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Abstract

Introduction: Globally, 27 million female refugees of reproductive age are subjected to numerous socio-ecological factors that increase their risks of mental health issues, especially during the postpartum period. This study seeks to explore Syrian refugee mothers' experiences and perceptions of postpartum depression.

Methods: We used a qualitative phenomenological approach to interview purposively sampled typical postpartum Syrian mothers living in informal camps in Lebanon to evaluate their maternal mental health perceptions, coping strategies, and help-seeking practices.

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Results: Results revealed three major themes: conceptualizing maternal depression as extraordinary and ordinary, cultural perceptions of mental health help-seeking, and coping with negative emotions.

Discussions: Findings are critical to Lebanon and other Muslim refugee-hosting countries as they can inform future health policies, health care delivery models, and community interventions. Utilizing culturally and religiously appropriate frameworks in assessing and providing mental health services to this vulnerable group can substantially improve mental health services' acceptance, utilization, and impact.

Keywords: psychiatric/mental health, public health policy, women's health, refugees and asylum seekers, other, migration

Background

Despite its public health importance, maternal depression is often overlooked in low- and middle-income countries (LMICs) (Atif et al., 2015). The highest mean prevalence of maternal depression is during the postnatal period (Atif et al., 2015). Postpartum depression (PPD) is a gender-specific group of mood disorders that can be triggered by underlying psychosocial factors as well as acute hormonal changes following delivery (Miller, 2002). Globally, the prevalence of PPD is approximately 17.22%; however, there are significant regional disparities in PPD, with women in LMICs disproportionately affected (Wang et al., 2021). Postpartum mood disorders can range from postpartum blues to depression with psychotic features. They can seriously impact the mother and her family, including disruption of marital relationships, social isolation, suicide, infanticide, and children's cognitive and social skills (Miller, 2002). The severity of PPD has been linked to multiple predisposing factors, including individual (e.g., unplanned pregnancy), familial/social (e.g., lack of family support), and ecological (e.g., low income, poor living conditions, violence exposure) (Beck, 2001; Letourneau et al., 2012; O'Hara & Swain, 1996; Wang et al., 2021).

Given the socio-ecological etiology of maternal mental health, it is perhaps unsurprising that refugee women are at significantly increased risk for experiencing PPD (Haque & Malebranche, 2020). More than 89 million persons were displaced globally at the end of 2021, which accounts for internally displaced persons (IDPs), refugees, and

"persons of concern" in exceptional circumstances (United Nations High Commissioner for Refugees [UNHCR], 2022a). Although the United Nations Refugee Agency, also commonly referred to by its former initialism "UNHCR," does not have publicly available statistics on women and girls of reproductive age, nearly 30% of the female refugee population is between 12 and 59 years of age (UNHCR, 2022d), making sexual and reproductive health a central concern. Maternal mental health among refugees is well suited to situational models, which describe how context—such as interpersonal, sociocultural, and ecological factors—influence mental health (Karasz, 2005). Within this framework, pre-migration risks for PPD include exposure to violence (including sexual- and gender-based violence), death of family members or loved ones, and heightened overall insecurity (Collins et al., 2011). Transit risks such as separation from usual sources of social support, inadequate and unsafe shelter, and food insecurity also exacerbate the risk for PPD (Tobin et al., 2018). Finally, postmigration stressors such as limited language proficiency, political climate and national views of refugees, limited-resource environments, poor access to care, and lack of perceived and real support are risk factors for poor maternal mental health (Brown-Bowers et al., 2015; Fellmeth et al., 2017; Tobin et al., 2018).

Exploration of such social and cultural elements as contributors to mental health is described by Summerfield (2000) as an alternative to addressing only the biomedical aspects of mental health among war-affected populations. Understanding how postpartum women perceive and address maternal mental health lends critical insight into supporting mothers and their families in humanitarian settings. Therefore, this study explores postpartum Syrian refugee women's experiences and perceptions of PPD in a refugee camp in Lebanon. This research provides nuanced insight into maternal mental health and fills a gap concerning women's experiences of forced displacement and health in LMICs.

The Syrian civil war forced about 6.8 million Syrians to seek refuge in many countries, including neighboring Turkey, Lebanon, and Jordan (UNHCR, 2022c). The UNHCR (2022c) estimates that more than 830,000 Syrian refugees are in Lebanon, with about 30% being females between the ages of 12 and 59. Given higher fertility rates in camps (i.e., 3.5 vs. 2.7 in refugee camps in Jordan and Syria,

respectively), increased early marriages, and poor living conditions, a higher incidence of PPD is anticipated among Syrian women residing in refugee camps (Samari, 2018). A study by Mohammad and colleagues in 2018 that used the Edinburgh Postnatal Depression Scale (EPDS) showed that nearly half of Syrian participants reported PPD symptoms (Mohammad et al., 2018). Poor maternal mental health was linked to poverty, low social support, and recent immigration from Syria. Another study supported these results using the Arabic Edinburgh Postnatal Depression Scale (EPDS) to compare maternal depression between Syrian refugees in Beirut, Lebanon, and low-income Lebanese mothers. They found higher rates of probable depression among Syrian mothers linked to the younger age of marriage, exposure to domestic violence, and a history of personal mental illness (Stevenson et al., 2019).

Methodology

Study Design

The reported qualitative findings are a component of a broader concurrent nested mixed-methods study (Kroll & Neri, 2009) that included validating a mental health tool among postpartum mothers (AlNaji, 2021) and semistructured in-depth interviews with postpartum Syrian refugee women in Lebanon. The validation focus meant we prioritized quantitative data; however, the concurrent nested design enabled us to explore the social and ecological aspects of maternal mental health, emphasizing the postpartum period, by gleaning greater insight into Syrian women's maternal stressors and coping strategies, cultural traditions around childbirth, sources of social support, and perceptions of PPD. Within the qualitative portion of the study, we used a phenomenological approach (Moustakas, 1994) to privilege participants' perspectives and meaning-making strategies. The Institutional Review Board at the University of Nebraska Medical Center approved the study under IRB # 787-20-EP on December 15, 2020.

Study Population and Context

Data collection focused on postpartum Syrian women residing in informal camps in Lebanon's Bekaa valley. Nearly 40% of Syrian refugees in Lebanon live in this region, which spans more than 4,400 km^2 (Bekaa (Zahle), 2021). The Lebanese government did not allow for formal refugee camps for Syrians due to the previous history of militarizing Palestinian refugee camps (Sanyal, 2017). This policy resulted in Syrians living in urban settings or tents in informal camps, predominantly on agricultural land in Bekaa Valley (Sanyal, 2017). The landowners rent out these establishments to either an individual or groups of families. Housing is often made of plastic-sheeting and timber structures and may involve informal community-led management (Sanyal, 2017). The main challenges for Syrians in Lebanon are unemployment, lack of health care services, limited access to education, and inadequate housing. Due to the political unrest in Lebanon, the Lebanese authorities have encouraged Syrian refugees to return home despite warnings that it is not yet safe (Alrababa'h et al., 2020).

To be eligible to participate, mothers needed to be at least 18 years old, identify as a refugee from Syria, be native Arabic speakers, and be ≤12 months postpartum. We used purposive criterion sampling to recruit typical postpartum Syrian women (Moser & Korstjens, 2018; Palinkas et al., 2015), a sampling strategy commonly used in hard-to-reach populations (Palinkas et al., 2015). Based on conversations with social workers, women did not have to have a positive screen for PPD to be eligible for the study. We recruited eight Syrian refugee women to participate in the in-depth, semi-structured interviews (Table 1). Phenomenological studies wherein participants share their lived experiences of specific phenomenon require small sample sizes, typically fewer than 10 individuals (Moser & Korstjens, 2018). Three Syrian social workers who worked closely with other women in camps and focused on maternal health were recruited as key informants. Social workers acted as cultural informants or liaisons, deepening our understanding of maternal mental health gaps. Social worker key informants noted the potential for the stigma associated with participating in a mental health study. Therefore, participants were recruited through (de-identified agency's) beneficiary list or previous clients of

social workers. Social workers recruited women who lived in informal settlements (camps) or rented houses in Lebanon's Bekaa valley. They identified five postpartum women who had given birth during COVID-19 lockdowns without access to typical resources or social supports and were subsequently vulnerable to increased risk for poor maternal mental health outcomes. Women were selected based on their interest in the study, availability, and willingness to share experiences through remote communication. Five of the study participants had at least one infant under the age of 1 year.

Data Collection

The lead author collected data from April to May 2021, following the Lebanese authorities' ease of the COVID-19 lockdown. A nighttime curfew of 10 p.m. to 3 a.m. was in place during the data collection period. A social worker familiar with the camps made initial communication with the mothers. Following initial approval to participate in the study, the principal researcher (lead author) communicated with each participant through WhatsApp mobile application and made an appointment for the interview. Due to the COVID-19 lockdown in Lebanon, qualitative data were collected through remote phone and virtual communication. Interviews were conducted by the principal researcher, a native Arabic speaker, using either a Zoom or a phone call. The consent form for the study was read to each participant before the interview, and verbal approval was taken. Questions and prompts addressed the following thematic areas: (a) women's understandings and personal or relational experiences with maternal mental health (with an emphasis on PPD in prompts); (b) perceptions of causes of and effective treatment for PPD; and (c) broader sociocultural perceptions of PPD (e.g., stigma and familial/ social treatment of women suffering from depression during the postnatal period). Each interview lasted around 30–40 minutes. With participants' permission, interviews were audio recorded. Each participant received a baby gift package (~$10) to acknowledge their time.

Phenomenological Reflexivity

Embedded in phenomenological research is the understanding that knowledge production is subjective and that researchers cannot detach

Table 1. Demographics and Background Information of Study Participants.

Name	*Age*	*Origin in Syria*	*Number of children*	*Postpartum period*	*Description*
Hadeel	29	Dara'a	2	N/A	Hadeel is a Syrian social worker and a mother of two. She worked with multiple NGOs as a social worker and as a secretary. She lost her husband and father due to the war in Syria. She lives with her mother and sister in Lebanon.
Norah	35	Damascus	2	N/A	Norah is a Syrian social worker and a journalist. She is interested in women's empowerment. Her daughter is getting married soon at the age of 18.
Ameerah	37	Homs	4	N/A	Ameerah is a Syrian social worker. She works with Syrian mothers and children in camps. Her husband is imprisoned in Syria, and she has not heard from him since 2013.
Rana	20	Aleppo	3	Seven months	Rana is a 20-year-old lady with three young children. She lives with her husband, mother-in-law, and three young brothers-in-law (one with special needs). She came to Lebanon as a young girl and did not continue her education. She got married at 16 despite her family's refusal to marry her that young.
Nadia	27	Homs	5	Six months	Nadia lives in a tent with her husband, five children, and her elderly mother-in-law. Since arriving in Lebanon in 2012, she moved multiple houses/tents mainly because she could not pay the rent. Due to the pandemic and economic crisis, her husband lost his job and now collects mental from trash to sell to recycling companies for little money.
Afnan	20	Homs	3	Two months	Afnan is from the countryside of Homs, where men are traditional and are ashamed of helping their wives. She lives with her husband and his family, but her family lives a short distance apart.
Manar	19	Aleppo	2	20 days	Manar is 19 with two kids. She lives with her husband and sister-in-law, who helps her with the kids. Most days, she and her husband need to take loans to buy diapers and milk for the little ones.
Sara	24	Damascus	3	Three months	Sara has three children and is raising her stepdaughter, who is 12. She lives far away from her family and relatives and often feels lonely. She only had one neighbor who helped her for a few days after giving birth.

their analyses and interpretations of data from their personal experiences and values (Groenewald, 2004). As the lead author, it is, therefore, crucial that I reflect critically on my positionality in the context of this study. I am a principally quantitative researcher trained in public health; however, I understand the importance of lived experience and sociocultural perceptions on maternal health and, therefore, decided to conduct a mixed-methods dissertation that both validated a survey measure (AlNaji, 2021) and gleaned insight into women's own perceptions and experiences related to maternal mental health. I identify as an Arab woman and lived most of my life in the Middle East. Growing up in the 1980s, I was influenced by the idealisms of Arab unity and solidarity. During the Arab spring, I was heavily touched by the chaos spreading quickly from one country to the next. When the demonstration in Syria turned into armed conflict and its citizens began fleeing to refugee camps, I could not help but picture myself and my family being in their shoes. My experience of motherhood and the stress of the postpartum period made me interested in understanding and highlighting the experiences of refugee mothers. These combined factors could have shaped my perspectives as a researcher during the data collection and analysis process. As an outside researcher not residing in the camps, it is possible that participants believed I was part of an organization and responded accordingly. Moreover, remote research during the COVID-19 outbreak limited what I could experience in women's lives (e.g., sensory aspects of research).

Data Analysis

Interviews were recorded with participants' permission and transcribed into English. Before the formal data analysis phase, members of the (de-identified research group) met to discuss transcripts and identify themes for this study. Using these preliminary themes, we decided to use Colaizzi's (1978) steps for descriptive phenomenological analysis. The first step is data immersion, where researchers read the transcripts multiple times to become familiar with the content of the interviews. Next, we identified significant statements across transcripts and discussed the meanings of these lines (e.g., coding), generating broader themes by clustering related codes/statements (Colaizzi, 1978). Finally, we condensed themes into essential descriptive

structures of the phenomenon. We validated themes with Syrian social workers to see if they had anything to add or change in our analyses as cultural informants. To manage and organize data, we used Dedoose, a qualitative software that allows multiple users to analyze data concurrently.

Findings

Participant postpartum Syrian mothers lived in refugee camps in the Bekaa region, Lebanon, while all social workers worked part-time with refugee women. Postpartum mothers were between the ages of 19 and 27, with an average of three children and a period between 20 days and 7 months postpartum. The social workers were between the ages of 26 and 37, with an average of three children.

We generated three major themes based on analyses: (a) Conceptualizing maternal depression as both extraordinary and ordinary; (b) Stigma versus compassion: Cultural perceptions of mental health help-seeking; and (c) Coping with negative emotions (**Table 2**). We use pseudonyms to protect the privacy of individuals. Reflecting on the findings, I (the lead author) believe that my deep understanding of participating women's cultural backgrounds helped identify and unpack their understanding of PPD. By probing with commonly used

Table 2. Themes and Subthemes of the Study

Themes	*Sub-theme*	*Number of sub-themes*
Conceptualizing maternal depression as both extraordinary and ordinary	The severe condition leading to the rejection of the baby	2
	Unfamiliar condition	6
	The stigma of seeking psychological support	5
	The compassion of society for mothers with PPD*	3
Stigma versus compassion: Cultural perceptions of mental health help-seeking	Stress and life circumstances	7
	Young age and lack of experience	4
	Sensitive personality	3
Coping with negative feelings	Praying and reading Quran	6
	Crying	1
	Getting busy with the kids	4

* PPD = postpartum depression.

Arabic words, instead of medical terms, I was able to capture the nuance in what mothers thought of as "ordinary" versus "extraordinary" (mild versus severe PPD). Similarly, in theme three, understanding the value Muslims place on religiosity, I addressed religious coping mechanisms first, then addressed other coping methods (which needed more probing). My personal experiences as an Arab mother are also seen in our recommendations for policy changes and community interventions suitable for Syrian mothers.

Theme 1: Conceptualizing Maternal Depression as Both Extraordinary and Ordinary

When asked if they had heard of PPD, six women told us they understood what it meant, but only two reported that they had heard of people who were ever diagnosed with PPD. Women who reported knowing a person with PPD described severe cases, which included women attempting to harm themselves or their babies. Manar, a 19-year-old mother of two, shared with us the story of her aunt:

> I have an aunt who had this condition before, and (she) tried multiple times to strangulate the baby. They took her to see the doctor. The doctor diagnosed her with postpartum depression. At that time, no one had heard of this condition before in our society. I only heard about it when it happened to my aunt. It took her three months until she was able to come close to her daughter or talk to others again. Before that, she did not speak to people.

Hadeel, a 29-year-old social worker and mother of two, shared a story of a 14-year-old mother in her family: "She could not handle the noise of the baby's crying. She would say: take the baby; I do not want her. They said that she had postpartum depression." Hadeel and Manar both agreed that they did not think these conditions were preventable and that the best treatment method was to seek a doctor's help.

The examples of women's understanding of PPD showcase extraordinary instances involving attempts to harm oneself or others and rejection of the baby. However, when we read a definition of PPD to participants (i.e., a depressed mood lasting two or more weeks

accompanied by symptoms such as loss of interest, trouble sleeping, fatigue, guilt, and lack of concentration), two women stated they believed they may have experienced PPD after giving birth but did not realize this at the time and, therefore, did not seek professional help.

For example, Rana, a 20-year-old mother of three, believed she had PPD with her first baby. She was 16 at the time and noted feeling overwhelmed with responsibilities. Rana was always concerned that something might happen to the baby and doubted her ability to care for her. According to Rana, these feelings lasted a few months, and she was able to get through them with the support of her family and friends. Rana described,

> It was very difficult because it was my first time giving birth, and my whole life changed. I had big responsibilities, and so many questions ran through my head without an answer. I would worry about my baby and keep thinking that something could happen to him. That made me feel overwhelmed and depressed.

Nadia, a 27-year-old mother of five, described being depressed following giving birth to her third daughter. She said,

> I had this before. When I had my third girl in a row, I felt disappointed because I had two girls and wanted a boy. I didn't know it was a girl when I was pregnant. My mental health was not well. I was very depressed.

When asked to describe their depression, participants described mixed symptoms of depression and anxiety. Rana described physical discomfort in tandem with emotional distress: "I used to feel that there was a rock on my chest and that I wasn't comfortable. I felt anxious all the time and felt afraid of the future. I would cry for any small reason." On the other hand, Nadia described her feelings as anger: "I didn't like myself. I was always angry. I didn't want to see anyone." Hadeel, a social worker and a widow with two children, described the depressive symptoms of a woman she worked with as the following:

> She would feel she wanted to die, and she would cry easily. She would be very anxious even about small things; she would be afraid. She won't feel calm, or maybe she will be frightened and uncomfortable all the time.

Although participants described extremes of formal PPD diagnoses, they largely attributed PPD to the life circumstances and environment around the mother. For instance, Afnan, a 20-year-old mother of three, also suggested, "The woman may hear bad news about a relative or a friend or witness something that bothers her after giving birth, which can cause depression. After giving birth, women become sanative and should stay away from stressful situations."

Another attribution described was the sensitive personality trait of the mother. Rana stated, "Some women are very emotional and sensitive, and they might be more prone to become depressed and overwhelmed." In addition, some participants attributed PPD to giving birth at a young age. They emphasized that teenage marriage is a common problem among Syrian girls. Rana, who was married at age 16, told us that elders perceived depression among adolescent mothers as normal; she stated, "When I was depressed after giving birth to my first child, my family and friends told me it is normal to feel this way, as I was a child who gave birth to a child (Walad Khalaf Walad)." Finally, one mother, Nadia, attributed depression to unmet hopes for the new baby; in her case, the infant's sex: "Some women may have depression when they wish for a boy and then have a girl."

Theme 2: Stigma Versus Compassion: Cultural Perceptions of Mental Health Help-Seeking

Women agreed that formal mental health help-seeking is largely stigmatized among Syrian adults. Hadeel summarized this in the following sentence: "In our society, when you go to see a mental health specialist, people think you are crazy." Despite broader sociocultural perceptions, the women we interviewed mentioned that they have been through a lot. They would not feel shame in seeking mental health services if needed: "I would not be ashamed to go see a specialist or take medications, and it is impossible that every time someone becomes depressed, they become crazy" (Rana). Rana's understanding

of mental health is similar to the conceptualizations described in the first theme, wherein poor mental health exists on a continuum. Participants perceived emotional responses due to difficulties adjusting to a new infant or adverse life circumstances as normal responses to hardship. However, this can escalate into more serious mental illness, which carries a more considerable stigma (i.e., being "crazy").

Manar described how family and community members were often compassionate toward women who had just given birth:

> In the case of my relative: After the doctor said that [PPD] was a disease and that this was out of her hand [i.e., not to be blamed], people did not say anything about it. They only prayed for her to recover and go back to her baby.

Theme 3: Coping With Negative Emotions

To cope with negative emotions during the postpartum stage, most women described praying and religious acts as their primary coping mechanisms against stress and negative feelings. For example, Nadia stated, "When I feel depressed or mentally tired, I wash, pray, and read Quran until I feel bored. Then I distract myself with something else and feel I am over my negative feelings." Afnan echoed this sentiment, "I put my eyes in God's eyes. Perhaps He gives us relief from this." In addition to prayer, several women described trying to distract themselves or keep themselves busy. This is consistent with the literature on coping as distracting from "thinking too much," which is a common idiom for experiencing emotional distress (Kaiser et al., 2015). Nadia said staying busy had the potential to "change something inside" and shift her emotions from sadness or anger to more pleasant feelings. Hadeel shared that playing with her children helped offset stress:

> We have a little park close by. I go with my kids, and we play, and we run. Some people are surprised that at my age, I play with kids, but for me, it is a way to release stress.

Supportive family and friends were also perceived as vital to effective coping. Rana noted, "If I were depressed, my family would support me and try to get me out of it. They would often talk to and

communicate with me to help me."

However, not every participant had available social support or felt they could burden others with their emotional distress. For example, Manar candidly stated, "I don't have anyone to talk to, but I cry. When I cry, it makes me feel a little better."

Discussion

PPD is a mental health illness that can have detrimental and extended impacts on the mother, newborn baby, spouse, extended family, and community. Given their unique personal, familial, social, and economic positionality, refugees are at much higher risk of having PPD compared with host country nationals. Cultural conceptualizations of PPD and perceived feelings around childbirth can widely differ across cultures, groups, and countries. This study focused on understanding the meaning and attributions of PPD among Syrian refugee mothers in Lebanon.

Overall, study participants generally understood the signs and manifestations of PPD. However, they initially reserved the condition for those with severe cases and clear manifestations, such as those who had attempted to hurt themselves or their babies. Such perceptions are consistent with a study of Syrian refugees in Canada, which reported that participants used the term depression only to refer to extreme cases which require treatment (Ahmed et al., 2017). These perceptions could be predominantly due to the cultural tradition that this period is a joyful time, and expressing depression may be thought of as a denial of blessing (Ahmed et al., 2017). Yet, when we described a standard definition of PPD, two participants stated they identified themselves with this conceptualization, noting they may have experienced PPD without being diagnosed. These findings suggest (a) a need for culturally specific vocabulary to avoid the medicalization (and potential stigma) of depression in this period and (b) a need for larger psychoeducation that includes diverse experiences of depression, including physical and emotional manifestations (e.g., the participant who described her postpartum experience of having rocks on her chest), to enhance help-seeking among women experiencing such symptoms.

Findings from our study suggest that Syrian women attributed PPD

to external factors, such as stressful life circumstances, and internal factors, such as age and sensitive personality traits. Most participants perceived depression following childbirth as something that cannot be controlled and that women who felt this way didn't have the power to change it, a perception primarily driven by rooted social beliefs. Attributing factors included living and economic stressors as well as being young and overwhelmed with the experience of caring for a newborn. Participants spoke compassionately of women who contend with the stigma of being depressed during a joyful time, describing less societal stigma around maternal depression than other mental health issues.

Nonetheless, the stigma of mental disease is common globally and known as a barrier to seeking mental health services among refugees from different cultural backgrounds (Haque & Malebranche, 2020). Our findings suggest that the stigma associated with seeking mental health services is a common issue among Syrian refugees in Lebanon. However, most women we interviewed stated they would not shy away from seeking mental health support if they felt they needed such support. They also mentioned that they could find and access these services if needed. This finding could indicate that mental health awareness is higher among younger generations of mothers, perhaps reflecting the efforts made by the United Nations and other aid organizations providing Mental Health and Psychosocial Support (MHPSS) services in Lebanon.

Another prominent finding was the use of religious acts and practices as a coping mechanism in times of stress. The vast majority of women in this study described praying and reading the holy text of the Quran as a primary coping mechanism. Seeking refuge in Quran was also described by Ahmed et al. (2017) as a crucial role in coping for Syrian mothers after resettlement in Canada. Similarly, Dorais (2007) described comparable religious practices among Iraqi refugees in the United States as relief from everyday struggles. Such findings expand on a growing field of research focusing on the effect of religion as a protector of mental health problems. A study that looked at post-traumatic growth among Syrian refugees showed that using religion as a coping mechanism against traumatic experiences and adversities predicts more significant growth (Ersahin, 2020). Krok (2014) described religion as a sacred lens that refugees often use to deal with stressors

and adversity, allowing for a positive interpretation of otherwise difficult life circumstances.

The United Nations reported more than 100 million people displaced by mid-2022 (UNHCR, 2022b). Nearly one-third of these individuals are women and girls of reproductive age (UNHCR, 2022d). To better address the diverse health needs of forcibly displaced women and achieve individual and population- level health outcomes, stakeholders (e.g., government entities, international and local humanitarian agencies, health care providers) should enact laws and regulations and adopt delivery models and approaches appropriate for the complex intertwined elements of such settings. Factors that impact displaced populations' health are double-tiered. The first tier relates to their personal, educational, cultural, social, and religious characteristics. The second tier pertains to their unique migration experiences (pre, transit, post). Addressing this complex matrix of factors requires integrated-tiered approaches. For example, national health laws and policies should be enacted to allow for more support and funding for humanitarian settings; these should be coupled with legislation providing educational and professional opportunities. Such approaches could facilitate refugees' integration into the host communities and significantly enhance their economic conditions, ultimately improving their physical and mental health. The health care models should focus on the unique health determinants of refugees by adopting a holistic approach that addresses physical, spiritual, and cultural well-being. In the case of Syrian refugees and similar Muslim groups, this could include working collaboratively with mosques and Imams to include religious individual or group sessions and provide individual or group support. Including peer-to-peer support as part of the health services provided during the postpartum period could mimic the support mothers initially receive from female kin. Muslim or religious female advisors can also be particularly helpful in fostering positive coping mechanisms. Holistic MHPSS approaches could also include the utilization of new technologies and social media to communicate with those who are in need of support. Finally, community interventions should align with national policies and laws, work closely with existing health care models, and depend on highly qualified, well-trained, and culturally, socially, and religiously oriented community health workers.

Limitations

Despite its numerous strengths, there are limitations associated with the presented study. Although qualitative research is not intended to be generalized, our distance recruitment relied heavily on Syrian social workers who provided services to refugees to identify participants. Therefore, our sample may be skewed toward women who already engage in help-seeking strategies related to emotional well-being and overrepresenting this group. Moreover, COVID-19 lockdowns in Lebanon required remote data collection, wherein it was difficult to glean additional ethnographic insight into perceptions and help-seeking practices via participant observation and informal discussions.

Conclusion

Findings from this study are critical to Lebanon and other Muslim refugee-hosting countries (e.g., Iraq, Jordan, Turkey, Bangladesh), mental health providers, community and religious organizations, and funding agencies. With the massive and diverse support and logistics needed to support the growing refugee populations on national and global levels, along with dwindling funding, our findings can inform future health policies, health care delivery models, and community interventions. Utilizing a culturally and religiously appropriate framework in assessing and providing mental health services to this vulnerable group can substantially improve mental health services' acceptance, utilization, and outcomes.

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