

Women's Experiences of Immigration to Canada: A Review of the Literature

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This systematic review of the literature on the experiences of first-generation immigrant women in Canada was conducted with the aim of describing the factors found in the peer-reviewed literature that affect all aspects of their adjustment and well-being. This review was as broad as possible, while restricting it to peer-reviewed studies published from 1980 through 2015. On the basis of a comprehensive search of key databases (ERIC, PsycINFO, Medline, PubMed electronic databases, and university library e-journal sources), 166 peer-reviewed articles were identified whose results described some aspect of foreign-born women's experiences in Canada. These articles were read and coded for (a) general topic of the study, (b) research methodology, (c) number of foreign-born women participants, (d) participant demographics (country of origin, legal status, and location within Canada), and (e) academic discipline of the study. A 3-step grounded theory approach was used to categorize the research topics of the articles. Six research topics emerged that exhaustively categorized all 166 articles: cultural transitioning, employment, housing, intimate partner violence, access to medical care, and mental health and well-being. The main findings of each article are described under those 6 topics. Foreign-born women faced economic, cultural, linguistic, and systemic barriers that impeded their access to health, social, and economic resources. Nonetheless, many studies revealed effective coping strategies and support networks that eased their transition to Canadian society. On the basis of these results, recommendations are made for further research on foreign-born women and for more effective and culturally sensitive mental health services.

Keywords: women, immigrant, Canada, mental health, acculturation

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Migration across international borders can be a challenging process because of the many unknowns that await immigrants in the new country. This is true even for immigrants to Canada, an immigrant- and refugee-receiving nation that promotes a multicultural value set by acknowledging its diverse ethnic and cultural communities. Migration is even more challenging for women because they face unequal opportunities, particularly at the decision-making junctures of the migration and resettlement process, especially when most women who immigrate to Canada do so as dependents of male family members (Chui, 2011). Because the migration and resettlement process affects all areas of these women's lives, this systematic review of the literature was conducted with the goal of identifying the broad range of issues faced by foreign-born women in Canada by describing the factors found in the peer-reviewed literature that affect their adjustment and well-being.

Immigrants to Canada came mainly from Europe until two pieces of legislation came into effect that dramatically changed patterns of immigration: the 1976 Immigration Act and the 1977 Citizenship Act. The Immigration Act created a separate status for refugees, whereas the Citizenship Act removed the special status for British subjects. Soon thereafter a series of political upheavals occurred around the world, including revolutions in Iran and Nicaragua, repression in Guatemala, and wars in Iran, Iraq, Sudan, South Yemen, Afghanistan, and Cambodia. The more open immigration policies, combined with increased political turmoil, led to a dramatic increase in non-European immigration to Canada, both economic and refugee.

The number of women immigrating to Canada has grown since 1980, including increasing numbers of visible minority women from underdeveloped and developing regions of the world. Since the 1990s, the Canadian government has emphasized attracting skilled professionals. As a result, more foreign-born women immigrating to Canada are highly educated and arrive as principal applicants, although most continue to immigrate as dependents, either under the family class category or as the spouse of a principle applicant (Chui, 2011).

Embarking on life in Canada poses unique challenges for foreign-born women as they must negotiate new social relationships, group membership, often learn a new language, and seek access to the resources necessary for living. Their experiences resettling in Canada are shaped by the social, political, and cultural contexts of the systems of power with which they interact while

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navigating the various areas of life in Canada. However, these systems of power in Canada rest largely on a Eurocentric consciousness that lacks the multicultural framework and sensitivity needed to effectively address the needs of non-European immigrants (Henry & Tator, 2006).

In an important contribution to our understanding of the literature on foreign-born women in Canada, Guruge, Thomson, George, and Chaze (2015) conducted a systematic literature review of the effects of social support on the mental health of foreign-born women in Canada, which identified factors that led to foreign-born women underutilizing formal social support, such as lack of access to information, cultural and linguistic barriers, transportation problems, and the stigma of seeking out mental health services. Although the scope of their review is narrower than that of the present review, and therefore used different search terms, many of the articles identified in their study were also independently included in the present literature review.

In this review, the term *foreign-born* refers to anyone born outside of Canada who has migrated to Canada to establish permanent residence, whereas the term *immigrant* is used when discussing articles that used that term. Although *gender* is a social construct distinguished from biological sex, we have accepted authors' operationalizations of gender, usually on the basis of self-report. *Visible minority* refers to members of a group considered a racial or ethnic minority.

Materials and Method

This literature review included peer-reviewed studies published in English from 1980 through 2015. The year 1980 was chosen because it marked the beginning of a new wave of immigrants and refugees entering Canada under the new citizenship and immigration legislation. The literature search was conducted using the ERIC, PsycINFO, Medline, and PubMed databases as well as university library e-journal sources. These databases were chosen because they include the journals most commonly cited in counselling research. In addition, a manual search of the reference lists of included studies and Google Scholar searches were also conducted to locate other relevant articles. Articles from the searches that were not peer-reviewed were excluded from the review. A combination of search terms and search strings was used to locate studies, including *foreign-born women Canada*, *immigrant women Canada*, *women immigrants refugees Canada*, *immigrant mental health Canada*, *immigrant health services*, *immigrant social conditions*, *immigrant socioeconomic factors*, *immigrant gender employment*, and *immigrant housing*. Because the goal of this review was to address studies of immigrant women's experiences in the Canadian context, studies were included only if they reported results that explicitly discussed the experiences of foreign-born women in Canada.

The process of categorization and review of the articles began with (a) doing a literature search using the selection of keywords mentioned earlier, (b) retrieving the articles, (c) excluding articles that were not peer reviewed and literature reviews, and (d) including peer reviewed articles listed in literature reviews, (e) excluding articles for which no data on women's experience could be extracted, and (f) reading each peer reviewed article in its entirety to ensure that all inclusion and exclusion criteria were met. A total of 166 research articles remained, which were then read by both authors. Using a grounded theory approach (Wolfswinkel, Furtmueller, & Wilderom,

2013), articles were then grouped by research topic, using a three-step process of (a) *open coding*, in which the main finding of each article was identified as it spoke to the experiences of foreign-born women (e.g., seeking educational opportunities); (b) *axial coding*, in which hierarchical relationships among the open codes were determined (e.g., *seeking education* was axially coded as a subcode of *adaptation*); and (c) *selective coding*, in which the relations among the highest-level axial codes are determined and refined (e.g., *medical care* was distinguished from *mental health*, whereas *mental health* was grouped with *well-being*). At each stage of coding, both authors discussed the coding and came to consensus. Only five articles (3 %) required a brief discussion before both authors reached consensus as to selective code. Where an article addressed more than one selective code, it was coded by its main finding as reported in its conclusion. Six research topics emerged from the selective coding which captured all of the articles reviewed: cultural transitioning (39 articles), employment issues (28 articles), housing issues (seven articles), intimate partner violence (10 articles), access to medical care (40 articles), and mental health and well-being (42 articles). Each article was then read by both authors, who determined the main research focus, the methodology used, the number of foreign-born women studied, the demographics (country of origin, legal status, location within Canada), as well as the academic domain of the article on the basis of the journal and the academic affiliation of the authors.

In each of the six following sections, the included articles are presented in table form, including the topic of research, methodologies used, the population under study, and academic discipline. This is then followed by a discussion of the results of the studies.

Cultural Transitioning and Negotiating Gender Roles by Foreign-Born Women

Key information about the 39 studies addressing cultural transitioning is summarized in Table S1 in the online supplemental materials. The resettlement process for foreign-born women often included taking on new roles such as entering the paid labor force, or pursuing higher education while delaying marriage and child bearing (Shirpak, Maticka-Tyndale, & Chinichian, 2011). Negotiating new gender roles and cultural expectations affected their ties to their families or ethnic communities and their integration into the Canadian society (Safdar, Lewis, & Daneshpour, 2006; Sina-core, Titus, & Hofman, 2013).

Some women challenged traditional gender roles "as a symbol of empowerment and autonomy," and adopted a multicultural ethnic identity (Sadeghi, 2008, p. 221), whereas others maintained a strong identity with their cultural group but deviated from traditional gender roles (Mac & Alderson, 2009; Malhi, Boon, & Rogers, 2009). Others remained ambivalent about gender roles and continued to assume traditional gender roles (Samuel, 2010), such as providing care to elderly family members and children (Spitzer, Neufeld, Harrison, Hughes, & Stewart, 2003). Maintaining ties to their cultural communities provided foreign-born women with a sense of identity, a sense of well-being, and facilitated their integration in Canada (Berry & Blondel, 1982; Choi, Kushner, Mill, & Lai, 2014a; Safdar, Lay, & Struthers, 2003). Some foreign-born women negotiated transnational identities through multiple migrations, and maintained strong ties both to Canada and their country of origin (Das Gupta, 2006).

Visible minority foreign-born women reported experiencing discrimination in Canada (Das Gupta, 2006; George & Ramkissoon,

1998; Poolokasingham, Spanierman, Kleiman, & Houshmand, 2014; Samuel, 2010; Sutherland & Cheng, 2009). Gidengil and Stolle (2012) found that foreign-born women lacked awareness of government services for obtaining help with discriminatory treatment, domestic violence, or unlawful rent increases. Women perceived more group than individual discrimination by majority-group Canadians, a perception that increased with the length of time in Canada (Lalonde, Taylor, & Moghaddam, 1992; Moghaddam & Taylor, 1987). Although they minimized their personal experience of discrimination and its impact (Malhi & Boon, 2007), the perception of group discrimination led to retention of their cultural heritage (Taylor, Wright, Moghaddam, & Lalonde, 1990), and strengthened their identification with their ethnic communities (Shemirani & O'Connor, 2006). Foreign-born women reacted differently to personal encounters of racism based on the extent to which they had adopted mainstream Canadian culture and their knowledge of their ethnic group's historical experiences of racism (Ku, 2005, 2012).

Ng (1981) concluded that ethnicity is not intrinsic but that immigrants find themselves being given an ethnic identity on arriving in Canada. Some visible minority foreign-born women position themselves in social spaces and express their identities by celebrating their ethnic or religious differences (Ku, 2012; Ruby, 2006) or through community involvement and activism within both their cultural communities and in the wider Canadian society (Tastsoglou & Miedema, 2003). Activism by visible minority foreign-born women played a significant role in their integration into Canadian society and served as a strategy to advocate for their ethnic communities in Canada (Miedema & Tastsoglou, 2000), and to resist racial discrimination (Ku, 2011, 2013).

Foreign-born women reported a strong desire to learn one or both official languages to improve their employment prospects, to gain better access to health information and services, (Dyck, 1993; see Table S5 in the online supplemental materials), and to take a more active role in their children's education (Kilbride & Ali, 2010). However, this did not imply a desire to abandon their mother tongue (MacPherson & Ghoso, 2008). Foreign-born women tended to rely more on informal networks to improve their language proficiency (Adamuti-Trache, 2012), and learning English served as a tool to negotiate their social identity (Morgan, 1997). However, informal learning of English proved difficult for older foreign-born women because of limited contact with native speakers (Wang, 1999), and factors such as work and child-care responsibilities were major impediments to women taking English classes (Kilbride & Ali, 2010). Duguay (2012) reported that government-sponsored language classes failed to improve prospects for finding employment.

Low English proficiency led to feelings of exploitation and powerlessness in the workplace (Kilbride & Ali, 2010). English language training in the workplace enabled foreign-born women to acculturate more effectively to the Canadian work environment (Duff, Wong, & Early, 2000) and gain a greater sense of autonomy (Wong, Duff, & Early, 2001), but failed to improve their workplace status (Fenwick, 2008; Harper, Peirce, & Burnaby, 1996).

Foreign-born women encounter opportunities and challenges as they transition to a new life in Canada, requiring the negotiation of new roles, language use, identities, and social ties, which can affect women's relationships with their families and their cultural groups in complex ways. Foreign-born women show a strong desire to learn an official language and contribute to the social,

political, and economic life in Canada through volunteer work and activism in various organizations in their ethnic communities and the wider Canadian society. However, visible minority foreign-born women remain a marginalized group, and experience discrimination in various Canadian contexts, indicating a need for more studies to shed light on the impact that discrimination and marginalization has on women's adjustment and well-being.

Employment Experiences of Foreign-Born Women

The 28 studies addressing employment experiences are presented in Table S2 (see the online supplemental materials). Foreign-born women gain a sense of identity from their employment (Brigham, 2011), especially as income earners (Anderson & Lynam, 1987), and gain financial security and a sense of independence (Suto, 2009). But, they are more likely to be unemployed than foreign-born men (Wilkinson, 2008) or their Canadian-born counterparts (Lamba, 2003), or underemployed in traditional female jobs, often part-time, earning lower incomes than Canadian-born women (Boyd, 1984). This remains true despite their having more education than Canadian-born women, and living in cities with more job opportunities (Premji, Shakya, Spasevski, Merolli, & Athar, 2014). Migration forced some women to change their employment trajectories to more female-dominated careers, despite having training in male-dominated fields (Ng & Shan, 2010).

Women experienced particular difficulty obtaining employment in their field of specialization (Sinacore, Mikhail, Kassan, & Lerner, 2009; Sinacore, Park-Saltzman, Mikhail, & Wada, 2011; Walsh & Brigham, 2007). Nonrecognition of foreign credentials and demands for Canadian experience perpetuated unemployment, underemployment, and deskilled labor among foreign-born women (Gibb & Hamdon, 2010; Man, 2004). Obtaining Canadian certification proved challenging for foreign-born women who faced competing demands of contributing to family income, fulfilling domestic responsibilities, and advancing their career (Suto, 2009). Often, internationally educated women accepted lower paid employment while trying to complete their recertification (Phillion, 2003; Walsh, Brigham, & Wang, 2011). Women reported having to conceal their professional skills and work experience in order to accept lower paying employment outside their careers (Shan, 2009b, 2015).

Low language proficiency kept foreign-born women in low-skilled and dangerous jobs (Fuller, 2011) and inhibited access to information about their rights concerning workplace health and safety (Premji, Messing, & Lippel, 2008). Maitra and Shan (2007) found that the on-the-job training that foreign-born women received did not help them advocate for themselves concerning working conditions. Further, women employed in hazardous jobs feared that reporting work related injury would endanger their employment status (Premji & Lewchuk, 2014).

Although barriers to employment in Canada have been shown to decrease foreign-born women's socioeconomic status (Shan, 2009a, 2009b) and affect their well-being (Sakamoto, Ku, & Wei, 2009), women actively engaged in strategies to overcome structural barriers (Sangha, Slade, Mirchandani, Maitra, & Shan, 2012). Foreign-born women volunteered their time, accepted lower wages and worked harder than did their Canadian-born coworkers in order to prove their skills and qualifications to employers (Tastsoglou & Miedema, 2005). Foreign-born women tended to prior-

itize their family's needs before their jobs (Hon, Sun, Suto, & Forwell, 2011) and sought childcare support from extended family members, such as by having grandparents provide childcare in Canada or sending children back to their country of origin to receive care from grandparents (Da, 2010; Man, 2011).

In summary, employment can provide foreign-born women with a sense of identity as income earners, but they are more likely to be employed in traditional female jobs at lower wages despite their having more education than Canadian-born women. Nonrecognition of foreign certification and education, lower language proficiency, and lack of Canadian work experience forced women to downgrade their career trajectories. Foreign-born women responded to these barriers by gaining Canadian experience through volunteering, taking low-paying jobs, seeking recertification, working harder than their Canadian-born counterparts, and seeking support from their families, especially with childcare.

Housing Experiences of Foreign-Born Women

Although there is extensive research on immigration and housing in Canada, most research used the household as the unit of analysis and did not report results by gender and so were excluded from this review. Table S3 presents the seven articles that reported the experience of foreign-born women in the Canadian housing market (see the online supplemental materials). Moghaddam, Taylor, and Lalonde (1989) found that although women with strong ethnic social networks tended to live in more segregated communities, they recognized that this led to feelings of alienation and a reduced sense of belonging in Canada. Elderly foreign-born women, especially if unmarried or widowed, were more likely to live with their family than were elderly foreign-born men (Ng, Northcott, & Abu-Laban, 2007), often for economic reasons (Boyd, 1991). Factors contributing to precarious housing situations included lack of knowledge about the housing process in Canada (D'Addario, Hiebert, & Sherrell, 2007); lack of larger units that met their needs for housing several generations of dependents (Dion, 2001); poor housing in unsafe and overcrowded neighborhoods (Sherrell, D'Addario, & Hiebert, 2007); and discrimination based on race, ethnicity, or immigrant status (Dion, 2001; Novac, 1999).

Sherrell et al. (2007) and D'Addario et al. (2007) found that foreign-born women in Vancouver were less likely than Canadian-born women to use homeless shelters, relying on family and community networks to find housing. Refugee claimants were more likely to experience frequent moves and homelessness, because of weaker ties to their ethnic communities, language barriers, and lack of access to resources. Novac (1999) applied a gender lens to analyze the narratives of two foreign-born women in Canada. Her analysis found that overt and covert discriminatory practices in renting were commonplace, but because of a lack of knowledge of tenants' rights, as well as a fear of retaliation, they were reluctant to contest such discrimination.

Only seven studies directly addressed foreign-born women's housing experiences in Canada, indicating a need for both large-scale studies to determine the extent of issues and in-depth studies that explore how women navigate these challenges. This need is underscored by Thurston et al.'s (2013) finding, discussed in the next section, that barriers to housing were a contributor to intimate partner violence among foreign-born women.

Intimate Partner Violence Among Foreign-Born Women

The 10 studies listed in Table S4 (see the online supplemental materials) indicate that foreign-born women in Canada often faced increased risk for violence because of differences in gender roles in Canada versus their cultural communities and families (Brownridge & Halli, 2002). Guruge, Roche, and Catallo (2012) found that between 27 % and 30 % of their samples of foreign-born women reported experiencing psychological violence in the previous 12 months by their intimate partner or spouse, often followed by physical or sexual violence. Agnew (1998) reported that patriarchal family expectations was a risk factor for intimate partner violence among foreign-born women because these families interpret women's acculturation and integration into Canadian society as a threat to the family's cultural norms. This is consistent with findings that rates of intimate partner violence increase with longer residence in Canada (Brownridge & Halli, 2002; Hyman, Forte, Du Mont, Romans, & Cohen, 2006a, 2009).

Further, foreign-born women who experienced intimate partner violence could be seen by members of their own ethnic community, and even by the women themselves, as being responsible for the violence they experienced (Hyman et al., 2011). However, in a large-scale study, using data from the Canadian Maternity Survey, Daoud, O'Campo, Urquia, and Heaman, (2012) found that foreign-born women living in immigrant neighborhoods reported lower rates of intimate partner violence and suggested that these neighborhoods could be sources of informal community support.

Although foreign-born women will report violence against them to the police in situations in which they fear for their lives, they are less likely to use social and health resources geared toward women's social welfare in intimate partner violence situations, often because they feared reprisal by family members (Hyman, Forte, Du Mont, Romans, & Cohen, 2006b). Guruge et al. (2012) found that foreign-born women underreported violence against them because of the "stigma and taboo associated with violence" in their ethnic communities (p. 12). They also lacked knowledge about the availability of social and health resources and how to use these services (Hyman et al., 2006b, 2009). As with other areas of service utilization, foreign-born women were more likely to seek support from service providers who speak their first language and were from the same cultural/ethnic community (Agnew, 1998).

Thurston et al. (2013) found that low proficiency in English or French, coupled with barriers to employment and lack of knowledge about legal rights, often forced foreign-born women who experienced intimate partner violence into "hidden homelessness," where they lacked housing but did not use services for the homeless. Stewart, Gagnon, Merry, and Dennis (2012) found that precarious immigration status resulted in increased risk for violence by refugee claimant women in Canada. They also found that foreign-born women with reduced social support, or not living with their partner, were at greater risk for intimate partner violence.

Although these studies demonstrate that there is an increased risk for intimate partner violence among foreign-born women, especially among refugee claimants, there is a need for further research on the factors that contribute to intimate partner violence and how women can successfully respond to it. It remains largely unknown what resources women seek or view as helpful to them

in such circumstances, and what their experiences are of utilizing social resources, such as social services and medical care.

Access to Medical Care by Foreign-Born Women

Table S5 presents the 40 studies that addressed foreign-born women's experiences with the Canadian medical system (see the online supplemental materials). Although one study (Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2011) found that visible minority foreign-born women were less likely to report unmet health care needs, most articles reviewed found that foreign-born women do not share in the *healthy immigrant effect*, which refers to the general good health of newcomers to Canada. The overall health outcomes of foreign-born women, particularly middle-aged or visible minority women, were not better than those of Canadian-born women (Kobayashi & Prus, 2012).

Structural barriers to foreign-born women accessing medical resources often go unacknowledged and unaddressed (Anderson, Blue, & Lau, 1991), leading to a devalued sense of self for those with chronic illnesses (Anderson, 1991). These barriers included a lack of knowledge about medical services (Vahabi, 2010), feeling uncomfortable asking questions about sexual health (Maticka-Tyndale, Shirpak, & Chinichian, 2007), a perceived lack of cultural sensitivity, and poor interaction with medical care providers (Bottorff et al., 2001; Johnson et al., 2004), and a lack of trust toward medical care professionals (Dastjerdi, 2012). Although foreign-born women reported language difficulties in communicating with medical professionals (Asanin & Wilson, 2008; Nimmon, 2010; Spitzer, 2004), Oelke and Vollman (2007) found that they often preferred to consult physicians outside their ethnic communities because of a lack of trust based on concerns about confidentiality.

Gender, ethnicity, immigration status, and class intersected and resulted in poor health outcomes for foreign-born women (Kobayashi & Prus, 2012; Veenstra, 2011). Socioeconomic status and unequal power relations affected visible minority foreign-born women's interactions with health professionals and influenced women's management of their health issues (Anderson et al., 1995). Women's access to resources was limited by their socioeconomic status, with women in physically demanding menial jobs finding it difficult to balance their work schedules and manage chronic illness (Anderson, 1990). Further, visible minority women constructed their health issues differently than did health professionals (Anderson, 1985), and they perceived health professionals as unapproachable and not understanding of their concerns (Anderson, Dyck, & Lynam, 1997). Moreover, women had reservations about disclosing their chronic illness to employers and co-workers for fear of losing their job. In turn, this nondisclosure led to reduced management of their illness in the workplace, thereby exacerbating their symptoms (Anderson, Blue, Holbrook, & Ng, 1993). Although one study found no differences in terms of access to medical care by immigrant status (Gagnon et al., 2007), a qualitative study by Merry, Gagnon, Kalim, and Bouris (2011) found that refugee claimant women experienced major interruptions to their medical and social health services for postpartum depression or postnatal follow-up due to the limited insurance coverage for refugee claimants.

Foreign-born women underutilized preventative services such as screening for cancer (Blackwell, Martinez, & Gentleman, 2008;

Lofters, Moineddin, Hwang, & Glazier, 2010; but see Tudiver & Fuller-Thomson, 1999, for a nonsignificant but contrary trend), because of cultural and familial pressure to keep sexual and reproductive health matters private (Woltman, & Newbold, 2007), a lack of knowledge about the medical necessity of screening, self-perception of low risk, their physician not encouraging screening, and a lack of access to female physicians (Schoueri-Mychasiw & McDonald, 2013), and the belief that cancer can be effectively prevented through diet and lifestyle (McWhirter, Todd, & Hoffman-Goetz, 2011).

Foreign-born women lacked culturally appropriate health information in their native language (Reitmanova & Gustafson, 2008). Strategies that they employed to understand and use health information included asking family and friends for translation, using the Internet, TV and written materials (e.g., pamphlets, books), asking their family physician, and using local and community organizations to access information (Todd & Hoffman-Goetz, 2011b). Greater acculturation also increased women's access to cancer information (Gupta, Kumar, & Stewart, 2002; Todd & Hoffman-Goetz, 2011a), with women with higher English fluency more likely to try to understand such information (Thomson & Hoffman-Goetz, 2009).

There is a need for dissemination of health promotion information through community centers, immigration services, ethnocultural and faith-based associations, and through vocational training programs and schools (Mitra, Jacobsen, O'Connor, Pottie, & Tugwell, 2006). Health promotion was also effective when adapted to women's cultural environment, such as being addressed to multiple generations rather than to the individual (Dyck, 1993), and emphasizing the integration of Western health and women's cultural practices (Thompson, 1987).

Foreign-born women communicated their medical concerns in ways that reflected cultural beliefs, such as a reluctance to discuss sexuality, mental illness, and violence with medical professionals because these were regarded as private, and first seeking medical advice from family (Bottorff et al., 2001) and relying on folk medicine before seeking formal medical support (Dyck, 1992; Jette & Vertinsky, 2011), as well as using faith and exercise to enhance their health and to manage chronic illness (Choi, Kushner, Mill, & Lai, 2014b). Cultural beliefs about medical care affected foreign-born women's health seeking behaviors; women holding more traditional beliefs about medical care were less likely to seek Western care (George, 1988). Myths and misunderstandings about the causes of health issues also undermined their perception of risk and thus decreased their likelihood of seeking medical care (Vahabi, 2010).

These findings indicate that health care programs need to be adapted to the needs of specific cultural groups in Canada. Moreover, increased cultural competency among medical professionals would increase the quality of medical care available to and utilized by foreign-born women and support their greater involvement in the planning and provision of health services. However, reduced governmental funding for health promotion and health prevention services has limited foreign-born women's access to health services (Donnelly & McKellin, 2007).

The overall findings from the articles reviewed indicate that (a) the healthy immigrant effect does not apply to foreign-born women, especially visible minority women; (b) there are barriers to accessing medical care especially among refugee claimants who

do not have access to provincial health insurance; and (c) specific cultural beliefs affect how foreign-born women seek out and use medical care.

Mental Health and Well-Being Among Foreign-Born Women

Table S6 summarizes the 42 articles that were dedicated to understanding the effects of foreign-born women's resettlement experiences in Canada on some aspect of their mental health (see the online supplemental materials). Women experienced greater autonomy and improved quality of life postmigration as a result of increased financial independence and greater decision-making powers within the family (Jibeen, & Hynie, 2012). One prominent theme emerging from the literature was that of the loss of social support networks (Ahmad et al., 2004; Dunk, 1989; Jafari, Baharlou, & Mathias, 2010) and postimmigration cultural isolation, which adversely affected women's well-being as they were separated from family, friends, and community of their country of origin (Ahmed, Stewart, Teng, Wahoush, & Gagnon, 2008; Choudhry, 2001). Women found it stressful to adjust to the cultural differences in Canada, and experienced a decreased sense of control as they attempted to integrate into the Canadian labor economy and society (Simich, Maier, & Ochocka, 2009).

Additional sources of stress were linguistic difficulties (Nimmon, 2007; Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008), not finding employment within their profession, financial worries related to job loss (Tang, Oatley, & Toner, 2007), adapting to new cultural expectations (Moghaddam, Ditto, & Taylor, 1990), and a decrease in leisure time (Ahmad et al., 2004). Furthermore, the stress associated with discrimination and marginalization in contexts such as employment (O'Mahony, Donnelly, Bouchal, & Este, 2012) and social interactions (Simich et al., 2009) had adverse effects on foreign-born women's mental health. Dossa (2005, 2006, 2008) found that visible minority foreign-born women's experience of being "othered" on account of their race, ethnicity, and physical disabilities contributed to stress and feelings of loneliness.

Foreign-born woman reported high rates of depression (Mechakra-Tahiri, Zunzunegui, & Seguin, 2007; Stewart, Gagnon, Saucier, Wahoush, & Dougherty, 2008) due to psychosocial stressors such as lack of social support and isolation, as well as socioeconomic factors (Morrow, Smith, Lai, & Jaswal, 2008; Zerkowicz et al., 2004; Zerkowicz et al., 2008). Refugee women who had fled their country of origin and had left behind family members reported poor mental health (O'Mahony & Donnelly, 2013). Furthermore, women's ethnic background (especially Caribbean, Maghrebi, and sub-Saharan African) inhibited their social and economic integration in Canada, which, in turn, contributed to incidence of depression (Miszkurka, Goulet, & Zunzunegui, 2010).

Although foreign-born women's coping with mental health issues was facilitated by receiving formal support from health care and community support providers (O'Mahony et al., 2012), women's ability to fully utilize mental health services was hindered by language barriers (Chiu, Ganesan, Clark, & Morrow, 2005; Stewart et al., 2006), poor knowledge of available support services within their community (Ahmad et al., 2004), location of services, transportation (Chiu et al., 2005), finances (Stewart et al., 2006), and a perceived lack of cultural sensitivity in public health and

social services (Ahmed et al., 2008; Stewart et al., 2006). Gender, cultural factors, and immigration status intersected to produce barriers to immigrant and refugee women seeking mental health support (O'Mahony et al., 2012). Negative attitudes, beliefs, and the stigma associated with mental health issues within their cultures, as well as economic dependence on their spouse strongly influenced their decisions not to seek mental health services (O'Mahony & Donnelly, 2013).

Several studies have established that social support improved foreign-born women's mental health and quality of life, acting as a buffer against the stressors encountered during resettlement (Alvi, Zaidi, Ammar, & Culbert, 2012; Hsiao & Schmidt, 2015; Spitzer, 2007; Stewart, Anderson, et al., 2008), and enhancing their resiliency (Gagnon, Carnevale, Mehta, Rousseau, & Stewart, 2013). Foreign-born women confronted challenges and stressors during their resettlement mainly by drawing on emotional support from family members and friends (Gagnon et al., 2013; Neufeld, Harrison, Stewart, Hughes, & Spitzer, 2002) and relying on friends and their community for social, instrumental, and informational support (Hynie, Crooks, & Barragan, 2011). However, other studies have reported that foreign-born women preferred to share personal or family experiences with "outsiders" rather than "insiders" from their ethnic communities because outsiders would be able to draw on less constraining values, and could be trusted to maintain confidentiality (Anderson, 1987; Lynam, 1985).

Good mental health was valued and supported through strategies such as maintaining close relationships with family members, being actively involved within their cultural communities, spirituality, cultural and religious practices, having a positive outlook, eating healthily, staying active, and relying on folk medicine to treat illnesses (Chan, 1983; Choudhry, 1998; Meadows, Thurston, & Melton, 2001). These strategies also affected whether or not women sought formal psychosocial support.

Foreign-born women's sense of agency, such as in building their social networks and their use of self-care strategies, promoted their mental health and resiliency (Koert, Borgen, & Amundson, 2011; MacDonnell, Dastjerdi, Bokore, & Khanlou, 2012; O'Mahony et al., 2012). Immigrant and refugee women's health and well-being reflected their resilience as women engaged in volunteer activities and activism within their ethnic and religious communities (Spitzer, 2007). Moreover, women actively coped with their stress by "reconciling cultural differences" and adapting to new cultural expectations in Canada (Simich et al., 2009, p. 261).

Focusing on foreign-born women's meaning making and understanding of mental health, Wong and Tsang (2004) found that mental health was regarded as being experienced in multiple dimensions, including esthetic, political, and spiritual. Acharya and Northcott (2007) found that by defining distress as a response to challenging life circumstances, elderly foreign-born women came to accept their distress and coped by attending to their "personal, family, social, cultural obligations" (p. 619). Anderson (1987) concluded that mental health issues are "seen as 'fact of life' by women, and not warranting professional care" (pp. 425–426).

The 42 articles on foreign-born women's mental health and well-being provided evidence that multiple influences, including loss of social support and sense of isolation, linguistic difficulties, economic difficulties, discrimination and marginalization, adversely affected their mental health. Moreover, these studies iden-

tified additional barriers to accessing mental health services, especially financial and language difficulties, cultural factors, and the perceived lack of cultural sensitivity. Facilitators to promoting mental health included women connecting to trusted support systems, families, and communities.

Conclusion

The 166 articles reviewed reveal a complex and nuanced understanding of foreign-born women's experiences in Canada from a broad range of disciplines: feminist studies, sociology, social work, anthropology, nursing, occupational health, geography, urban studies, public health, political science, women's health, education, psychology, psychiatry, and counselling. The focus of most research has been to provide an understanding of the experiences of foreign-born women in navigating a specific aspect of the cultural, social, political, or economic landscape of Canada, such as negotiating new cultural identities; seeking employment and housing; and accessing governmental, public, and private resources. Although these studies used a wide range of methodologies, the results highlight the barriers that foreign-born women face in multiple areas, increasing their degree of disadvantage.

These results indicate that foreign-born women experience multiple, intersecting factors that differentially affect their well-being. Foreign-born women experience social inequalities due to segregation into lower social economic status neighborhoods; the devaluing of their labor; and the lack of accessible and culturally sensitive medical, social, and mental health services. These disadvantages are greater for visible minority and refugee women who experience even greater marginalization and discrimination. These systemic barriers heighten foreign-born women's experience of gender inequality, both in their own ethnic communities and the larger Canadian society. Foreign-born women are further marginalized as they negotiate new gender roles, which may conflict with both those of their ethnic community and those of the general Canadian culture. One striking finding in this review is that the family and ethnic community served as a support network for some foreign-born women, whereas for others they acted as barriers to seeking help, as in the case of intimate partner violence.

Four broad critiques of this body of research have emerged from our reading. First, there was often a lack of specific data that contextualized foreign-born women's experiences. Many studies did not specify the immigration category of participants, whereas others grouped together women from multiple countries of origin. Second, almost all of the research reported here was conducted in large cities, where foreign-born women have access to more resources as well as ethnic community support. Third, many foreign-born women are also members of visible minorities, which complicates simple comparisons between ethnic groups, as well as between foreign-born and Canadian-born women. Fourth, some research, such as that on housing, tended to take the household as the unit of analysis, obscuring the experience of foreign-born women. Larger scale quantitative research shed light on the extent of some phenomena but often failed to provide insight into why foreign-born women fare poorly. This points to a need not only for more quantitative research on the challenges that foreign-born women face, but also for qualitative research that explores the reasons for and responses to these challenges, as well as more mixed-methods studies that combine both approaches.

Suggestions for Future Research

Age, country of origin, immigrant status, ethnicity, visible minority status, and religious background, among others contributed separately and interactively to shape foreign-born women's experiences in Canada. A number of studies reviewed here have adopted a problem-based model, which ignores how these women cope with and navigate these issues. A strength-based, multicultural approach can position foreign-born women as resilient, active social agents rather than people with problems, such as the studies that identify culturally and ethnically appropriate coping mechanisms. This is especially needed for women who arrive as refugees. A few studies reviewed here have taken an intersectionality lens, which provides a holistic understanding of foreign-born women's experiences and conceptualizes the impact of various inequalities on their lives. This approach can result in research findings that can be directly translated into practical guides for policies, programs, and services that would better serve the diverse needs of foreign-born women.

Although these results point to the issues faced by foreign-born women, few examined foreign-born women's experiences with mental health or counselling services. Research is needed to help mental health professionals understand the unique needs and strengths of this diverse group. There is also a need for research on effective strategies and practices that facilitate foreign-born women's access to mental health services.

Implications for Mental Health Practice in Canada

Practitioners' understanding of the complex lived experiences of these women is central to overcoming one barrier identified in this review, the perceived lack of cultural sensitivity among service providers. Mental health professionals could develop this cultural competency through workshops that teach culturally competent strategies for working with this diverse group of women, many of whom prefer dealing with professionals who are not members of their own cultural communities. Structural factors such as language and finances also create barriers to accessing mental health services. To bridge the language gap, mental health providers could use trained interpreters, as well as cultural informants or brokers with linguistic proficiency and cultural competency. Mental health agencies should hire ethnic or minority counselors or trained paraprofessionals who can provide services in women's native language, and who can also act as cultural brokers for clients, while being sensitive to the client's sense of trust toward members of their own cultural community. Access to mental health services could be facilitated by use of a sliding scale fee and by advertising this through community organizations.

Another barrier identified in this review was the lack of access to information about mental health issues. This could be remedied by developing educational materials, especially in the women's native languages, and making these available to cultural and religious community centers, at immigration and resettlement organizations, and online. Mental health professionals could also partner with community organizations serving these women, which could help to reduce the stigma associated with mental health issues. Outreach could also be achieved by providing community organizations with information about the issues faced by foreign-born women and by working to advance policies that promote women's

well-being by serving on advisory boards at private and public sector organizations.

Résumé

La présente revue systématique des écrits consacrés aux expériences des immigrantes de première génération établies au Canada a été réalisée dans le but de décrire les facteurs trouvés dans la littérature approuvée par les pairs qui influent sur l'ajustement et le bien-être de ces femmes. Cette revue se voulait d'une portée aussi large que possible, tout en se limitant aux études examinées par les pairs publiées entre 1980 et 2015. Au terme d'une recherche exhaustive effectuée dans d'importantes bases de données (ERIC, PsycINFO, Medline, PubMed, des bases de données électroniques et des revues électroniques de bibliothèques universitaires), 166 articles examinés par des pairs ont été relevés, dont les résultats décrivent certains aspects de l'expérience des Canadiennes nées à l'étranger. Ces articles ont été lus et codés en fonction (a) des grandes lignes de l'étude, (b) de la méthode de recherche, (c) du nombre de participantes nées à l'étranger, (d) des données démographiques sur les participantes (pays d'origine, statut juridique et emplacement au Canada), et (e) de la discipline universitaire de l'étude. Une approche théorique à base empirique en trois étapes a été employée pour catégoriser les sujets de recherche des articles. Six sujets de recherche sont ressortis pour catégoriser de manière exhaustive les 166 articles : le processus de transition culturelle, l'emploi, le logement, la violence conjugale, l'accès aux soins de santé, ainsi que la santé mentale et le bien-être psychique. Les principales conclusions de chaque article sont décrites sous chacun de ces six sujets. Les femmes nées à l'étranger sont confrontées à des obstacles économiques, culturels, linguistiques et systémiques qui entravent leur accès à des ressources sanitaires, sociales et économiques. Néanmoins, bon nombre d'études ont mis en lumière des stratégies d'adaptation efficaces et des réseaux de soutien qui ont facilité leur transition dans la société canadienne. Sur la foi de ces résultats, des recommandations sont formulées afin d'approfondir la recherche sur les femmes nées à l'étranger et sur l'élaboration de services en santé mentale plus efficaces et mieux adaptés sur le plan culturel.

Mots-clés : femmes, immigrantes, Canada, santé mentale, acculturation.

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