2019; Maghami et al., 2021). By foregrounding sleep as a central pathway through which emotional distress is experienced and amplified, this study extends existing knowledge and identifies sleep deprivation as a key mechanism shaping emotional vulnerability and help-seeking needs. These findings underscore the need to integrate culturally responsive sleep-focused postpartum care into existing services.

Barriers for Seeking Formal and Informal Help.

The qualitative study demonstrates that Middle Eastern refugee women in New Zealand face multiple, intersecting barriers to seeking support for postpartum emotional and mental distress. These barriers operate across the individual, interpersonal, cultural, and systemic levels of the socio-ecological model (Figure 3), underscoring the layered and interconnected nature of women's postpartum experiences. These findings closely align with the scoping review, which identified similar multi-level barriers among Middle Eastern refugee women in Australia, Canada, Turkey, and United States (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021; Vigod et al., 2017). Recognising these interconnected influences is critical for developing culturally responsive and equitable interventions to support postpartum emotional and mental wellbeing among this vulnerable population.

At the individual level, the interviewed participants' experiences revealed that limited health literacy and insufficient knowledge of available maternal and mental health services were key individual barriers to formal help seeking. These findings closely align with the scoping

review, which identified lack of health literacy and limited knowledge of maternal care services as prominent individual challenges faced by Middle Eastern refugee mothers across the studies conducted in Australia, Canada, the United States, and Turkey (Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025). Many of the Middle Eastern refugee women in these countries frequently reported not knowing where to go, whom to contact, or how to raise their mental health concern safely and securely (Alsamman et al., 2025; Cameron et al., 2022; Qutranji et al., 2020)

Limited health literacy is strongly associated with poorer postpartum mental health outcomes and reduced help seeking among refugee women (Boyle et al., 2019; Cassim et al., 2022; Mortensen, 2011). Disrupted education due to conflict and displacement can limit literacy even in women's first language, while unfamiliarity with host-country healthcare systems, language barriers, and limited digital literacy further restrict understanding of available maternal and mental health services (Floyd & Sakellariou, 2017; Kanengoni-Nyatara et al., 2024; Shrestha-Ranjit et al., 2020). These intersecting challenges increase vulnerability to delayed recognition and treatment of postpartum mental health difficulties (Cassim, Kidd, et al., 2022; Firth et al., 2022; Mortensen, 2011; Shrestha-Ranjit et al., 2020). This underscores the need for targeted, culturally and linguistically appropriate postpartum mental health education in New Zealand (Clapham et al., 2024).

Further, at the individual level, the communication challenges described by interviewed participants closely mirror those identified across the scoping review. Evidence from Canada, Australia, the United States, and Turkey identified in the scoping review consistently demonstrates that language barriers, inadequate or inconsistent interpreter services, and reliance on untranslated written materials undermine health literacy and substantially hinder effective postpartum communication for Middle Eastern refugee women (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021; Vigod et al., 2017). Similarly, in the New Zealand context, the interviewed participants reported limited language proficiency and written information provided almost exclusively in English, with little explanation or checking of understanding, as primary obstacles to seeking formal help and limiting meaningful engagement with maternal healthcare.

The interview participants also described written materials as exhausting to translate when sleep deprived, inaccessible to women with disrupted education, and ineffective without verbal explanation. Importantly, some women highlighted that limited literacy was not confined to English, noting that a proportion of Middle Eastern refugee mothers are unable to read confidently in Arabic due to interrupted schooling caused by war and displacement. Although this was not explicitly addressed in the scoping review, the wider refugee maternity health literature reports that some refugee women have limited reading ability even in their first language (Brannelly et al., 2024; Cassim, Kidd, et al., 2022; Kanengoni-Nyatara et al., 2024; Sherif et al., 2022; Shrestha-Ranjit et al., 2020). This suggests that written information alone, even when translated, may be insufficient to support postpartum mental health literacy and understanding seeking formal help pathways (Shrestha-Ranjit et al., 2020).

Interpreter-related challenges further weakened communication around emotional and mental wellbeing and explaining the support needed. The interviewed participants described telephone interpretation as impersonal and emotionally flat, limiting their capacity to articulate distress. This also reduced providers' ability to accurately recognise and respond to psychosocial needs. This was similarly reported in the scoping review as telephone-based interpretation often failed to convey tone, emotion, and cultural nuance, while dialect differences created misunderstanding and frustration (Ahmed et al., 2017; Cameron et al., 2022; Hearn et al., 2024; Qutranji et al., 2020; Salameh et al., 2025). These findings illustrate how interpreter interactions may involve misunderstandings and confusion between healthcare service providers and refugee women that may constrain timely, meaningful engagement with formal postpartum mental health support (Sullivan et al., 2023).

At the interpersonal level, the loss of traditional postpartum support is identified as a central determinant of women's emotional and mental recovery during the postpartum period (Place et al., 2024). Among the interviewed participants, separation from mothers, sisters, and extended female relatives emerged as one of the most powerful contributors to distress and loss of informal support. Women described how this absence intensified loneliness, exhaustion, and anxiety, leaving them feeling unsupported during a particularly vulnerable period. This finding closely aligns with the scoping review findings, which consistently identified social isolation as a major contributor to the loss of informal postpartum support for Middle Eastern refugee women resettled in Australia, Canada, Turkey, and the United

States (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024; Qutranji et al., 2020; Salameh et al., 2025; Stirling Cameron et al., 2021).

Participants who later experienced a birth supported by a visiting mother described markedly improved emotional recovery, better sleep, and a greater sense of calm and confidence. This intra-individual contrast offers compelling qualitative evidence of the protective function of traditional female networks at the interpersonal level. By comparison, support from friends or small social circles, while appreciated, was described as limited in duration and depth, unable to fully replicate the cultural familiarity and sustained presence of family care. Similar accounts were reported in the scoping review, where Middle Eastern refugee women described rebuilding restricted networks that functioned as a "chosen family," offering intermittent practical and emotional assistance but lacking continuity and cultural resonance (Alsamman et al., 2025; Qutranji et al., 2020; Stirling Cameron et al., 2021). Overall, separation from traditional support systems represents a profound rupture from culturally expected postpartum care and support, where continuous physical assistance, shared responsibilities, and emotional reassurance are typically provided by close female relatives (Firth et al., 2022; Merry et al., 2021; O'Mahony et al., 2012; O'Mahony, 2011).

Within these constrained social environments, husbands became the primary, and in some cases the only, source of informal support provider (Haque & Malebranche, 2020). The scoping review acknowledged that social isolation and reduced community networks often compel women to rely more heavily on their nuclear family (Ahmed et al., 2017; Cameron et al., 2022); however, most studies focused on the absence of extended family rather than examining partners' roles in depth. In contrast, the qualitative findings of this study clearly position husbands as central figures in women's postpartum emotional experiences. The interviewed participants described their partners as simultaneously crucial and constrained: crucial because they were the only available source of immediate support yet constrained by limited awareness of postpartum emotional needs. In addition, cultural gender norms often positioned childcare and emotional labour as the women's responsibility. This illustrates how these norms not only shape women's help-seeking behaviours but also restrict partners' capacity to recognise and respond to postpartum emotional difficulties (Antoniou et al., 2022; Haque & Malebranche, 2020).

Given the established importance of partner support as a protective factor for postpartum emotional wellbeing, and the typical absence of female kin for migrant and refugee women during the postpartum period, husbands are often required to assume a greater role in providing both emotional and practical support (Antoniou et al., 2022; Haque & Malebranche, 2020; Khan et al., 2009). Viewed through a socio-ecological lens, this positions partners as a critical interpersonal determinant of women's informal postpartum mental health support (Brandon et al., 2012).

Although partners play an important role during the postpartum period, their lack of awareness of postpartum emotional and mental health changes limited their ability to provide meaningful support (Pebryatie et al., 2022). Interviewed participants explained that their husbands attempted to help but did not understand the emotional challenges of early motherhood. Many had never received education about postpartum mental health. While the scoping review did not explicitly examine partners' roles, the wider maternity literature emphasises the importance of involving husbands. Targeted education about their supportive role is crucial for enhancing women trust to seek their emotional and mental support (Istiana & Cahyati, 2025; Pebryatie et al., 2022).

Participants also highlighted that limited partner availability during the critical early weeks after birth was often shaped by economic hardship and precarious employment. These accounts mirror scoping review findings from the United States and Canada, where financial insecurity and employment precarity intensified emotional distress among Middle Eastern refugee mothers (Khalil et al., 2024; Vigod et al., 2017). The wider refugee maternal literature similarly notes that partners may themselves experience stress, unemployment, and cultural adjustment challenges that restrict their capacity to provide consistent support (Boyle et al., 2019). Evidence indicates that mothers with limited partner support are at greater risk of postpartum emotional distress (Istiana & Cahyati, 2025; Pebryatie et al., 2022), underscoring the need for more generous parental leave policies and workplace protections to strengthen family wellbeing and support new mothers help needs (Heshmati et al., 2023).

At the cultural level, traditions and culturally embedded perceptions of childcare and motherhood strongly shaped women's views on help seeking during the postpartum period (Dennis & Chung-Lee, 2006; Firth et al., 2022). The scoping review identified cultural beliefs, stigma, and privacy concerns as key influences on help-seeking behaviours among

Middle Eastern refugee women in Canada, Turkey, and the United States, where women often feared community judgement, being labelled “crazy,” or bringing shame to their families (Ahmed et al., 2017; Alsamman et al., 2025; Qutranji et al., 2020; Salameh et al., 2025; Vigod et al., 2017).

These same dynamics were reflected in the Aotearoa New Zealand context. Interviewed participants described how mother’s emotional suffering was often considered her own responsibility to manage. Fear of stigma and cultural misunderstanding around mental health further discouraged participants from expressing their mental needs, as participants worried about judgement, or being perceived as “mentally ill” by their husbands or community members. These findings echo both the scoping review and wider literature which report that stigma operates simultaneously at individual, family, and community levels, silencing emotional distress and constraining engagement with formal mental health services (Ahmed et al., 2017; Kanengoni-Nyatara et al., 2024; Salameh et al., 2025; Shrestha-Ranjit et al., 2017).

A particularly important insight from this qualitative study is the transformative potential of resettlement to enable positive shifts in gender roles and caregiving expectations among Middle Eastern men. Several participants described exposure to parenting practices in Aotearoa New Zealand, such as observing men engaged in childcare, domestic work, and active emotional support, and this helped normalise paternal involvement and encouraged some husbands to share caregiving responsibilities more equitably over time. While this gradual shift toward more egalitarian partnerships was not explicitly explored in the scoping review, similar shifts have been noted in wider maternity-migration research. It has been observed that male partners moved from limited involvement during pregnancy and the postpartum period to becoming the primary source of support for their wives following resettlement, largely due to the absence of extended family networks (Haque & Malebranche, 2020; Russo et al., 2015). These findings highlight the potential for resettlement contexts to soften rigid gender norms and foster more collaborative partnerships, offering a hopeful and actionable dimension on family-support interventions (Haque & Malebranche, 2020).

At the systemic and service level, the qualitative findings closely mirror and extend the scoping review’s themes related to complex healthcare systems, baby-centred care, and inequitable practices. The scoping-review highlighted that refugee women struggle to

navigate inflexible, Western-designed health systems in Australia, Canada, Turkey, and United States (Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Qutranji et al., 2020; Salameh et al., 2025). Healthcare systems in high-income countries are predominantly grounded in Western biomedical models, which often fail to accommodate refugee women's cultural contexts, language needs, and lived experiences, resulting in fragmented and inequitable care (Boyle et al., 2019; Sherif et al., 2022).

Interviewed participants described significant confusion and stress when attempting to understand New Zealand's Lead Maternity Carer (LMC) model, identify and contact midwives, and secure continuity of care. Participants explained that the expectation to independently select an LMC through multiple phone calls or emails, often in English and with minimal guidance, created substantial barriers, particularly for pregnant women who had newly arrived. These New Zealand-specific findings extend the scoping review evidence which revealed that booking and referral processes are frequently opaque, administratively burdensome, and poorly communicated to refugee mothers (Alsamman et al., 2025; Cameron et al., 2022). The persistent lack of culturally and linguistically appropriate information and guidance, leaving refugee women uncertain about how to navigate maternity and mental-health services and reinforcing systemic barriers to timely and effective seeking formal postpartum support (O'Mahony et al., 2012; Verschuuren et al., 2025).

Participant's perceptions that midwives in New Zealand avoided clients requiring interpreters or women with limited English proficiency also aligns with scoping-review themes of inequitable access to culturally and linguistically appropriate care (Ahmed et al., 2017; Cameron et al., 2022; Salameh et al., 2025). However, women's accounts that midwives suddenly became "busy" or "fully booked" once interpreter needs were disclosed suggest a subtle yet consequential form of selection and exclusion. While this practice was not explicitly documented across the scoping review, related experiences of marginalisation were reported in studies from Canada, where Middle Eastern and Muslim refugee women described feeling excluded due to their refugee status or visible religious identity, particularly among women who wore the hijab (Ahmed et al., 2017; Cameron et al., 2022). These dynamics reflect organisational-level inequities that are consistent with the broader analyses of decreased help seeking behaviour among disadvantaged populations (Arefadib et al., 2022; Daellenbach et al., 2024).

Furthermore, our findings are consistent with literature that postnatal services are predominantly baby-centred and task-oriented (Cameron et al., 2022; Salameh et al., 2025; Walsh et al., 2025). Participants described New Zealand postpartum contact focused primarily on infant weight, feeding, immunisations, and brief physical checks, with little sustained attention to maternal mood, fatigue, or coping. Also, mental health screening, where it did occur, was described to be often experienced as superficial and checklist driven. This echo concerns found in the scoping review that postpartum depression assessments tend to be opportunistic, rushed, and poorly adapted for culturally diverse populations, which affects Middle Eastern refugee women's trust when seeking formal help (Ahmed et al., 2017; Salameh et al., 2025; Vigod et al., 2017).

In the same vein, several participants felt that the framing and repetition of violence-related questions carried implicit assumptions about domestic violence, reinforcing stereotypes about Arab or Muslim men. While the scoping review identified refugee women's fears of scrutiny and child-protection involvement in Canada and the United States (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022), it did not explicitly document this pattern of narrowly focused violence screening within routine postpartum care. This study offers an important new insight into postpartum care, showing that routine postpartum checks were perceived as disproportionately focused on family-violence screening, at times overshadowing broader maternal emotional and mental health needs. This may lead to inadvertently increase fear, reduce disclosure, and undermine engagement with services (Royal Women's Hospital, 2020).

Participants' accounts also point to the potential influence of conscious or unconscious bias and stereotyping among maternity healthcare providers. Such bias may arise when prior experiences, assumptions, or limited cultural understanding, lead providers to generalise about individuals or communities based on ethnicity, migration background, or perceived vulnerability, shaping how care and questioning are delivered (Royal Women's Hospital, 2020). When screening is experienced as interrogative or stereotyping rather than supportive, women may feel judged, misunderstood, or unsafe, which can further discourage open discussion of emotional distress and reduce trust in maternity services (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022). These findings underscore the importance of trust, respect, and relational safety in sustaining engagement with maternal health services

and encouraging help- seeking, particularly for refugee women (Hayward et al., 2025; O'Mahony et al., 2012; Wu et al., 2021).

Additionally, participants' descriptions of midwives and Plunket nurses as rushed and mechanistic, characterised by "ticking boxes" or "behaving like robots," closely align with scoping-review evidence showing that Middle Eastern refugee mothers in Australia, Canada, and the United States often experience maternity care as impersonal and culturally disconnected (Ahmed et al., 2017; Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024). Notably, studies on maternity and child health services in New Zealand have similarly reported that mothers in the general population of New Zealand perceive postpartum and early child healthcare as adopting a "tick-box" approach, which is experienced as inflexible and insufficiently responsive to individual needs (Clapham et al., 2024; Walsh et al., 2025). This model of care has been criticised for prioritising organisational requirements over the relational and contextual needs of mothers, babies, and families. This tension can create an environment which may further intensify barriers to engagement and help-seeking for maternal mental health needs (Clapham et al., 2024).

In contrast, when care interactions departed from this mechanistic model, the participants described markedly different experiences. Participants recounted feeling validated and supported when a Plunket nurse explicitly linked maternal wellbeing to infant wellbeing, or when a social worker took time to explain available options respectfully and without judgement. Such reports reinforce scoping-review recommendations advocating for trauma-informed, culturally safe, and relationship-based models of care, and demonstrate their potential positive impact at a practical, service-delivery level (Ahmed et al., 2017; Cameron et al., 2022; Hearn et al., 2024; Salameh et al., 2025). This echoes recommendations within maternal and mental health research in Aotearoa New Zealand calling for strengthened cultural competence and relational practice within maternity and mental health services (Brannelly et al., 2024; Sherif et al., 2022; Shrestha-Ranjit et al., 2017). This is a critical strategy to reduce barriers to early intervention and improve women mental health (Brannelly et al., 2024; Clapham et al., 2024).

Several participants also felt they were treated differently from other mothers and interactions were shaped by stereotypes. This left them feeling discriminated, unseen and unequally treated. Similarly, the scoping review documented how Middle Eastern refugee women in

host countries often experience maternity services as impersonal and exclusionary. Across studies in Australia, Canada, and Turkey, Middle Eastern Refugee women described being perceived as “outsiders” or “strangers” within healthcare systems (Ahmed et al., 2017; Cameron et al., 2022; Hearn et al., 2024; Salameh et al., 2025; Vigod et al., 2017). Such perceptions frequently resulted in dismissive or paternalistic care that failed to recognise Middle Eastern refugee women’s trauma histories and contextual vulnerabilities, further eroding trust and decreasing engagement with maternal services (Ahmed et al., 2017; Cameron et al., 2022; Salameh et al., 2025). Our findings similarly demonstrate how systemic inequities, cultural incompetence, and exclusionary practices within maternal-health systems serving Middle Eastern refugee women determine their help-seeking behaviours (Ahmed et al., 2017; Cameron et al., 2022; Hearn et al., 2024; Salameh et al., 2025; Vigod et al., 2017).

Overall, Middle Eastern refugee women faced multi-level barriers to seeking both formal and informal support during periods of postpartum distress. The qualitative findings contribute several context-rich insights to the existing literature on postpartum mental health among Middle Eastern refugee women in high-income countries. These particularly include foregrounding sleep deprivation as a central determinant, highlighting the expanded role of husbands as primary kin support in the absence of extended family, and drawing attention to experiences of biased or stereotyped screening practices. Recognising these interconnected and multi-layered determinants is essential for developing effective interventions that address the broader individual, social, cultural, and structural conditions shaping Middle Eastern refugee women’s postpartum mental health and help-seeking experiences in Aotearoa New Zealand.

Recommendations

Several recommendations were identified in both the scoping review and the participant interviews. The need for culturally appropriate postpartum maternity care was recommended in both sources. The scoping review consistently identified that culturally competent care, including provider training on Middle Eastern cultural and religious norms and family relationships, is essential for improving communication and trust (Alsamman et al., 2025; Cameron et al., 2022; Hearn et al., 2024; Khalil et al., 2024). The qualitative interviews echoed these findings, emphasising that misunderstandings often occurred because maternity-care providers lacked accurate knowledge about diverse cultures.

Further, the Middle Eastern refugee women in New Zealand strongly preferred Arabic-speaking maternity-care staff or in-person interpreters, which aligns with the scoping review's recommendation for language-concordant care and trained interpreters to reduce barriers to communication (Ahmed et al., 2017; Qutranji et al., 2020; Salameh et al., 2025; Vigod et al., 2017). Also, both the scoping review and the qualitative interviews highlighted the need for clear, centralised, multilingual information early in pregnancy.

Participants' experiences further reinforced the literature's recommendation to strengthen community-based follow-up and ensure equitable access to essential services. The scoping review similarly highlighted the need for accessible health information and culturally targeted educational programmes to support family understanding of maternal mental health (Cameron et al., 2022; Khalil et al., 2024). In line with this, participants in the qualitative study described how partners often lacked awareness of postpartum emotional needs and would have benefited from direct guidance from midwives or structured educational programmes.

Practical support also emerged as a recurring recommendation across both the qualitative findings and the literature. Participants explained that childcare challenges were particularly acute for mothers with toddlers who were below the age of eligibility for subsidised early childhood education in Aotearoa New Zealand. As a result, women caring for multiple young children were unable to access affordable childcare support, leaving them with no opportunity for rest or recovery during the postpartum period. This challenge intensified exhaustion and limited women's capacity to focus on their newborn and their own emotional wellbeing. Similarly, the literature emphasises the importance of practical assistance, including transport support, home visiting services, and childcare services, in improving postpartum experiences and mental health outcomes for refugee mothers (Alsamman et al., 2025; Salameh et al., 2025; Vigod et al., 2017).

Finally, several participants emphasised the emotional importance of family presence and suggested more flexible visa options to allow mothers or sisters to visit after childbirth. Although the literature rarely addressed immigration policy directly, it consistently highlighted the protective role of social and familial support networks in reducing postpartum distress (Hearn et al., 2024; Khalil et al., 2024).

Overall, these recommended actions are consistent with the New Zealand Maternity Standards (MOH, 2011), which state that all district health boards must work collaboratively with professional organisations and consumer groups to identify the needs of their local populations and ensure that services are appropriate and responsive. The standards further require that maternity services be culturally safe and culturally appropriate, and that women and their babies have equitable access to all levels of maternity and newborn services, including mental health support, when clinically indicated. Strengthening cultural and linguistic responsiveness, expanding Arabic-speaking workforce capacity, improving partner-focused education, and reducing practical access barriers therefore directly fulfil national expectations for safe, equitable, and culturally aligned maternity care in Aotearoa New Zealand.

Limitations

The findings of this qualitative study cannot be generalised to all Middle Eastern refugee women in New Zealand due to the small sample size and the specificity of participants' backgrounds and experiences. Future investigations could strengthen representativeness by recruiting a larger and more diverse sample along with including the perspectives of healthcare providers who deliver postpartum care to refugee mothers. This would also offer a more comprehensive understanding of the system-level factors influencing maternal emotional wellbeing.

Language barriers presented an additional limitation. All interviews were in Arabic language, so translation of transcriptions was required, and although care was taken to ensure accuracy, the process of translation carries the risk that certain culturally embedded expressions or emotional meanings may not be fully conveyed in English. Some concepts have no direct linguistic equivalent, which may result in partial loss or alteration of nuance.

Despite these limitations, this study offers valuable insights into the emotional and mental health needs of Middle Eastern refugee women and the barriers they encounter when seeking help during the postpartum period.

Regarding the scoping review, the search strategy was systematic, using recognised databases and guided by Arksey and O'Malley (2005) methodological framework, with article management supported by Covidence. However, the available evidence base remains limited. Few studies have focused specifically on Middle Eastern refugee women, particularly within the past five years. Additionally, unpublished reports, community-based evaluations, or grey literature that may contain relevant insights were not included due to limited accessibility. This gap may restrict the breadth of current knowledge and underscores the need for further research in this area.

Future Research Work

Further research is needed to deepen understanding of the postpartum emotional and mental health needs of the wider population of refugee women in New Zealand, given the complex interplay of factors that shape their experiences. While qualitative methods are well suited to capturing the richness of women's narratives, integrating quantitative approaches such as validated maternal mental-health assessment tools would strengthen the evidence base.

Refugee mothers caring for infants or young children with medical, developmental, or complex health needs represent another under-researched group. These women often experience heightened emotional strain, yet their postpartum experiences remain largely absent from the current literature. Existing evidence indicates that mothers of infants with medical conditions have higher rates of postpartum depression and more severe symptoms than mothers of healthy infants (Tahirkheli et al., 2014). Research that examines how the demands of managing a child's health needs and long-term maternal mental health interact with resettlement stressors would provide critical insights to inform more targeted and responsive support for refugee families.

Furthermore, the experiences of working refugee women who return to paid employment within the first 12 months postpartum remain underrepresented in New Zealand research and policy (James et al., 2025; O'Mahony et al., 2012; O'Mahony, 2011; Röder et al., 2018). Language barriers and limited access to culturally responsive care may further delay help-seeking (O'Mahony & Donnelly, 2010), increasing reliance on alternative sources of support. By examining postpartum experiences alongside employment demands, this study generates

policy-relevant evidence to inform parental leave provisions, workplace conditions, and maternal health support for refugee women in New Zealand.

Future research should also involve collaboration with government agencies, maternity services, and community health organisations to design, implement, and evaluate culturally responsive intervention programmes. At present, there is a significant lack of evidence-based evaluations of maternity mental-health promotion initiatives targeted toward refugee and migrant women, which limits informed policy development. Studies that assess the effectiveness, acceptability, and cultural relevance of such interventions would play an important role in shaping equitable and responsive maternal mental-health care in Aotearoa New Zealand.

Conclusion

The number of refugees coming to New Zealand from the Middle East region has increased significantly over recent decades. How to understand Middle Eastern women's emotional and mental postpartum experiences, and the barriers they face when seeking help, is a legitimate concern for both the women who need support and the healthcare providers responsible for delivering maternity care. Thus, the purpose of this study was to explore how individual, cultural, interpersonal, and systemic factors influence Middle Eastern refugee women's postpartum emotional wellbeing and their ability to seek and receive appropriate help.

The scoping review examined international evidence on the postpartum mental-health experiences of Middle Eastern refugee women resettled in high-income countries, including Australia, Canada, Turkey, and the United States. The review identified multiple, intersecting barriers to emotional wellbeing and help-seeking across individual, interpersonal, cultural, and systemic levels, including limited health literacy, language and communication barriers, social isolation, cultural stigma, and challenges navigating maternity and mental-health services.

The qualitative study extended and contextualised these findings within the setting of Aotearoa New Zealand. It demonstrated that Middle Eastern refugee women's help-seeking experiences were shaped by a complex interplay of limited health literacy and service knowledge, language and interpreter barriers, social isolation and loss of traditional

postpartum support, constrained partner awareness, culturally embedded gender norms and stigma, and structural barriers within maternity services. Despite these challenges, participants demonstrated considerable resilience and articulated clear, practice-relevant recommendations for improving care. These included the provision of culturally and linguistically appropriate services, greater partner-focused education, practical postpartum supports such as childcare and transport, and more accessible, culturally safe, equitable, and responsive maternity care for refugee mothers in Aotearoa New Zealand.

Strengthening cultural competence, improving interpreter services, addressing practical barriers, and supporting family involvement are all essential steps toward enhancing postpartum adjustment and emotional wellbeing among this growing population. Ultimately, supporting Middle Eastern refugee women during the vulnerable postpartum period is not only a matter of clinical responsibility but also an integral part of New Zealand's commitment to equitable, compassionate, and culturally informed healthcare for all.

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Generative AI use statement

In accordance with Massey University guidelines on the ethical use of generative artificial intelligence (AI), I acknowledge that AI tools were used in a limited and supportive capacity in this research as follows:

1. The automatic transcription functions in Microsoft Teams and Zoom were used to generate initial interview transcripts. All transcripts were manually checked against the original audio recordings for accuracy and completeness.
2. Grammarly, Google Translate, and ChatGPT were used to assist with the translation of de-identified interview transcripts from Arabic to English. These tools were also used to enhance clarity and readability while preserving the original cultural meanings of participants' narratives. All translations were reviewed and verified by me to ensure fidelity to the original data.
3. Grammarly and ChatGPT were used for language editing and proofreading of the thesis, including checking grammar, sentence clarity, table formatting, and visual presentation of graphs.
4. Grammarly, Google Translate, and ChatGPT were used to proofread and enhance the clarity of study materials, including the interview guide, participant information sheets, and recruitment advertisements.

All outputs generated by these tools were carefully reviewed and modified by me to ensure accuracy, consistency with the original meaning, and alignment with my own scholarly work.

Appendices

Appendix A-Ethical Approval Massey University

10/06/2025

Dear: Esraa Ahmad

Re: Ethics Application - OM1 25/17 - Understanding Postpartum Mental Health in Refugee Mothers: Attitudes, Challenges, and Help-Seeking Behaviours.

Thank you for the above application that was considered by the Massey University Human Ethics Committee:

Ohu Matatika 1 at their meeting held on **Tuesday, 8 April 2025**

On behalf of the Committee I am pleased to advise you that the ethics of your application are approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Tracy Riley,

Acting Chair, Research Ethics Chair's Committee

Appendix B- participants Information Sheets-English Version

Information Sheet for Participants

English Version

Kia ora, السلام عليكم (As-salamu alaykum),

My name is Esraa Ahmad, and I am completing a master's degree in public health at Massey University. I am originally from Jordan, in the Middle East, and I moved to New Zealand 10 years ago. Initially, I lived in Auckland, then moved to Wellington for three years before returning to Auckland.

As a mother of three children and like many migrant and refugee women, I navigated the challenges of motherhood without family support. All three of my children were born in New Zealand, and while raising them, I personally experienced a range of emotions after giving birth, particularly after having my youngest child, who is now 3.5 years old. I gave birth to him shortly after moving to Wellington, where I felt isolated because I was new to the city and all my friends and support networks were still in Auckland. This experience has given me a deep understanding of the emotional challenges that can come with giving birth in a new country, far from family support.

As a Jordanian, I also understand the journey of displacement and migration. Jordan has been home to many refugees from neighbouring countries affected by conflict, and I have witnessed firsthand the challenges that come with starting a new life in a different country. Because of this, I can truly relate to your journey of moving to New Zealand and the emotional struggles that can come with it.

My research aims to explore your thoughts, experiences, and feelings about postpartum mental health, including any challenges you may have faced and the support you have

received. Your voice is important, and this study will help inform better support for Arabic-speaking refugee women in the future.

I am being supervised by Prof Linda Murray and Prof Leigh Signal, who are experienced researchers at Massey University.

What is this study about?

Postpartum mental health is an important issue for women, especially for those who have experienced displacement and resettlement as refugees. Research shows that refugee women are at higher risk of postpartum depression (PPD) due to challenges such as cultural adjustment, language barriers, and limited access to mental health services. However, there is very little research that focuses on the experiences of Arabic-speaking refugee women in New Zealand.

This study aims to:

- Learn about your experiences and feelings related to postpartum mental health.
- Understand the challenges you may have faced in accessing mental health support.
- Identify what kind of support would be most helpful for Arabic-speaking refugee women during the postpartum period.

Dear sister, you are invited to take part in one-on-one interviews. Participation is entirely your choice. There is no pressure to take part, and you are encouraged to take your time to decide whether or not you would like to participate. If you are interested, please read through the information below and complete the consent form.

Who can take part?

We are looking for Arabic-speaking women who:

- Have given birth in New Zealand within the last five years, and
- Are former refugees or have resettled in New Zealand as refugees, and
- Are fluent in Arabic or English.

We aim to interview 8–10 women for this study.

What is involved if I decide to take part?

If you choose to participate, here is what will happen:

- **Read this information sheet**: You can discuss it with family, whānau, or friends if you wish. If you have any questions, please get in touch with me or my supervisors (details below).
- **Consent form**: If you would like to participate, you will need to sign a consent form. You can return it to me via email or bring it to the interview.
- **Interview**: The interview can be conducted either **in person or online**, depending on your location and preferences. Whether in person or online, the interview will be scheduled at a time that is convenient for you. If conducted in person, the location will also be arranged based on your preference and accessibility.
  The interview should take **no more than 90 minutes of your time, including around 60 minutes for the interview itself. It will be audio recorded using the Microsoft Teams app,** and can be conducted in **either Arabic or English**, depending on your preference.

  Children are welcome to accompany you during the interview if needed. For in-person interviews, we aim to choose locations that are child-friendly, and interviews can be paused or rescheduled as needed to accommodate your child's needs. Baby setting could be arranged to supervise your child.

  You are welcome to have a support person present during the information and consent process. However, once the interview begins, the support person will be asked to leave the online meeting space or, for in-person interviews, wait in a comfortable waiting area nearby. This is to ensure that you can speak freely and without influence.
- **Koha**: As a thank-you for your time, you will receive a 40NZD Prezzy gift card.

What will happen to your information?

The interview will be audio-recorded and transcribed into a digital written document.

All research data will be stored securely to protect participant privacy. All personal data will be de-identified to ensure confidentiality. Digital data will be saved in password-protected files on Massey University's secure OneDrive system, accessible only to the researcher and supervisors. Physical data, such as signed consent forms, will be stored separately in locked cabinets at the Sleep/Wake Research Centre at Massey University. All data will be retained for a minimum of five years and then securely destroyed in accordance with Massey University's Research Data Management Policy.

My thesis, academic publications, and presentations will share this study's findings. If requested, you and any community organizations will receive a summary of the findings.

What are the possible risks and benefits of taking part?

Benefits

- This is an opportunity to share your experiences and contribute to better support for Arabic-speaking refugee women in New Zealand.
- Your participation will help inform future research and policies to improve postpartum mental health services.
- You will receive a gift voucher as a token of appreciation for your time.

Risks

- Some questions may bring up difficult emotions or memories. You are free to skip any questions or stop the interview at any time.
- If you express concerns about self-harm or harm to others during the interview, I may need to share this information with my supervisors or a mental health professional to ensure your safety.

Your rights as a participant

Your participation is completely voluntary, and you have the right to:

- Ask questions at any time.
- Withdraw from the study up until two weeks after we have returned the transcript to you. After this time, your data may already be included in the analysis and cannot be removed.
- Decline to answer any questions.
- You may ask for the audio recording to be stopped at any time, especially if you feel emotional or uncomfortable. If you choose to pause or stop the recording, I will pause the interview and give you a time to take a break or refresh. Afterward, I will check in with you to see if you feel comfortable continuing. You are also completely free to end the interview at any point if you prefer.
- Receive a summary of the study findings when the research is completed.

Ethics Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika1, Application OM1 25/17. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 1. email: humanethics1@massey.ac.nz.

The Project Contacts

If you have any questions or concerns, please feel free to contact me or my supervisors:

1. **Esraa Ahmad**: The main researcher.
   Master student.

Massey University, Wellington, New Zealand.

Email : Esraa.Ahmad.1@uni.massey.ac.nz

2. **Prof Leigh Signal**: The research supervisor.
Associate Professor

Sleep/Wake Research Centre, School of Health. Massey University, Wellington, New Zealand.

Email: t.l.signal@massey.ac.nz

3. **Prof Linda Murray**: The research supervisor.
Associate Professor School of Health sciences

Massey University, Wellington, New Zealand.

Email: L.Murray1@massey.ac.nz

If interested to participate:

If you would like to participate, please contact me at Esraa.Ahmad.1@uni.massey.ac.nz . I will provide you with a consent form and contact you to arrange a suitable time and place for the interview.

Thank you for considering being part of this important research. Your contribution will help improve support for Arabic-speaking refugee women in New Zealand. Please feel free to take your time before deciding to take part.

Resources

If you would like additional support or information, here are some resources that may be helpful:

1. Refugees as Survivors New Zealand (RASNZ): Provides mental health and well-being support for refugees.
   Website: www.rasnz.co.nz | Phone: 09 270 0870
2. Mental Health Foundation of New Zealand: Offers resources and support for mental health.
   Website: www.mentalhealth.org.nz
3. Plunket Line: Provides support for new mothers, including mental health advice.
   Phone: 0800 933 922

If you would like more information, please contact me at any time.

Appendix C- Consent form-English Version

Please tick Yes or No (whichever applies) to the following statements:

Statement	Yes	No
1. I have read, or had read to me, the Information Sheet and understood what this study involves. My questions have been answered to my satisfaction, and I understand that I can ask further questions at any time.		
2. I have been given enough time to consider whether I want to take part in this study and understand that taking part is voluntary and that I can withdraw at any time before data analysis begins.		
3. I know whom to contact if I have any questions or concerns about the study.		
4. I agree to participate in this study under the conditions set out in the Information Sheet.		
5. I agree to the interview being audio-recorded.		
6. I wish to receive a summary of the study's findings.		
7. I understand that participation in this study is confidential. Direct quotes may be used, but no material that could identify me or my family will be included in reports.		
8. I understand that if I become distressed during the interview, I can take a break or stop at any time. I have been provided with a list of support services I can contact if needed.		

Participant Details

Full Name: _____

Signature: _____

Phone Number: _____

Email: _____

Date: _____

Once you have completed and signed this form, you can return it to the researcher Esraa in person or via email to esraaahmadoct83@gmail.co

Thank you for your time and participation.

Appendix D-Study Advertisement -English Draft

Understanding Postpartum Mental Health in Refugee Mothers

Arabic-speaking refugee women needed

CAN YOU HELP?

We are seeking 10 Arabic-speaking refugee women who have given birth in New Zealand within the past five years to take part in a confidential research study exploring experiences of postpartum mental health.

What is involved?

- One-on-one interview in Arabic or English
- Scheduled at a time and place that suits you
- A 40$ gift card will be offered in appreciation

TO FIND OUT MORE

Please contact Esraa Ahmad

Email: Esraa.Ahmad.1@uni.massey.ac.nz

TE KUNENGA KI PUREHUROA | MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 25/17. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 1, email humanethics1@massey.ac.nz

Appendix E -The Interview Guide

Interview Schedule Guide

Study title: ***Refugee Mothers' Voices: Exploring Emotional and Mental Health Experiences After Resettlement and Childbirth in New Zealand***

- **Participant Eligibility Check**:

Check (✓)	Eligibility
	Middle Eastern refugee women
	Gave birth in New Zealand.
	Baby age < 5 years

- **Pre-Interview checklist (10–15 minutes)**

Check (✓)	Welcome, Introduction and Consent
	Introduce myself and the study.
	Explain the purpose of the interview.
	Ensure the participant understands the consent form.
	Sign the consent form.
	Reassure the participant of confidentiality and the right to withdraw at any time.

- **Interview Questions (30–40 minutes)**

Section 1: Demographic and Background Information

Check (✓)	Question

	Where are you from?
	What is your age?
	What is your highest education level?
	How long have you been in New Zealand?
	How many children do you have, and how many children you gave birth in NZ?
	What is your youngest child age ?
	How was your delivery? Did you require hospital or postnatal care?

Section 2: Experiences, Awareness, and Barriers

Check (✓)	Question	Arabic
	How would you describe your emotional experience during the first 12 months after giving birth (or since giving birth if baby under 12-month-old)? To what extent did you feel your emotions were stable and healthy?	كيف تصفين تجربتكِ العاطفية خلال الأشهر الاثني عشر الأولى بعد الولادة (أو منذ الولادة إذا كان عمر الطفل أقل من 12 شهرًا)؟ وإلى أي مدى شعرتِ أن عواطفكِ كانت مستقرة وصحية؟
	Did you choose the midwife yourself? And was it easy to understand the maternity system in New Zealand?	هل اخترتِ القابلة بنفسكِ؟ هل كان من السهل فهم نظام رعاية الأمومة في نيوزيلندا؟
	How well do you think your partner or family understood your emotions after giving birth? How would you describe the support they gave you?	إلى أي مدى تعتقدين أن شريككِ أو عائلتكِ كانوا يفهمون مشاعركِ بعد الولادة؟ وكيف تصفين الدعم الذي قدموه لكِ؟
	What was your sleep like after giving birth? Did you receive any information or support to help with	كيف كان نومكِ بعد الولادة؟ وهل تلقيتِ أي معلومات أو دعم للمساعدة في تحسين نومكِ؟ وما الدور الذي لعبه النوم في صحتكِ النفسية والعاطفية؟

	your sleep? What role did sleep play in your mental and emotional well-being?	
	What barriers might make it difficult for you to discuss your emotional needs with your partner or family?	ما العوائق التي قد تجعل من الصعب عليكِ مناقشة احتياجاتكِ العاطفية مع شريككِ أو عائلتكِ؟
	How did your postnatal healthcare providers check in with you about your emotional and mental well-being?	كيف كان مقدمو الرعاية الصحية بعد الولادة يسألوكِ أو يتابعوكِ بخصوص حالتكِ النفسية ومشاعركِ؟
	How has the information you received from your maternity care providers (during pregnancy and after birth) shaped your understanding of maternal emotions and signs of concern?	كيف أثرت المعلومات اللي أخذتيها من مقدمي رعاية الحمل والولادة (وقت الحمل وبعد الولادة) على فهمكِ لمشاعر الأمومة والعلامات اللي ممكن تكون مقلقة؟
	Did your maternity care providers give you clear information about available mental health resources or support services in case you felt emotionally unwell?	هل قدّم لكِ مقدمو رعاية الأمومة معلومات واضحة عن الموارد أو خدمات الدعم النفسي المتاحة في حال شعرتِ بعدم الاستقرار العاطفي؟
	What barriers might make it difficult for you to discuss your emotional needs with postnatal healthcare providers?	شو الأشياء اللي ممكن تخلي من الصعب عليكِ تحكي عن احتياجاتكِ العاطفية مع مقدمي الرعاية الصحية بعد الولادة؟

Section 3: Recommendations for Improvement

Check (✓)	Question
	What could influence or support your confidence to discuss your maternity emotion needs with your health providers and services could support you?

	شو الأشياء اللي ممكن تساعدكِ أو تخليكِ واثقة أكثر إنكِ تحكي عن احتياجاتكِ العاطفية بعد الولادة و ما أنواع الدعم التي من شأنها أن تساعد في تعزيز الصحة النفسية والعاطفية ؟

- **Post-Interview checklist (5 minutes)**

Check (✓)	Closing and Debriefing
	Thank the participant for their time and insights.
	Ask if they have any final thoughts or comments.
	Provide information on available mental health support services if needed.
	Remind them that their responses will remain confidential.
	Give the participant a gift voucher as a token of appreciation
	Inform the participant they will have the opportunity to review the interview transcript.
	Confirm their preferred method of receiving the transcript (email, printed copy, etc.). Discuss any follow-up communication if necessary.
	Thank the participant for their time and insights.

Appendix F-Scoping Review Studies Summary Tables

Summary Table Part I

NO	Study Title	Authors	Date of Publishing	Study Design	Study Country	Study Population	Refugees Sample	Middle Eastern Participants country of origin
1	Perceptions and Experiences of Inequity for Women of Refugee Background Having a Baby during the COVID-19 Pandemic in Melbourne, Australia.	Hearn, F., Brown, S. J., Szwarc, J., Toke, S., Alqas Alias, M., Essa, M., ... & Riggs, E.	2024	Qualitative; Semi structured	Melbourne, Australia	Refugees	whole refugees' population N=17, including N=8 from Middle East	Syrian; Iraqi; Sudanese; Assyrian
2	"COVID affected us all:" the birth and postnatal health experiences of resettled Syrian refugee women during COVID-19 in Canada.	Stirling Cameron, E., Ramos, H., Aston, M., Kuri, M., & Jackson, L.	2021	Qualitative Semi structured	Canada	Refugees	8	Syrian

3	Barriers to postpartum health and opinions on a postpartum peer navigator program amongst refugee women resettled in California.	Alsamman, S., Tadesse, R. T., Sarferaz, K., Mohamed, A. S., & Mody, S. K.	2025	Descriptive qualitative study utilizing semi-structured one-on-one interviews	United state	Refugees	Whole refugees N=26, including N=14 (53.8%) Arabic speaking /Middle East	Sudanese /Syrian
4	Refugee women's well-being, needs and challenges: implications for health policymakers.	Qutranji, L., Silahl, N. Y., Baris, H. E., & Boran, P. E. R. R. A. N.	2020	Mixed method: Patient Health Questionnaire - Quantitative; A descriptive qualitative study (Semi-structured interviews)	Turkey	Refugees	47	Syrian
5	The postnatal experiences of resettled Syrian refugee women: Access to healthcare and social support in Nova Scotia, Canada.	Cameron, E. S., Aston, M., Ramos, H., Kuri, M., & Jackson, L.	2022	Qualitative; Semi structured	Canada	Refugees	11	Syrian

6	Maternal stressors and maternal bonding among immigrant and Refugee Arab Americans resettled in the United States.	Khalil, D., George, Z., Dannawey, E., Hijawi, J., ElFishawy, S., & Jenuwine, E.	2024	a cross-sectional design	United state	Refugees; Forced Migrants; Immigrants		Middle Eastern/Syrian, Palestinian, Lebanese, Yemeni, Iraqi
7	Postpartum mental health of immigrant mothers by region of origin, time since immigration, and refugee status: a population-based study	Vigod, S. N., Bagadia, A. J., Hussain-Shamsy, N., Fung, K., Sultana, A., & Dennis, C. L. E.	2017	Cohort Population Study	Canada	Refugees; Immigrants	Whole refugees (N = 15,505). From which MENA refugees (n=3,588)	Middle Eastern and North Africa (MENA)- Arabs
8	Maternal depression in Syrian refugee women recently moved to Canada: A preliminary study	Ahmed, A., Bowen, A., & Feng, C. X.	2017	A qualitatively driven mixed methods- Questionnaire and focus group discussion	Canada	Refugees	12	Syrian
9	Syrian refugee women's experiences of barriers to mental health services for postpartum depression	Salameh, T. N., Sakarya, S., Acarturk, C., Hall, L. A., Alâ€□Modallal, H., & Jakalat, S. S.	2025	A descriptive qualitative study- semi-structured telephone interviews for participants scored	Turkey	Refugees	15	Syrian

				≥10 on Edinburgh Postnatal Depression Scale assessments				

Summary Table Part II

No	Title	Study Aim	Data Analysis Method	Study Findings and Interventions Summary
1	Perceptions and Experiences of Inequity for Women of Refugee Background Having a Baby during the COVID-19 Pandemic in Melbourne, Australia.	aimed to (1) understand how women of refugee background in Melbourne, Australia experienced access to health information and maternity and/or early parenting care during the COVID-19 pandemic and (2) whether pandemic health directives had an impact on structural inequities for women of refugee background who received maternity and/or early parenting care during the COVID-19 pandemic.	Qualitative/ Thematic	Barriers Lockdown-related isolation and family separation intensified stress, anxiety, and depression. Language barriers and inadequate access to health information in preferred languages limited understanding of pandemic guidelines and maternity care. Telehealth limitations: short appointments with interpreters reduced opportunities to ask questions; loss of face-to-face cues affected trust. Economic hardship: inadequate household income; exclusion of asylum seekers from government payments led to destitution. Fear and stigma: reluctance to leave home due to visible police presence; fear of being non-compliant. Structural inequities amplified: visa-related restrictions, limited transport access, and reduced cultural safety. Gaps Insufficient culturally safe communication and limited early engagement with refugee communities during pandemic planning. Lack of research on the intersectional effects of structural inequities on maternal and neonatal health outcomes. Standard telehealth models failed to meet interpreter-dependent women's needs. Recommendations: early community consultation, culturally safe audiovisual

				information, longer interpreter-supported appointments, and inclusive social support (including for asylum seekers).

2	"COVID affected us all:" the birth and postnatal health experiences of resettled Syrian refugee women during COVID-19 in Canada.	To understand Syrian refugee women's experiences accessing postnatal healthcare services and supports during the COVID-19 pandemic.	Qualitative/ Thematic	Barriers Strict hospital restrictions: many women laboured and delivered alone; doulas and support people often excluded. Loss of informal support networks: family separation, stay-at-home orders, and closure of schools/daycare increased childcare burden and exhaustion. Language barriers: limited in-person interpretation; phone-based interpretation was slow and inadequate, sometimes unavailable; women struggled with English-only public health information. Interrupted services: in-home visits by public health nurses and doulas cancelled; delayed access to preferred long-acting contraception. Fear of COVID-19 exposure led to missed appointments. Gaps Pandemic amplified pre-existing gaps: fragmented interpreter access, inadequate social support, and under-recognition of postpartum mental health needs. Telehealth models were poorly adapted for interpreter-dependent women. Lack of equity-focused crisis planning for refugee maternal care. Recommendations: classify doulas and interpreters as essential care team members, expand virtual family-centred support, and develop equity-oriented crisis policies.

3	Barriers to postpartum health and opinions on a postpartum peer navigator program amongst refugee women resettled in California.	This study explores the postpartum experiences of refugee women and assesses their interest in and opinions on a postpartum peer navigator program.	Qualitative/Thematic, quantitative	Statistics Participants: 26 refugee women; 50% Syrian, 53.8% Arabic-speaking; average age 30 years; average time in the US 4.5 years; all publicly insured; 88.5% used interpreters. Barriers Mental health: Many reported postpartum depression, loneliness, and anxiety linked to displacement, family separation, and cultural isolation. Postpartum care access: Most attended at least one postpartum visit but felt recommendations were unclear or misunderstood due to language issues. Information gaps: Insufficient or incomprehensible postpartum care information, especially about contraception. Reliance on family/friends or online sources led to misinformation. Displacement and isolation: Separation from family and the absence of traditional support systems worsened postpartum mental health. Stigma and fear: Reluctance to seek postpartum mental health care due to cultural stigma, fear of being labelled as unfit mothers, or concerns about child custody. Interpretation challenges: Distrust of interpreters, male interpreters causing discomfort, dialect mismatches, and misinterpretations leading to confusion (e.g., incorrect cancer diagnosis). System navigation difficulties: Limited understanding of the U.S. healthcare system; postpartum visits felt rushed and culturally insensitive Gaps Lack of culturally and linguistically appropriate postpartum support.

				No systematic approach to address postpartum depression stigma or misinformation about contraception. Interpreter services insufficient; shortage of female and dialect-matched interpreters. Few programs that bridge medical, cultural, and emotional support. Recommendations: integrate peer navigators as cultural mediators, offer Arabic-language resources, and design trauma-informed, stigma-sensitive care.

4	Refugee women's well-being, needs and challenges: implications for health policymakers.	Aim to understand Syrian refugee women's needs for care and the predisposing and enabling factors to healthcare access and utilisation.	Qualitative/ Thematic	Barriers Several barriers impacting access to support and care were highlighted: Cultural Barriers: Stigma and shame surrounding mental health in their cultures. Beliefs that motherhood should bring joy, making it hard to admit emotional struggle. Fear of judgment from community members or family. Language and Communication: Limited English proficiency created challenges in expressing emotional distress and navigating healthcare. Lack of culturally appropriate interpretation services reduced quality of care. Healthcare System Challenges: Unfamiliarity with Western medical systems Inadequate cultural competence among providers. Providers lacked understanding of refugees' cultural and trauma backgrounds. Socioeconomic Barriers: Low income, lack of transportation, and limited access to childcare. Social isolation and lack of extended family support. Insecure housing or immigration status. 3. Gaps Insufficient integration of cultural values and understanding in care practices. Lack of routine mental health screening in a culturally appropriate manner. Underrepresentation of refugee women's voices in mental health policy. Lack of support networks, especially for newly arrived or socially isolated

				women. Recommendation: Promote trauma-informed, culturally competent care tailored to refugee women’s experiences.

5	The postnatal experiences of resettled Syrian refugee women: Access to healthcare and social support in Nova Scotia, Canada.	to understand the lived experiences of access to postnatal services and supports among refugee women who have resettled in Nova Scotia, Canada.	Qualitative /Thematic	Barriers Separation from family and limited informal support intensified postpartum depression, homesickness, and physical recovery difficulties. Language barriers: reliance on interpreters, long delays, and discomfort with male interpreters; miscommunications led to traumatic birthing experiences. Childcare and transport difficulties: many women missed appointments due to lack of childcare; dependence on public transport (3–4 buses), with long delays, especially in winter. Provider paternalism: women felt dismissed or judged, with limited autonomy in decisions about mental health referrals, feeding choices, and family planning. Gaps Irregular and inadequate interpreter services; insufficient culturally and linguistically competent care. Lack of accessible in-home postpartum support (e.g., doulas, navigation programs). Limited availability of social and financial resources, with newcomer families relying heavily on income assistance. Need for anti-racist, culturally safe, patient-centred training for healthcare providers. Recommendations: strengthen interpreter access, expand in-home supports (Arabic-speaking doulas, peer navigators), and address systemic inequities as part of reproductive justice.

6	Maternal stressors and maternal bonding among immigrant and Refugee Arab Americans resettled in the United States.	Investigate the relationship between maternal psychosocial stress (acculturative stress, posttraumatic stress), maternal depressive symptoms, and maternal bonding with the infant and child	Quantitative, Qualitative	Statistics : Total sample: 78 Arab American mothers; 56% were refugees. Depressive symptoms: 19% scored above the EPDS cutoff; prevalence was higher in refugees (23%) vs. immigrants (12.5%). Posttraumatic stress: 18% had clinically significant symptoms; refugees had higher rates (24%) vs. immigrants (11%). Refugees were older, less educated, had lower incomes, and shorter stays in the US. Posttraumatic and acculturative stress correlated with depressive symptoms ($\rho = 0.48–0.60$) and maternal bonding impairment ($\rho = 0.39$). Barriers Premigration trauma (war, persecution, displacement) and resettlement stress (minority identity, loss of social support, language barriers). Economic hardship: 89% had family incomes < $40,000; most relied on WIC, Medicaid, and food stamps. Cultural factors: shrinking support networks in a collectivist culture increased stress and depression. Gaps Refugee Arab mothers are underrepresented in maternal mental health research; few studies examine how acculturative and posttraumatic stress affect bonding.

				Recommendations: early screening, culturally sensitive interventions, home visiting, perinatal education, mental health and mindfulness interventions to support bonding.

7	Postpartum mental health of immigrant mothers by region of origin, time since immigration, and refugee status: a population-based study	generate epidemiological evidence about differences in postpartum mental health care utilisation among immigrant women by examining postpartum mental health contact among immigrant women by region of origin, time since immigration, and refugee status	Quantitative, Qualitative	Statistics: Total immigrant cohort: N = 123,231, including 15,182 from MENA, of whom 23.6% were refugees. Mental health contact within 1 year postpartum: Overall: 14.1% had any mental health contact. Outpatient: 16.9% for MENA (aOR 1.09 vs. European/North American immigrants). Emergency department (ED): 0.65% for MENA; refugees had 1.81× higher odds of ED visits. Psychiatric hospitalization: 0.16% for MENA; refugees had 1.78× higher odds of hospitalization. Most common diagnoses: depressive and anxiety disorders; psychotic disorders were rare in MENA (0.2%). Barriers Under-utilization of outpatient care among recent immigrants (<5 years), including MENA refugees (aOR 0.83). Stigma and cultural attitudes toward mental illness reduce help-seeking; fear of disclosure persists. Awareness and understanding of postpartum mental health issues may be low; stigma is higher in collectivist and developing countries. Gaps Higher acute care use (ED and hospitalization) indicates unmet needs and inadequate outpatient support for refugee women. Limited capacity to measure unmet mental health needs—administrative data do not capture women who did not seek care. Few studies examine culturally tailored interventions for MENA refugees.

				Other findings Refugee women’s increased ED and hospital use indicates more severe or crisis-level postpartum mental health episodes. Targeted screening and culturally safe outpatient follow-up are recommended to reduce crises and hospitalizations

8	Maternal depression in Syrian refugee women recently moved to Canada: A preliminary study	explore refugee women's experiences of expecting or having a baby after resettlement in Canada from a mental health perspective to inform service providers and policy makers to develop the services and programs that meet the needs of this specific population.	Thematic; statistics	Statistics More than half (7/12; ~58%) screened positive for possible depression (EPDS ≥10). Half (6/12; 50%) screened positive for possible anxiety. One-sixth (2/12; 16%) screened positive for PTSD. Rates are nearly five times higher than Canadian-born women Barriers Stigma and privacy concerns: fear of being labelled “crazy”, reluctance to disclose symptoms, concerns about confidentiality, especially when interpreters are used. Cultural perceptions: depression often described as “boredom” or “tiredness”; maternal depression seen as uncommon among Syrians; reliance on faith for healing. Separation from family support: loss of traditional postpartum care and social networks. Language barriers: difficulty communicating with healthcare providers and maintaining privacy. Gaps Lack of awareness about maternal depression symptoms, causes, and treatment among refugee women and their families. Limited culturally sensitive mental health services; need for gender-specific programs and interpreters with strong privacy protections. Study limitations: small sample size (12 women), single focus group, and qualitative design limit generalizability. Other significant findings Protective factors: emotional and practical support from family, partners,

				spiritual practices (prayer, Quran), hope and safety in Canada, and culturally appropriate social programs. Women prefer non-medication approaches and wellness-framed support programs to avoid stigma. Family reunification and gender-segregated recreational spaces were seen as critical for mental well-being
9	Syrian refugee women's experiences of barriers to mental health services for postpartum depression	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 Turkiye	Qualitative/ Thematic; Quantitative	Statistics 33 (16.5%) scored ≥10 on the Edinburgh Postnatal Depression Scale (EPDS), suggesting risk for postpartum depression. Of those, 15 participated in interviews; 66.7% reported an unmet need for PPD treatment Barriers (five dimensions of Levesque's model): Approachability: Lack of knowledge and misconceptions about PPD; low awareness of psychosocial services; many did not perceive the need for treatment. Acceptability: Stigma of mental illness, fear of discrimination, legal status

				barriers, strong cultural preference for female providers, language barriers threatening privacy. Availability/Accommodation: Transport difficulties, distant clinics, no childcare support, and lack of time due to domestic responsibilities. Affordability: Financial hardship, transportation costs, interpreter fees, and incomplete health insurance coverage. Appropriateness: No routine screening for PPD; services were intermittent and focused on childcare rather than maternal mental health Gaps PPD screening and culturally adapted interventions are largely absent in routine maternal care. Legal and structural barriers (insurance, ID card restrictions) are unaddressed. Mental health programmes prioritize infant care over maternal well-being Other findings Stigma and privacy concerns prevented women from disclosing symptoms, especially when interpreters were involved. Recommendations: culturally tailored care, Arabic-language resources, telehealth options, and strengthening legal and financial protections for refugee women