Abstract

The Healthy Immigrant Effect refers to the phenomenon of declining health among immigrants after relocating to Western countries, including Canada (Newbold, 2006). Health can be defined in holistic terms as physical, mental and social well-being, and the role of publicly-delivered physical activity opportunities is often overlooked when considering the health of recent immigrant women. Instead of conceptualizing health as a result of individual choices, this study drew on an intersectional approach to understanding how three social determinants of health (SDH), migration, socioeconomic status, and gender, are interrelated and mutually reinforcing (Hankivsky & Christoffersen, 2008). The purpose was to better understand how these three SDH influence the health of women who recently immigrated to Canada, and how their participation in community-based physical activity may (or may not) be affected. Qualitative interviews were conducted with women who recently immigrated to Canada as skilled workers (n = 18, <5 years in Canada, 18+ years old) from a number of different countries and who resided in one community in the Metro Vancouver Area. Data were coded using ATLAS.ti and attention was paid as to how participants discussed health and physical activity in relation to migration, gender and socioeconomic status. A majority of study participants defined health as a balance of physical and mental health. For women who found difficulty securing stable employment and income, who had difficulties communicating in English, and/or who had limited social support, particularly their mental health was negatively affected due to their expectation and need to be employed in Canada. Community-based physical activity was often sought out as an avenue to promote physical and mental health, as well as to build social networks; however, participation in opportunities and such sought-after benefits were not always possible. Thus, it is recommended that providers of community-based physical activity address issues such as affordability, lack of women-only opportunities, accounting for the gap in local knowledge and language facility, and facilitating social and intercultural opportunities through physical activity.
Preface

This master’s thesis is based on data collected in a larger research study (Wendy Frisby, Principal Investigator) funded by the Social Sciences and Humanities Research Council, for which ethical approval was received from the University of British Columbia’s Behavioural Research Ethics Board (UBC BREB # H1101158).

The approved project was entitled, “Learning from the local: Examining a sport and physical activity inclusion initiative for immigrant women” of which I was a student investigator. With input from Dr. Wendy Frisby (University of British Columbia) I developed the interview questions, co-created recruitment materials, conducted English-language interviews with study participants, mentored multi-lingual research assistants who conducted interviews in Farsi and Korean, and conducted data analysis.

Furthermore, I wrote the initial manuscript for Lee, Frisby, and Ponic (2014), a published book chapter that was revised by Wendy Frisby and Pamela Ponic. I also contributed significant revisions primarily to the theoretical framework, literature review, and research context sections of the Forde, Lee, Mills, and Frisby (2015) published journal article that was originally drafted by Shawn Forde and Wendy Frisby.

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Chapter 3. Portions of the text are used with permission from Forde et al. (2015) of which I am an author, as this was based on a preliminary version of my master’s thesis.

Chapter 5. Portions of the text are used with permission from Lee et al. (2014) of which I am an author, as this was based on a preliminary version of my master’s thesis.
Table of Contents

Abstract .................................................................................................................................................... ii
Preface ..................................................................................................................................................... iii
Table of Contents ................................................................................................................................... iv
List of Tables .......................................................................................................................................... vi
Acknowledgements ................................................................................................................................ vii

Chapter 1: Introduction ......................................................................................................................... 1
    Conceptual framework ............................................................................................................. 4
    Purpose and research questions ............................................................................................... 8

Chapter 2: Review of Literature...........................................................................................................10
    Intersectionality and the social determinants of health ...........................................................10
    Intersectionality theory .......................................................................................................12
    An intersectional social determinants of health approach ....................................................15
    SDH and skilled worker immigrant women ...........................................................................17
    Migration and immigrant women’s health ...........................................................................18
    Socioeconomic status and immigrant women’s health .......................................................23
    Gender and immigrant women’s health .............................................................................28
    Immigrant women’s physical activity .....................................................................................33
    Promoting inclusion of immigrant women in community-based physical activity ............39

Chapter 3: Methodology ........................................................................................................................43
    Research site ...........................................................................................................................43
    Participant recruitment ............................................................................................................45
    Data collection ........................................................................................................................46
    Semi-structured qualitative interviews ...............................................................................47
    Background survey .............................................................................................................49
    Ethical considerations ..........................................................................................................50
    Data analysis ..........................................................................................................................51
    Reflexivity and positioning myself in the research .................................................................54
    Methodological challenges and limitations ............................................................................58
Chapter 4: Findings and Discussion ................................................................. 63

Background on participants ................................................................................. 64
Participant backgrounds ......................................................................................... 64
Reasons for migration ............................................................................................... 66
Perspectives on health ............................................................................................. 68
Physical activity experience prior to migration .................................................... 72
How migration intersects with socioeconomic status and gender ..................... 75
Health following migration ..................................................................................... 76
Employment status ................................................................................................ 81
Financial (in)security .............................................................................................. 89
English language ability ......................................................................................... 93
Social support and isolation ................................................................................ 97
How community-based physical activity fit into the women’s lives .................... 104
Self-reported physical activity after migration .................................................... 105
Reasons for participation ....................................................................................... 106
Physical health ....................................................................................................... 106
Mental health and physical activity ..................................................................... 108
Seeking social connection ..................................................................................... 111

Chapter 5: Conclusions and Recommendations .................................................. 114

Recommendations for practice .......................................................................... 118
Future directions ................................................................................................... 126

List of References .................................................................................................. 129

Appendices .............................................................................................................. 154

Appendix A: Interview questions ......................................................................... 154
Appendix B: Background survey .......................................................................... 156
List of Tables

Table 1: Study participant profiles ...........................................................................................................65
Table 2: Education and previous employment ...........................................................................................66
Table 3: Perspectives on health ................................................................................................................68
Table 4: Pre-migration physical activity frequency ..................................................................................72
Table 5: Health after migration ...............................................................................................................78
Table 6: Post-migration employment status ...........................................................................................82
Table 7: Post-migration family income (before tax) .................................................................................89
Table 8: Post-migration family status .......................................................................................................98
Table 9: Pre- and post-migration physical activity participation ............................................................105
Table 10: Self-reported post-migration physical activity levels ..............................................................106
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Chapter 1: Introduction

Migration refers to a permanent or semi-permanent physical transition of an individual or group from one geographical location and social context to another, within or across national boundaries (Loue & Galea, 2007; Thurston & Vissandjee, 2005). Decisions to emigrate are often related to a combination of: 1) push factors, such as poverty, unemployment, persecution, conflict, political instability, or natural disasters; and/or 2) pull factors that attract a person to a specific destination (Cymbal & Bujnowski, 2010; Loue & Galea, 2007). A majority of recent immigrant women are admitted to Canada as permanent residents as part of the family category or as dependent spouses of economic immigrants. About 13% of them live in Canada as lone parents (Chui, 2011). Gendered familial roles and the prioritizing of the husband’s economic integration often undermines the ability of skilled immigrant women to make the most of their skills and qualifications after moving to Canada (Banerjee & Phan, 2015). These norms also limit many women’s time and abilities to access supportive networks or to upgrade their work-related or language skills (Spitzer, 2012). Thus, for many women, migration intersects with gender and socioeconomic status resulting in limited opportunities to engage in fulfilling employment, financial insecurity, and a loss in social status, thereby affecting their mental and physical health.

The Healthy Immigrant Effect (HIE) refers to a pattern of declining health among immigrants after relocating to Western countries, including Canada (Newbold, 2006). However, some immigrants report no change or an improvement in their health status (De Maio, 2010; Dean & Wilson, 2010), and declining health is unevenly distributed among certain immigrant sub-groups, including older adults, women, immigrants living on low income, and members of racialized groups (Hyman & Jackson, 2010; Kobayashi & Prus, 2011). That
declining health is unevenly distributed among certain groups of immigrants provides a compelling rationale for further examining the intersections of interrelated determinants of health.

With a social determinants of health (SDH) approach, health is embedded in daily living conditions that are structured by social relations related to aspects of life such as income distribution, un/employment, education, social exclusion, gender, and racialization (Mikkonen & Raphael, 2010). Increasingly, migration is seen as a determinant of health that creates a new set of circumstances in which individuals must rebuild and re-establish their lives in a new environment. This transition is often accompanied by the negotiation of social relationships with a new identity of ‘immigrant’ (Folson, 2008; Meadows, Thurston & Melton, 2001; Vissandjee, Thurston, Apale & Nahar, 2007).

The kinds of opportunities for work, education, and recreation that are available to immigrants in their communities all play a role in health (Mikkonen & Raphael, 2010). Though some believe that physical activity opportunities are not a priority for immigrant women in the face of other challenges experienced after migration, some report that they do seek out such opportunities to connect socially in their new communities and to promote their own health (Frisby, 2011).

In Canada, Citizenship and Immigration Canada (CIC) is the federal department that oversees immigration programs and grants permanent residency and citizenship. The Federal Skilled Worker (FSW) program supports national economic goals and was designed to “select permanent residents based on their ability to become economically established in Canada” (CIC, 2010, p. 17). It assesses applications for permanent residency in Canada from citizens of other nations based on six criteria including: “i) work experience; ii) education; iii) language;
iv) age; v) arranged employment; and vi) adaptability elements that involve factors such as…

spousal (partner’s) education, family relations in Canada, post-secondary study and work experience in Canada’’ (ibid, p. 1-2). English or French language skills are assessed by a third party or applicants must provide documentation of related training (Hiebert, 2006). Health screening is also required as part of the application process to prevent entry of communicable or costly diseases into Canada’s socialized health care system (Gushulak & MacPherson, 2011). Points are allocated for each of the six categories, and successful applicants score a minimum of 67 points out of 100 (Hiebert, 2006). Spouses of the primary applicant are also considered to be economic immigrants, but are not assessed through the points system (Suto, 2009), though they also tend to be highly educated and have desirable work experience (Chui, 2011).

Although more women enter Canada as dependent spouses, the percentage of women being accepted as economic class principal applicants has increased from 20% in 1980 to 41% in 2014 (Chui, 2011; CIC, 2015). This rise was seen in the 1980s as Canada recruited female nurses from developing nations to fill employment gaps at a low cost, and in the 1990s as reduced funding for training doctors, nurses and teachers coincided with labour shortages (Kofman & Raghuram, 2006). The points system was designed to ensure immigrants possess the assets and resources, or human capital, for economic integration shortly after landing, and some research has indicated that the FSW program has led to positive outcomes for the majority of migrants who meet its requirements (CIC, 2010; Hiebert, 2006). However, critics have argued that the points system inherently implies the future success of accepted applicants, given that acceptance is based on one’s ability to meet the education, skills and experience criteria desired by the receiving nation (Hiebert, 2006). Research has shown that some skilled
immigrants arrive expecting that their education and experience will be assets, but wind up feeling frustrated, confused and angry over the discrepancy between the federal policy and actual employer hiring practices (Somerville & Walsworth, 2010; Suto, 2009). The persistent disparity may also be unexpected as Canadian government recruitment programmes have actively invited skilled workers in other countries to apply for permanent residence (Zuberi & Ptashnick, 2012).

**Conceptual framework**

A social determinants conceptualization draws attention to the broad definition of health espoused by immigrant women in previous research (Ahmad et al., 2004; Dean & Wilson, 2010; Meadows et al., 2001) and takes into account how structural conditions affect health, particularly through the inequitable distribution of power, income, goods and services (CSDH, 2008). Broadly defined, the determinants of health refer to inequitable social, economic, political, environmental and cultural conditions in society that directly or indirectly influence health outcomes unequally (Meadows et al., 2001; Raphael, 2004).

Understanding [women’s] health through a social determinants lens means thinking about the systems and structures in which [they] live as opposed to privileging inquiries about individuals as separate from their social contexts. (de Leeuw & Greenwood, 2011, p. 56)

SDH is not a new concept. In the mid-19th century, Friedrich Engels wrote about health disparities between the social classes and theorized about the factors responsible for the poor health of the working class (Raphael, 2004; Willis et al., 2007). Poor living and working conditions were identified as key influences on health, including the quality of housing, poor
sanitation and diet, and the day-to-day stress of living in poverty (Raphael, 2004). At the turn
of the 20th century, W. E. B. Du Bois acknowledged the influence of race and gender on health
when he wrote about health disparities between black and white Americans in Philadelphia, as
well as between black women and men (Williams & Sternthal, 2010). According to Williams
and Sternthal (2010), Du Bois recognized that “although the causes of racial differences in
health were multifactorial, they were nonetheless primarily social” (p. S16). These early
observations of a social gradient, where health disparities are more pronounced with each rung
down the socioeconomic ladder, were further confirmed in more recent studies conducted in
the United Kingdom that examined correlations between poor health, level of income, and
disadvantage (Raphael, 2004; see Marmot, 1993). Since that time, a large body of evidence has
been collected internationally to show that health is related to the distribution of relative power
and wealth, that is the level of equity, in a given society (Wilkinson & Pickett, 2010).

According to Dhamoon and Hankivsky (2011), an intersectional analysis, particularly
at the individual and group levels, brings to the forefront several complexities that are relevant
for moving women’s health research forward. First, it places an emphasis on the “voices,
experiences, perspectives, and agency of those who are traditionally marginalized and erased in
mainstream academic literature and public policy” (Dhamoon & Hankivsky, 2011, p. 21).
Second, an intersectional approach recognizes that women occupy multiple social locations
simultaneously and can, at one and the same time, be in a relative position of privilege and of
disadvantage (Collins, 2009). Finally, intersectional approaches seek to situate experiences,
perspectives, and agency within a broader context that links not only to one’s identities and
social locations, but also considers how they are changeable and dependent on circumstances
(Dhamoon & Hankivsky, 2011). This is particularly relevant in the lives of recent immigrant
women because through the migration process they often move from one set of social, political, economic and cultural circumstances to another in a short period of time and in very different geographic spaces. Attached to these contextual changes is the new label of ‘immigrant woman’ and the need to negotiate new social locations and identities (Folson, 2008). Dhamoon and Hankivsky (2011) recognized that “it is important to examine how specific interactions occur in specific contexts and how these function in relation to other interactions at different levels of life and across time and space” (p. 28). They argue that the category of immigrant woman with its related assumptions and power relations must be problematized by researchers.

Studies exploring the impact of SDH on immigrant health have focused on socioeconomic status, unemployment/underemployment, discrimination/racialization; access to health care services, language proficiency, acculturation and the adoption of unhealthy lifestyles, and gender (Dean & Wilson, 2009; Dean & Wilson, 2010; Dunn & Dyck, 2000; Meadows et al., 2001; Newbold, 2006; Pottie, Ng, Spitzer, Mohammed & Glazier, 2008; Simich & Jackson, 2010). Immigrant women are often positioned as ‘in need’ or ‘at risk’ of poor health (MacDonnell, Dastjerdi, Bokore & Khanlou, 2012), but Vissandjee and colleagues (2007) explained that:

[the] gradual loss of health and well-being is related to multidimensional social factors, including isolation and loss of pre-existing support systems, language barriers, unemployment or work in employment ghettos with unsafe or unhealthy work conditions, and prolonged social insecurity and feelings of vulnerability arising through poverty, prejudice, and discrimination. (p. 226)
Not only is physical health negatively affected by these inequalities, but mental health can also
decline (Dean & Wilson, 2009; Jafari, Baharlou & Mathias, 2010; Meadows et al., 2001).
Many of these factors are embedded in interconnecting assumptions and social relations related
to migration, gender, and socioeconomic status (Vissandjee et al., 2007), and these social
determinants are the focus of my study.

A majority of extant literature on physical activity participation of immigrant women has not adequately considered the complexity within categories of difference and has reproduced problematic ways of thinking. First, for example, a majority of research has focused on behavioural constraints and individual-level motivations for participation (Kivel, Johnson & Scraton, 2009). A host of barriers to participation for immigrants have been identified such as lack of time, lack of energy, cultural or religious beliefs, language barriers, gender role expectations, and environmental barriers, including neighbourhood safety and weather conditions (Caperchione, Kolt & Mummery, 2009; Skowron, Stodolska & Shinew, 2008). However, an emphasis on individual barriers decontextualizes the causes of lower participation from broader social conditions that have an influence on individual choices.

Second, much of the research has documented differences in physical activity participation based on racial or ethnic categorizations, thereby reproducing categories of difference by not challenging the use of these categories (Floyd, 2007). Categorizing people based on skin colour, cultural heritage, or ethnic ancestry is problematic because it assumes that there are inherent differences between groups based on these characteristics, and ignores salient differences within categories. For example, there may be many differences in access and participation between a Canadian-born woman of Japanese descent who is fluent in English, and a woman who migrated to Canada from Japan in adulthood with limited English-
language fluency. As well, categories of race and ethnicity are often used interchangeably (Henderson & Ainsworth, 2001) with little attention being paid to the effects of the migration process and immigrant status. As a result, the unique challenges faced by immigrants become conflated with essentialized assumptions about racial and ethnic minorities (Stodolska & Walker, 2007). My study aims to disrupt these approaches to research that treat categorized groups as static homogenous entities and often overlook individual agency by better understanding how differing contextual factors influence immigrant women’s physical activity participation after migration.

Several studies have also found that there is an assumption made by recreation and social service providers that physical activity is not a priority for immigrant women or that they are discouraged from participating due to cultural or religious norms (Dossa, 2004; Frisby, 2011; Taylor & Toohey, 1999). However, few studies have explored immigrant women’s perspectives on whether and why they seek out physical activity after migrating to a new country. One notable exception was Suto’s (2013) study that found immigrant women in the Vancouver area sought out both active and sedentary forms of leisure to help improve their mental health. I intend to build upon this line of enquiry.

**Purpose and research questions**

The purpose of this study was to better understand how women who are skilled workers experience health and publicly delivered physical activity opportunities following migration. Skilled workers, whether they are admitted to Canada as principal or spousal applicants, tend to have relatively high levels of education, work experience, and language proficiency upon migrating to Canada (Chui, 2011). This could theoretically mean they have more resources to access opportunities to promote their health and physical activity participation.
Migration is not always considered a social determinant of health so I felt it was important to explore this further, and gender and socioeconomic status are clearly tied to my sample of recent immigrant women who migrated to Canada as skilled workers. However, I acknowledge that intersecting SDH such as racialization and exclusion based on ethnocultural background are also important aspects to consider in future studies. Since it is not possible to examine all SDH in the limited space of this study, I decided to focus on the intersections of migration, gender and socioeconomic status.

The research questions were:

(RQ1) How does the migration process, as it intersects with gender and socioeconomic status, influence the health of recent immigrant women who migrated as skilled workers?

(RQ2) How did community physical activity fit into their lives, if at all?

In the next chapter, related literature is reviewed, and in Chapter 3 the research methods are described. This is followed by a discussion of the findings in Chapter 4 and the conclusions and recommendations in Chapter 5.
Chapter 2: Review of Literature

In this review of literature, I first discuss the conceptual framework that guided my study. An intersectional SDH approach provided a way to understand how an individual’s situation can be patterned by intertwining social processes that affect one’s health. In the second section, studies that explored the shifting social and economic situations of recent immigrant women are reviewed. These studies demonstrated how migrant status and socioeconomic status are intertwined with gendered relations, and explained why it is important to engage in women’s health research from an intersectional point of view. In the third and final section, studies that examined immigrant women’s health and physical activity participation are reviewed. In particular, mental health is considered given the stresses related to migration. Given the wealth of existing research, the physical activity literature was reviewed less in terms of barriers to participation, and more in terms of transformative approaches that may be instrumental in addressing identified barriers.

Intersectionality and the social determinants of health

Population health studies have estimated that up to half of the variation in health outcomes in Western societies are due to social, economic, and political conditions that cause particular groups of people to have higher rates of ill health (Browne & Varcoe, 2009). For example, as already noted, the Healthy Immigrant Effect describes a trend where immigrant subgroups including women, those living on low income, racialized individuals, and older adults have higher rates of declining health after migration to Canada than other populations (Hyman & Jackson, 2010; Kobayashi & Prus, 2011). As explained in a report by the World Health Organization:
The poor health of the poor, [and] the social gradient in health… are caused by the unequal distribution of power, income, goods, and services, …the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life.

(Commission on Social Determinants of Health, 2008, p. 1)

Adopting a SDH approach involves recognizing that certain social divisions or categories are correlated with different health outcomes due to inequalities and exclusion in society. Health inequity refers to inequalities in health outcomes that are unnecessary or avoidable due to unfair or unjust situations (Browne & Varcoe, 2009). SDH is recognized internationally by the World Health Organization (Wilkinson & Marmot, 2003; CSDH, 2008), and nationally Health Canada recognizes twelve determinants of health (Public Health Agency of Canada, 2010). Mikkonen and Raphael (2010) put forth the following list of SDH: income and income distribution; education; unemployment and job security; employment and working conditions; early childhood development; food insecurity; housing; social exclusion; social safety net; health services; Aboriginal status; gender; race; and disability. Increasingly, scholars are also calling for migration to be considered a SDH because it creates a context where individuals undergo significant transitions, and must rebuild and re-establish their lives and identities (Meadows et al., 2001; Vissandjee et al., 2007). While there is no universal list of SDH, evidence overwhelmingly shows that disparities in health are influenced more by socially constructed conditions and social experiences of everyday life, than individual biology, genetics or behaviours (CSDH, 2008; Raphael, 2004; Wilkinson & Pickett, 2010).
However, limitations of the SDH approach also need to be considered. Raphael (2012) warned that SDH language can be co-opted in ways that draw attention away from differences in relative power and the inequitable distribution of resources towards discourses that individualize health problems. For example, when determinants of health are simply presented as barriers or adverse living conditions that can simply be removed through individual action and motivation, it denies persistent structural inequalities (ibid). Second, SDH are often presented as factors or independent variables in health studies, without recognition of the clustering effects of these determinants (Hankivsky & Christoffersen, 2008). Deploying the notion of SDH in these ways oversimplifies the complexity of real life situations, as multiple inequities are often experienced together. However, by applying an intersectional lens and understanding social determinants as intersecting categories of social difference refocuses attention on how social categories are patterned by socially constructed power hierarchies (Dhamoon & Hankivsky, 2011; Hankvisky & Christoffersen, 2008). Furthermore, an intersectional approach to SDH draws attention to the interconnectedness of health determinants and helps to identify the systems of power that contribute to the intractable effects of these categories. However, a key challenge is that it is not possible to consider the intersections of all SDH in any one study. As a result, only three determinants – migration, gender and socio-economic status were considered in my study, even though I acknowledge that other SDH require further attention.

**Intersectionality theory**

Davis (2008, p. 68) defined intersectionality as “the interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangement, and cultural ideologies and the outcomes of these interactions in terms of power.”
The term emerged in reaction to scholarship produced by white feminists that assumed an essentialized category of *woman* whereby all women share experiences of gender discrimination in the same way. Black feminists and women of colour argued that multiple forms of discrimination based on race, class and gender are experienced in a simultaneous and intertwined manner, and that feminist social theories require further development to account for these different and multiple experiences (Dhamoon, 2011). Although the category *woman* was deconstructed as early as 1851 by Sojourner Truth, a former slave, and anti-slavery and women’s rights activist (Brah & Phoenix, 2004), the term intersectionality was first introduced in 1989 by Kimberle Crenshaw, a legal scholar who rejected the idea that black women should need to choose whether they experienced either racial discrimination or gender discrimination (Davis, 2008). She argued that black women face both forms of discrimination simultaneously and that the combination results in experiences that are different from the racism felt by black men or the sexism felt by white women (Dhamoon, 2011).

Collins (2009) further pointed out that different forms of oppression not only intersect with one another, but that these patterns of social relations mutually reinforce one another, and serve to socially locate individuals based on the intersections of *identity markers*. Identity markers are categories of difference or social divisions, and refer to the ways people are categorized by themselves and/or by others (Paraschak & Tirone, 2008; Yuval-Davis, 2006). Brah (1996, p. 109) argued that it is analytically productive to consider how different social relations are articulated together within defined historical contexts when she wrote that: “Structures of class, racism, gender and sexuality cannot be treated as ‘independent variables’ because the oppression of each is inscribed within the other – is constituted by and is constitutive of the other”. She called upon scholars to “not compartmentalise oppressions, but
instead formulate strategies for challenging all on the basis of an understanding of how they interconnect and articulate” (p. 127). Though socially constructed, these categories of difference have real life consequences.

Intersectionality scholars work to draw connections among four levels of analysis by examining: 1) “identities” of individuals (e.g. Chinese immigrant woman, Somalian refugee women) or, 2) groups who share socially constructed “categories of difference” (e.g., race, ethnicity, gender, class, nationality, sexuality, ability, age), usually through narratives where study participants discuss their perspectives, experiences, and material realities (Dhamoon & Hankivsky, 2011, p. 20). In order to not lose sight of structural reasons for injustice, it is important for intersectionality scholars to examine how categories of difference are underpinned by 3) real “processes of differentiation” (e.g., racializing, gendering, or demarcating a particular status such as immigrant), and 4) “systems of domination” (e.g., racism, sexism, patriarchy, colonialism, nationalism) that are culturally ingrained (Dhamoon & Hankivsky, 2011, p. 20). For example, by understanding how certain groups such as immigrants are positioned as different from those born in Canada, the real-life “material consequences of these categories of difference in the experiences of women of colour” such as oppression, discrimination and exclusion may be exposed (Davis, 2008, p. 73). An “examination of how identities and/or categories are constituted, resisted, and governed in the first place” (Dhamoon & Hankivsky, 2011, p. 24), is required in order to study the processes and systems influencing the health of recent immigrant women.

Davis (2008, p.74) explained that intersectionality “takes up the political project of making the social and material consequences of the categories of gender/race/class visible, but does so by employing methodologies compatible with the post-structuralist project of
deconstructing categories, unmasking universalism, and exploring the dynamic and contradictory workings of power” (also see Brah & Phoenix, 2004, p. 82). As Brah (1996) defined it, difference is the “variety of ways in which specific discourses of difference are constituted, contested, reproduced, or resignified” (p. 125). According to interpretations of Foucault’s work, power is not a possession, rather it is imbued in the relationships between people and played out through discourses and practices that “guide another’s conduct” (Markula & Pringle, 2006, p. 38). Classifying groups of people is a technique of power that serves to control individuals through the use of binary categorizations by separating ‘abnormal’ from ‘normal’ (Markula & Pringle, 2006). The reiteration of such differences over time can lead to false beliefs about permanent characteristics of a group (Brah, 1996). This can be seen in nationalistic discourses where the articulation of ‘Canadian’ often reflects a social position associated with a given race, class, place of origin, and dominant language(s). By default this also signifies who does not count as being Canadian (Brah, 1996). Thus, intersectionality theory can help scholars avoid oversimplifying, collapsing, or conflating the importance of categories (Dhamoon, 2011). Applying an intersectional lens destabilizes categorical authenticity and emphasizes diversity within categories of difference, while also shedding light on the social hierarchies ingrained in social thought and practice (Brah & Phoenix, 2004; McCall, 2005).

**An intersectional social determinants of health approach**

Applying intersectionality theory to the study of immigrant health would thus require fuller theorizing about the *meaning* of these markers under specific contexts, and about how these *meanings* are mutually influenced by race, class, gender and other social

Although there is no unified theory of intersectionality, the theoretical tensions that have shaped it illuminate ways to conceptualize the interconnected nature of the SDH and how they impact health on multiple levels. First, an intersectional approach sheds light on how multiple determinants or categories of difference are embedded in power hierarchies that shape resulting experiences (Hankivsky & Christofferson, 2008), drawing attention to the structural causes of health inequities, such as the political, economic and social structures in our culture and society (McGibbon & McPherson, 2011). By recognizing the unique ways that individual or group health is impacted at these intersections, the focus shifts to the context that shapes health outcomes, moving beyond a focus on individual health behaviours. As well, intersectionality theory not only points to underlying structural conditions that reinforce health inequalities, there is also the potential to identify actions that can lead to systemic change (Neuman, 2003).

Secondly, using an intersectional approach to understanding the SDH responds to calls by health researchers for concepts and methodologies that reflect the complexities shaping health disparities in Canada (Lee & Sum, 2011; Reid et al., 2007). As Guruge and Khanlou (2004) stated, “[there] is a growing recognition of the complexity surrounding multiple axes or dimensions of social identity and how they intersect to influence the health of immigrant and refugee women” (p. 33). The influence of intersecting categories of difference varies depending on the person and which identity categories are foregrounded in each context, providing insight into how power plays out through interpersonal social relations. Researchers drawing on intersectionality theory do not assume that the impacts of SDH are predetermined.
because there is room for variation and differences depending on the context, and this helps to resist essentializing the experiences of particular groups who may be categorized similarly (Hankivsky & Christofferson, 2008).

Finally, researchers using an intersectional analysis are encouraged to pay attention to the agency of women within the context of the SDH, rather than seeing women as passive subjects to which phenomena happen. Feminist migration researchers often look at the impact of migration on women, however, intersectionally-framed research would also consider how women are intentional actors through the migration process who experience both opportunities as well as hardships (Vissandjee et al., 2007). For example, Lee and Sum (2011, p. 148-150) contended that:

“[racialized women] have the capacity and ability to act as conscious agents, creating and re-creating strategies of survival, negotiation and resistance in their everyday lives” [and they] “actively negotiate, utilize, and make sense of diverse ways of being when living within oppressive systems.”

**SDH and skilled worker immigrant women**

Health is a difficult term to define because of the numerous and changing meanings that are attributed to it (Raeburn & Rootman, 2007). Health is often understood in medicalized terms as illness or disease that may be modified or avoided through individual lifestyle choices (ibid). According to Raeburn and Rootman (2007): “it is reasonable to assume that almost always when one hears the term ‘health’ in the health sector, it usually means ‘illness,’ conceived in a medical/clinical frame” (p. 19). Many studies based on population data exploring the healthy immigrant effect consider ‘health’ in terms of the development of chronic
diseases, hospitalization, mortality, obesity and birth outcomes (De Maio, 2010). Women’s health has been historically pathologized in relation to the reproductive system, while disparities in health between men and women have been mostly ignored, and the diversity in health amongst women has not been adequately accounted for (Cohen, 1998; Ponic, Reid & Frisby, 2010). Women’s health is also often influenced by political and cultural constructions that instill a moral connotation with health (Fullagar, 2013). For example, healthism refers to discourses and practices that excessively promote individual healthy lifestyle choices in diet, exercise and emotional wellness (Petersen, Davis, Fraser & Lindsay, 2010). In liberal democratic societies, individuals are expected to make smart choices and take responsibility for their health, and a failure to do so puts one at risk of poor health thereby burdening the health care system (Petersen et al., 2010). Thus, overweight and obesity have become conflated with health status, particularly for women (Fullagar, 2013). Immigrant women in particular “are represented in mainstream discourse as a homogenous population ‘in need,’ in terms of their risks for disease, lack of access to culturally relevant services, and thus their burden on the health system” (MacDonnell et al., 2012, p. 1). However, the dominant biomedical framing of health as a deficiency, which underpins Canada’s public health care system, belies more holistic framings of health that are embraced both by many health promotion advocates and immigrant women themselves (Ahmad et al., 2004; Dean & Wilson, 2010; Meadows et al., 2001). Furthermore, it again overlooks variations in health due to social and economic arrangements in society and culture.

**Migration and immigrant women’s health**

Although in daily usage one may use the term ‘immigrant women’ innocuously to denote women who were born in one country and have moved transnationally, either by choice
or out of necessity, feminist migration researchers have expressed caution in using this terminology (Folson, 2008; Suto, 2013). This is because the term is imbued with a history of marking the ‘Other’ in white settler societies, such as in Canada. Historically, the label of immigrant women has not been applied to white, Christian women from a Western European nation who immigrated to Canada, as they were seen as settlers, pioneers, or members of founding nations (Suto, 2013). In contrast, non-white migrants were exploited as unskilled, indentured or cheap labour and marginalized from white society (Folson, 2008). Furthermore, upholding the settler/immigrant binary served to maintain the erasure of Aboriginal women and men from mainstream history. Therefore, for some there is unease with using the term ‘immigrant women’ as it reinforces socially constructed notions of who is a ‘real’ Canadian, and who is not. As I have not found a more suitable term, in my study, immigrant women refers to both white and non-white women who have migrated to Canada.

Migration creates unique situations whereby individuals are assigned (and/or adopt) the identity of immigrant after the migration process, and must negotiate new meanings and social relations that come with this label (Folson, 2008). In theorizing migration as a SDH or identity marker in settler societies such as Canada, I drew on Bhabha’s (1990) discussion about liberal relativism. It refers to the tenet that each individual in liberal democratic societies is considered to have the universal right to pursue her or his own goals, but there is often a hidden sentiment that those goals should align with the acceptable range of goals or morals of the dominant group. This is exemplified in Canada’s uptake of federal multiculturalism that supposedly entrenches the embrace of ethnic and racial diversity and the right of all Canadians to preserve and share their cultural heritages in policy discourse (Frisby, Thibault & Cureton, 2014). However, this is problematic when the taken for granted dominant culture is grounded in
Canada’s white British and French colonial settler history and language, and is assumed to clash with those of increasingly multiethnic and multilingual newcomers (Li, 2003). National belonging of immigrants may be marked by interrelated aspects including race, ethnicity, place of origin, language fluency, attire, lack of or type of accent, as well as markers related to faith and religious expression. Ultimately migrants need to negotiate social relations that signal to them who has the right, legitimacy, and power to fully participate in democratic Canadian society, and who does not (Li, 2003).

The concept of social closure has been used to describe processes of exclusion by a dominant group that prevent others from accessing or utilizing resources to maintain or raise their privilege and social position (Frank, 2013). Crenshaw (1991) explained how overlooking differences in the provision of social support services disadvantages immigrant women when resources are unwittingly prioritized for English-speaking women and are therefore unavailable for non-English-speakers. By being blind to differences and not allocating resources for translation and multilingual staff, inequalities related to gender, class, race and place of origin become institutionally reinforced (Crenshaw, 1991). Some immigrant women report the need to rely on their children to play the role of interpreter with health care professionals. However this practice can be problematic because mothers were reluctant to discuss intimate concerns in the presence of their children, and the translation of meaning may not have been accurate (Elliott & Gillie, 1998). Such oversights in service provision can be particularly damaging when personal safety and health are compromised.

Vissandjee and colleagues (2007, p. 226) have noted that particularly for immigrant women:
[the] gradual loss of health and well-being is related to multidimensional social factors, including isolation and loss of pre-existing support systems, language barriers, unemployment or work in employment ghettos with unsafe or unhealthy work conditions, and prolonged social insecurity and feelings of vulnerability arising through poverty, prejudice, and discrimination.

This point was made not to reify discourses that position immigrant women as being ‘at risk’ of poor health (MacDonnell et al., 2012), but rather it points to the ways that health can be negatively influenced by the intersecting SDH that create inequitable situations.

The process of migration itself can have an effect on health because it spans both time and geography (Thurston & Vissandjee, 2005). Some studies have found that immigrants reported improvements in health status, such as a decrease in headaches, colds and influenza, and allergies, which were attributed to a superior physical environment in Canada including fresh air, high quality water, less pollution, improved access to amenities and grocery stores, and better working conditions (Dean & Wilson, 2010; Meadows et al., 2001). On the other hand, physical health concerns identified in Elliott and Gillie’s (1998) study included fatigue, aches and pains, family members’ health, and seasonal colds and influenza. Declines in both physical and mental health of immigrants were frequently contextualized by experiences associated with migration, including, for example, a lack of income, loss of employment-related skills, loss of social status, experiences of discrimination, homesickness, English fluency, and communication problems (Dean & Wilson, 2009; Jafari et al., 2010; Meadows et al., 2001).

Given the web of challenges related to migration, many of these issues overlap to adversely influence mental health. For the purposes of this study, mental health refers to “the
realization of one’s abilities, the capacity to cope with daily stressors, participate in fulfilling relationships with others, work productively and fruitfully, and contribute to community life” (Parry, 2013, p. 217). Mental health also encompasses emotional health, including the ability to control and express emotional reactions appropriately (Parry, 2013). Mental health is often conceptualized in terms of feeling above average, a sense of subjective well-being or happiness, the ability to enjoy life, and the ability to cope with and learn from challenges when they arise (Vaillant, 2012). Coping mechanisms include seeking social support, intentional strategies to mitigate or master stress, and involuntary mental strategies such as denial or sublimation (“turning lemons into lemonade”) (ibid, p. 98). Mental health concerns identified by immigrants have included stress, anxiety, depression, unhappiness, sadness, worry, tension, irritation, sleeplessness, crying, and frustration (Dean & Wilson, 2009; Meadows et al., 2001).

In Meadows and colleague’s study, immigrant women spoke of health as a physical experience rather than specific ailments indicative of illness (2001). For example, a number of women discussed emotional trauma such as sadness, depression and anxiety that they experienced in their home country prior to migration due to war and political tension in society. After migration, they also described feeling aches, pains, sleeplessness and depression related to their migration experiences (Meadows et al., 2001).

MacDonnell and colleagues (2012) found that immigrant women in their study rarely used the term ‘mental health’ and more frequently referred to ‘stress’, which may be attributed to the stigma surrounding mental health. Among Iranian immigrants in Vancouver, Jafari, Baharlou and Mathias (2010) found that in English the term ‘mental health’ was often translated into Persian terminology that literally meant mental illness or psychiatric disorder. However, others in their study understood mental health to mean happiness, mental tranquility
or spiritual calmness. Fullagar (2013) noted that Maori in Australia do not have an equivalent term for ‘mental health’ *per se*, but rather refer to a more holistic idea of emotional well-being. Dossa (2004) cautioned researchers to be wary when using mental health discourses to situate the effects of dislocation along with social and economic exclusion. She suggested that mental health discourses, however inadvertently, imply that immigrant women cannot handle the stress of migration, thereby individualizing the problem and detracting from the social and institutional issues that immigrants face. Along similar lines, Mohanty (2003) warned Western feminist scholars to beware of unwittingly positioning ‘Other’ women as powerless victims by passively representing them as objects affected by social processes or institutions, rather than as intentional actors within a larger system.

**Socioeconomic status and immigrant women’s health**

Professional closure is experienced by some immigrants particularly through the positioning of skills and qualifications gained internationally as being different or deficient in Canada (Shan & Guo, 2013). Socioeconomic status is a SDH that refers to the combination (or intersection) of several measures including income, education, and occupation (Reid, 2007). These interrelated aspects may be analyzed in terms of employment and working conditions, income and its distribution, opportunity for education, unemployment, and job security (McGibbon, 2012; Raphael, 2012). For some immigrants, socioeconomic status is intertwined with migration in terms of the devaluation of foreign education, credentials and experience, and as will be discussed, with gender as seen by low wages associated with highly feminized segments of the labour market. This draws our attention to notions of national belonging and repercussions for social status, which is important because, as Liversage (2009, p. 123) noted, “social status in the Western world today is strongly tied to labour market position, [thus] the
inability to use former credentials holds critical implications for who immigrants are able to ‘become’ after migration.”

In a qualitative study conducted by Dean and Wilson (2009), the health impacts of persistent unemployment and underemployment of skilled immigrants living in Mississauga, Ontario were examined. Immigrants in their study entered Canada via the Skilled Worker Program, indicating that they were selected based on desired educational credentials, work experience, and language proficiency. However, they remained unemployed or were employed outside of their field of training following migration. The resulting situation of a lack of income, the loss of employment-related skills (or de-skilling), and the loss of social status created stress and negative health outcomes related to strenuous working conditions, especially for those who were working in survival jobs (Dean & Wilson, 2009). Participants in Meadows et al.’s (2001) study also discussed how their socioeconomic status had lowered due to discrimination in both social and employment situations.

For skilled workers, a primary site where they must negotiate the label of immigrant is in the social relations of employment. A persistent issue cited by skilled workers has been the concern over the disjuncture between federal government selection criteria and the desire or willingness of Canadian employers to accept foreign credentials (Somerville & Walsworth, 2010; Suto, 2009). As Shan and Guo (2013) demonstrated, institutions from professional certifying bodies, to settlement agency employment programs, through to employers, privilege experiences and credentials gained in Canada. The devaluing of non-Canadian credentials has long been a reason for employers to deny some skilled immigrants employment (Somerville & Walsworth, 2010). Professional certifying bodies often require applicants to enroll in courses at Canadian educational institutions to upgrade their credentials, as well as have Canadian work
experience before granting Canadian credentials (Ontario Human Rights Commission, 2013; Shan & Guo, 2013). However this creates a dilemma for skilled migrants because they require certification in order to gain relevant work experience in Canada, but in order to become certified they must have Canadian work experience (Shan & Guo, 2013). Furthermore, Shan and Guo (2013) argued that the negation of international work experience and credentials systematically “distinguishes immigrants as the others who are different and by default deficient” (p. 36). The Canadian work experience requirement emphasizes a migrant’s social location as ‘not Canadian’, devalues a skilled worker’s existing work experience, and creates an artificial barrier that structurally streams immigrants into lower skilled and lower paid positions.

Studies have confirmed that skilled immigrants with higher proficiency in English or French tend to gain employment more quickly than those with less dominant language facility (Hiebert, 2006; Frank, 2013). However, even though one of the immigration assessment criteria for Federal Skilled Workers includes English or French language proficiency, it is possible to achieve a lower language score if other criteria, such as education and work experience, are assessed to be at a high level (Adamuti-Trache, 2013). Concurrently, language acquisition is often limited by few opportunities to interact with native English speakers due to isolation, non-participation in the workforce, or work in an occupation that does not require communication in English (Adamuti-Trache, 2013). Taking a closer look at attitudes towards language further illustrates the workings of social hierarchies. Han (2012) argued that language is symbolic of national and international linguistic hierarchies by which individuals are identified (or not) as part of the dominant group. “Successful communication means being recognized as a legitimate speaker speaking a legitimate language… [but migration] often
means the loss of linguistic legitimacy” (Han, 2012, p. 137). Creese and Kambere (2003) argued that perceptions of language fluency are bound together with notions of national belonging and Canada’s colonial history because accents serve to racially mark individuals. While British or Australian accents are considered acceptable in Canadian society, other accents mark individuals as ‘Other’ (Creese & Kambere, 2003). Participants in Jafari et al.’s (2010) study noted that lack of English fluency led to isolation, marginalization, anxiety, and other mental health problems, particularly because it made it difficult to secure employment, communicate meaningfully, and develop relationships with members of the host society. This in turn led to unemployment or the need to accept survival jobs, feelings of loss of status, and financial insecurity (Jafari et al., 2010).

Although some skilled immigrant women have expressed an appreciation for more gender equality and opportunities for women in Western societies (Gupta & Sullivan, 2013), many continue to face gender-based hierarchies, as well as those based on race, ethnicity, and nationality. As one Statistics Canada report noted, almost 50% all recent immigrant women held a university certificate or degree compared with 23% of Canadian-born women, in the fields of business, management and public administration, as well as health, parks, recreation and fitness. However, the actual employment rate for recent immigrant women was much lower, and they were more likely to be employed part-time (Chui, 2011). Immigrant women also experienced wage gaps when compared with Canadian-born women and immigrant men. Recent immigrant women who worked full-time for a full year in 2005 earned a median income of $26,700, 70% of that earned by Canadian-born women and 78% of that earned by immigrant men (Chui, 2011). Furthermore, based on 2006 census data, 32.1% of all recent immigrant women were living in low income situations (after tax, based on the Statistics
Canada Low Income Cut Off line) (Chui, 2011). Unfortunately, the Statistics Canada Longitudinal Survey of Immigrants to Canada (LSIC) ended in 2008, and until very recently, Canada stopped conducting the long-form census so more recent statistics are not available.

Poverty rates among immigrants have been on the rise since the 1970s (Hiebert, 2006). Chui (2011) found that in 2006, almost one third of recent immigrant women lived on low income, and Picot, Lu and Hou (2009) confirmed that low income rates have risen between 1989 and 2006 among recent immigrants. As well, there is a growing body of related literature examining the links between the growing racialized and gendered aspects of poverty in Canada (Wallis & Kwok, 2008). Immigrants admitted under the economic immigrant category, including skilled workers, are required to demonstrate that they have the financial means to avoid becoming a burden on Canada’s social safety net. Federal Skilled Worker principal applicants on average arrived in Canada with C$31,000, but after six months had only $14,300 remaining (Hiebert, 2006), which leaves little to survive on when economic exclusion was unexpected (Suto, 2009). Although voluntary immigrants, such as those who apply through Canada’s Federal Skilled Worker program, can plan, gather resources and exercise some level of choice in their migration, they still experience stressors related to uprooting and re-establishing in a new society, along with possible changes in family dynamics and gender relations (Vissandjee et al., 2007). Anderson and colleagues (2010) questioned whether downward mobility and the loss of social position of immigrants had become normalized in Canadian society, and challenged health promoters, educators, and policy makers to continually examine the social, political and economic contexts that influence health.
Gender and immigrant women’s health

Gender is another multifaceted SDH that refers to socially constructed differences between women and men that are embedded in cultural practices and enacted through social relationships (Paraschak, 2007). Gendered relations often reproduce hierarchies that afford men more power than women and become naturalized over time so that “most individuals accept them as appropriate and necessary for the effective operation of their society” (ibid, p. 137). Although this definition is limited because it reinforces binary categorizations of gender, it nevertheless captures dominant beliefs around gender roles that often shape material realities and have an influence on the health of immigrant women. As Spitzer (2012, p. 119) explained:

Although the enactment of caregiving responsibilities can be fulfilling, it may also bind women closer to the home and limit their opportunities to enter the labour market, to access supportive networks, to upgrade their skills or to learn French or English as a second language.

Elliott and Gillie (1998) found that South Asian Fijian immigrant women living in the lower mainland of British Columbia consistently discussed their social location in relation to their roles as wife, mother, caregiver, and waged worker, and prioritized the importance of these roles over their own health. Furthermore, fatigue was the primary health concern for most of the women and this was contextualized within the migration experience as being related to depression, overwork due to women’s ‘double duty’ or stress due to lack of work, as well as tensions tied to changing gendered norms within the household (Elliott & Gillie’s, 1998). Meadows and colleagues (2001) also found that shifting perceptions relating to gender roles after migration sometimes caused tensions between spouses or parents and their children, which had a negative influence on women’s physical and mental health. As well, when
immigrant women had been able to enter the job market, despite their previous training and work experience, many wound up in traditionally gendered and low-paying occupations, including working as cooks, cleaners, and clerical staff, or becoming ‘housewives’ (Man, 2004; Mojab, 1999).

Though the non-recognition of credentials, the requirement of Canadian work experience, and language facility are barriers to economic integration faced by both men and women, Suto (2009) argued that when those issues are intertwined with gendered social relations (e.g., notions about feminized occupations and family responsibilities) women face additional barriers that immigrant men often do not. Salaff and Greve (2003) argued that structural barriers to employment encountered at the institutional level outweigh variations in human capital at the individual level. They noted that Canada’s labour market is gendered in ways that are different from other countries, such as China. Thus, immigrant women who held professional positions in China may be streamed into limited gendered occupations in Canada that are deemed suitable for women, but cause them to attain lower status occupational positions than men and Canadian women because they are not seen to have the language and cultural skills to manage people (Salaff & Greve, 2003). Immigrant women who were medical doctors, engineers or lawyers in China experienced more success after migration by retraining to attain lower status positions, such as medical technicians or drafters, or seeking female dominated and sometimes racialized occupations such as child care, settlement services, and community work, rather than the professional or managerial positions they previously held (Salaff & Greve, 2003; Shan, 2009; Shan & Guo, 2013). This was also seen in Denmark, where highly skilled women leveraged their new immigrant identities to build careers in new feminized fields, including as immigrant settlement support workers, multicultural teaching
assistants, and translators (Liversage, 2009). In another study based in Toronto, immigrant women indicated that “their intellectual capacity had been undermined in Canada and, consequently, they were seen as a potential source of manual labour” (Mojab, 1999, p. 125). Many immigrant women faced the erosion of their professional knowledge and skills over time, known as de-skilling, as they took on unrelated employment or were excluded from relevant work altogether (Man, 2004; Mojab, 1999).

Related challenges pertain to gendered family divisions of work and the dilemma of prioritizing work or family, particularly given the lack of a coordinated effort in Canadian society to ensure affordable child care (Liversage, 2009; Suto, 2009). Prior to migration, skilled women often had family and social support to care for children, or had the means to hire nannies and housekeepers in order to pursue full-time careers (Ho, 2006; Suto, 2009; Meares, 2010). In addition, some women must adjust to lone parenthood if their partners remained or returned to their country of origin to earn an income (Shan, 2009). Ho and Bedford (2008) used the term “astronauting” to refer to transnational families that have “adopted a deliberate strategy of living in two or more countries in order to maximize opportunities for education, employment and social advancement for family members” (p. 43). However, after migration, if affordable child care is not available, the responsibility of caregiving often falls on women who must choose employment or training options that work around children’s schedules (Dossa, 2004; Shan 2009). In Liversage’s (2009) study, highly skilled Eastern European women who immigrated to Denmark lamented their loss of professional identities and shared their fears of becoming ‘just housewives’. Retraining and job searching was facilitated by Denmark’s socialized child care system, though many still had difficulty with other aspects of labour market entry (ibid).
In contrast, in countries with no comprehensive national childcare strategy such as Canada, decisions to pursue employment, retraining and credentialing are more influenced by family dynamics and economic circumstances. Skilled immigrant women often needed to balance their own professional aspirations, such as desires to gain local credentials, retrain or enroll in language learning, with economic realities and family responsibilities, such as the uptake of part-time work, child care, and food acquisition (Huot, Laliberte Rudman, Dodson & Magalheas, 2013; Shan, 2009). Additionally, the double burden of work and household responsibilities often required them to arrange their workforce participation around their household responsibilities (Ho, 2006). Subsequently, some women focused on domestic responsibilities or accepted part-time employment after migration in order to fulfill this caregiving role (Ho, 2006). However, part-time employment often entailed low pay and irregular hours of work, making it challenging to schedule time for training or English classes (Zuberi & Ptashnick, 2012).

To cope with occupational downgrading, skilled migrants sometimes reframe their current situations. For example, in one study, Chinese immigrant women focused on settling their children and setting up their households, reframing this as a priority, while putting their own careers on hold after migrating to Australia (Ho, 2006). Graham and Thurston (2005) conceptualized this as a coping strategy, as immigrant women reframed their additional household responsibilities as a re-oriented positive goal related to raising their families instead of having a successful career. Zuberi and Ptaschnick’s (2012) study involved immigrants who migrated through various immigration categories, but nonetheless were educated, skilled, and held professional occupations such as teachers or pharmacists prior to resettling in Vancouver, BC. These skilled migrants de-emphasized their downgraded professional status and justified
their sacrifice as a way of ensuring their children’s future success, or accepted it because they were new to the country or because they were not yet fluent in English (Zuberi & Ptashnick, 2012).

In studies where immigrant women were asked to discuss what health meant to them, it was often discussed in positive and holistic terms as a state of balanced physical and mental health. For example, in Dean and Wilson’s (2010) qualitative study that involved both immigrant women and men, only a few participants defined health as “not being sick” (p. 1222), while most discussed it as physical and mental well-being, including for some, spiritual fulfillment. In Elliott and Gillie’s (1998) study, South Asian Fijian immigrant women referred to health as “the balance between physical, emotional and spiritual well-being” (p. 331). Similarly, recent immigrant women from China and India in Ahmad and colleagues’ (2004) study emphasized a holistic view of health. As well, Meadows et al. (2001) found that a diverse group of immigrant women discussed health in relation to physical, mental and spiritual aspects. When discussing health problems, study participants focused more on physical factors that limited their functional ability to fulfill social roles of “mother, spouse, caregiver and/or employee” (Meadows et al., 2001, p. 1453). These women voiced the importance of maintaining physical health in order to perform these roles rather than for self-care. Immigrant women in MacDonnell et al.’s (2012) study situated discussions of their mental health and overall well-being within dynamics of family, community, and structural contexts during settlement.

To summarize, there is evidence to suggest that when issues related to migration, gender and socioeconomic status intersect there can be material effects on immigrant women’s physical and mental health. While social support and feeling like a contributing member of
society may have a positive effect on health, the multifaceted barriers that many immigrant women face limit their resources and ability to do so (Spitzer, 2012). Furthermore, the disjuncture between one’s expectations and hopes, and a reality that has undercurrents of different forms of discrimination can cause chronic stress (*ibid*). As Spitzer (2012) explained, social and material deprivation, stigma, social exclusion and negative emotional effects may be expressed through women’s bodies as a cluster of symptoms that some studies have linked to hypertension and Type II diabetes. As demonstrated in the literature, such disparities are underpinned by gendered social hierarchies that are ingrained in the dominant culture. Thus, it is not simply the category of ‘immigrant women’ who are ‘at risk’ of poor health, but it is the social arrangement of how power and privilege are distributed in particular contexts that makes a difference in health.

Next, the literature on immigrant women’s physical activity participation will be reviewed.

**Immigrant women’s physical activity**

Canadian research has shown that immigrant women, racialized groups, and people living on low income have lower overall rates of participation in leisure time physical activity than other segments of the population (Chen, Ng & Wilkins, 1996; Spinney & Millward, 2010). For the purposes of this paper, I will refer to leisure time physical activity opportunities that are funded and delivered by a public body, such as a municipal recreation department, as community-based physical activity. In recent years, researchers have called for more complex and structural analyses of immigrant women’s physical activity participation and health. Particularly, Kivel, Johnson and Scraton (2009) challenged researchers to move beyond describing experiences, to situating them “within broader social, cultural discourses of
institutional oppression such as racism, sexism, ableism, and heterosexism” (p. 474). Ageism is another consideration as community-based physical activity programs are mostly directed as youth, children, and seniors rather than middle aged adults (Frisby, Alexander, & Taylor, 2010).

This challenge was issued in response to the wealth of studies examining individual level constraints to physical activity participation among immigrant women that draw on psychological theories of individual behaviour change (Kivel et al., 2009). Barriers to physical activity participation for immigrant women are also well documented including lack of time, lack of motivation, lack of energy, cultural or religious beliefs, language barriers, gender role expectations and lack of social support. Socio-economic barriers include low income, low educational attainment, and low literacy levels; and environmental barriers include neighbourhood safety and weather conditions (Caperchione et al., 2009; Devlin et al., 2011; Skowron et al., 2008). Stodolska (2000) identified individual constraints to leisure participation and the reasons why Polish immigrants in her study decided to change or maintain their participation in a variety of recreational activities, including physical activity. Although her study provided an opportunity for Polish immigrants to voice their experiences, the analysis framed participation in terms of individual choice and did not consider broader social conditions that shape these choices.

Another line of enquiry has examined the physical activity participation of specific population sub-groups, such as ethnic minority women, but this may result in overly simplistic predictive models of behaviour (Ainsworth, Mannell, Behrens & Caldwell, 2007; see for example Maxwell, Bastani, Vida & Warda, 2002). In another example, using Canadian cross-sectional data from the 1996-97 National Population Health Survey (NPHS), Wong and Wong
(2003) identified ‘modifiable lifestyle risk factors’, including leisure time physical inactivity, to analyze cardiovascular risk factors among immigrant women. Their study supported findings that immigrant women from China and other countries reported less physical activity than immigrant women from the USA, UK, and Australia (Wong & Wong, 2003). While they acknowledged that a lack of physical activity participation may be due to a range of socially determined factors, the authors focused on individual rather than structural barriers and concluded that: “[these] women may not appreciate the importance of leisure-time physical activity to health promotion” (Wong & Wong, 2003, p. 117). Furthermore, they emphasized the importance of cultural competence in health education because “Western health promotion programs are usually ineffective for people of non-Western values” (ibid, p. 120). Although these researchers suggested important structural strategies for reducing health promotion disparities, their approach to analysis and use of language was problematic. They overemphasized the importance of intrapersonal barriers and reinforced the notion that inherent traits of the women’s ethnic background directed decisions about health practices. Positioning research findings and recommendations in these ways, as explained by Browne and Varcoe (2009), is culturalist because they reinforce stereotypical beliefs about people from different ethnocultural groups, and they assume that culture is the primary consideration in decisions about health.

In contrast, Dossa (2004) demonstrated why barriers cannot be taken at face value in her study exploring Iranian women’s mental health during settlement. Some women discussed their difficulty participating in physical activity programs due to lack of language fluency, low income, and transportation. Delving further, the language barrier was not from lack of trying to learn English, as one participant attended ESL classes for four years and was frustrated that she
still had language difficulties. Other participants noted that even a $5 program fee was too much to spend, and bus travel was no longer an option when transit rates went up. Yet a recreation coordinator who was interviewed expressed that there was nothing that could be done if immigrant women just do not want to participate in programs (Dossa, 2004). Following cautions from Dossa (2004) and Mohanty (2003), I am wary of positioning barriers as problematic behaviours or psychosocial constraints of the women or of laying responsibility at the individual level. It is important to gain a better understanding of how immigrant women themselves see physical activity (or lack thereof) connecting to their health and lives after migration.

Although there are few studies that have examined community-based physical activity among recent immigrant women, and particularly those who are skilled workers, some qualitative studies provide relevant insight. Some studies have examined the role of leisure, which encompasses community-based physical activity, in the lives of immigrants of both genders (Stodolska, 2000; Stodolska & Alexandris, 2004), as well as of immigrant and ethnic minority women (Frisby, 2011; Tirone & Pedlar, 2000). Stodolska (2000) found that Polish immigrants chose to engage in leisure for different reasons, including maintaining social ties with those who shared a common cultural heritage, as well as building social networks with those from the so-called broader community, in part to help develop work opportunities. As Tirone and Pedlar (2000) identified in their study with ethnic minority South Asian youth, leisure was a means for participants to engage in activities with their family and friends, connect with individuals from different cultures, and engage in practices that expressed cultural differences from the dominant mainstream.
Suto (2013) found that migrant women in the Vancouver area sought leisure activities, both active and sedentary forms, for relaxation, reducing feelings of stress, and coping with depression, anxiety, and loneliness. For many women, this was necessary because tasks that were previously simple and conducted with ease prior to migration became and remained unexpectedly challenging. As Suto explained: “Previously routine interactions with children’s teachers, health care providers, and neighbours that required tacit knowledge were changed by time, place, language and expectations” (2013, p. 54). To address this, some of the women had the financial means and mobility to travel to nearby municipalities to conduct activities such as shopping and banking in their language of choice, and some chose to engage in leisure that afforded the opportunity to socialize in their primary language (Suto, 2013). This study clearly demonstrated that an individual’s choice to engage in and ability to benefit from leisure activities is facilitated by one’s access to resources.

With regard to physical activity specifically, Sodergren, Hylander, Tornkvist, Sundquist and Sundquist (2008) conducted qualitative focus groups with women from Chile, Iraq and Turkey who had migrated to Sweden. This study explored these women’s ideas for enabling exercise, which the women saw as being more structured and demanding than physical activity that was done in everyday tasks. They expressed a desire for group activities with other women, activities that were arranged at a convenient time and place with an instructor, and were considered gender-appropriate and pleasant. However, the women found it difficult to participate without prior experience with exercise and some hesitated in their participation due to lack of financial subsidy.

Frisby (2011) called for the use of a social ecological approach to understanding a lack of physical activity participation and demonstrated that broader approaches must be taken in
order to enable participation of immigrant women. For instance, she found that citizen engagement promoted communication and mutual learning between immigrant women and program and policy developers. This was important to better understand particular circumstances that immigrant women faced (Frisby, 2011), and to disrupt assumptions of physical activity providers that immigrant women are simply not interested in participating in physical activity (Dossa, 2004; Taylor & Toohey, 1999). Lee, Frisby and Ponic (2014) found that whether or not immigrant women were able to participate in physical activity varied greatly based on numerous circumstances, including the availability of a stable income and employment opportunities, social support, English language facility, comfort level in mixed-gender situations, sense of belonging in the community, and gendered norms including childcare responsibilities and whether children’s participation was prioritized. Regardless of whether they were able to participate or not, it was clear that many of these women actively sought community physical activity in order to develop social networks and intercultural connections, as well as address mental health concerns such as minimizing stress and anxiety (ibid).

Physical activity participation has been linked to improved mental health. In a review of empirical evidence, Caldwell (2005) found that active leisure promoted physical, social, emotional and cognitive health by providing people opportunities for prevention, coping, and transcendence. Prevention referred primarily to the potential stress relieving qualities of leisure participation, such as decreased anxiety and depression, and the possibility for social inclusion, self-confidence and self-expression. Caldwell highlighted Iwasaki and Mannell’s (2000) typology of leisure-based coping strategies, including palliative (participating in an activity for temporary diversion from stress), mood enhancement (participating in an activity for emotional
levity), and leisure companionship (participating in an activity for social support or connection). Caldwell (2005) furthermore identified that leisure is a means to help individuals “transcend negative life events” (p. 15) by providing new meaning to one’s life or an avenue of hope or future vision. However, it was clear that the author drew on literature that emphasized enabling individuals to “self-determine their interests and learn how to pursue them” (p. 21), and downplayed social and structural conditions that constrained one’s ability to access these benefits. Keleher and Armstrong (2005) concluded that community-based physical activity interventions can be effective for promoting mental health when they include an aspect of social interaction.

Promoting inclusion of immigrant women in community-based physical activity

This section turns to studies that consider practices to promote inclusion of immigrant women in community-based physical activity. It combines recommended actions from the health and physical activity related literature, primarily because there was a great deal of overlap between the two. Simich, Beiser, Stewart and Mwakarimba (2005) called for ways of working that “promote a positive shift in public discourse, from a tendency to categorize newcomers to Canada as needy service recipients to an emphasis on newcomers’ contributions, resilience and well being” (p. 265). Likewise, Huang, Frisby and Thibault (2012) shed light on Canada’s gendered, racialized, and classed structures that contribute to the exclusion of Chinese immigrant women from physical activity opportunities. They argued that service providers must seek more direct consultation with Chinese immigrant women to better understand their social, political, and cultural histories, as well as their post-migration challenges, rather than relying on essentialized characterizations to inform policy and service delivery. In addition, they suggested that interculturalism, or learning from the cultural
practices of others, may be a way to move beyond the White, Eurocentric privilege that underpins Canadian social policy. Particularly, they highlighted the difference between what Sandercock (2004) called shallow versus rich multiculturalism, where the former is a superficial celebration of diversity, and the latter includes “political and policy support and encourages meaningful adjustment, intercultural exchange, and collaboration” (Huang et al., 2012, p. 143).

Anderson et al. (2010) suggested that one way to promote health and prevent the exacerbation of health issues is to fund English as a Second Language courses “to a level that enables fluency in English so that people can be competitive in the labour market” (p. 110). A lack of information about available services and opportunities to participate hindered engagement, particularly as participants in Lai and Hynie’s (2010) study noted that they mostly received information via word of mouth from other newcomers whose own knowledge about the community was often limited. They were reluctant to blame discrimination by community service providers, but noted that service providers lacked awareness and understanding of immigrants situations, which further deterred participation (ibid). Furthermore, some newcomers do not have the benefit of taken-for-granted knowledge that local people have access to. Sandercock (2003, p.78) explained local knowledge as “knowledge that comes from living, from simply being, as well as from doing.” It can be garnered by individuals “in their specific contexts, shaped by gender, ethnicities, histories and local ‘embeddedness’” (Smith, 2010, p. 214). Knowing where to go and who to speak with in order to gather information can be a challenge for newcomers who are not familiar with local practices, social structure and institutions. Immigrants in Simich et al.’s (2005) study suggested that coordination among public sector institutions, including schools, health centres, libraries, and community centres to
share information would help address the information gap experienced by many. They also suggested that follow up mechanisms after information is distributed could help ensure access to social and health services (Simich et al., 2005).

In support of other research, commodified physical activities were not options for many of the study participants due to the challenges these women faced in economic integration in Canada (Suto, 2009, 2013). However, simply providing a financial subsidy has been shown to do little in the way of promoting inclusion because it does not account for the myriad of other challenges faced (Reid, Frisby & Ponic, 2002).

Social support is also known as a key determinant of health, and although it is often seen as an individual-level problem, it is possible for institutions to create conditions that facilitate social interaction and support (Lee et al., 2014). Furthermore, an important aspect of inclusion is the degree of choice available to community members in their level of engagement, ranging from straightforward participation in recreational programs, to involvement in planning and decision-making (Ponic & Frisby, 2010). As well, Keleher and Armstrong (2005) noted that solitary physical activity does not improve depression, and emotional benefits of physical activity and active leisure are more possible when environments ensure social interaction. Scraton and Watson (1998) similarly noted that it is not enough to consider difference as merely “plurality or diversity,” but rather as “sites of power relations where mechanisms of exclusion are continually being reproduced and reinforced” (p. 135). Building on the notion of interculturalism and the need for both newcomers and long-time residents to communicate, learn and adapt, opportunities for such a dialogical process can be facilitated by service providers to begin building relationships and understanding, and shifting power imbalances. As Scraton and Watson (1998) stated: “Leisure spaces and places can be both sites
for the production and reproduction of structural relations and where counter and contradictory discourses are developed. They can be sites for inclusion and exclusion” (p. 135). Although South Asian women in their Leeds-based study were accommodated with an aerobics class specifically offered for them, they still felt racially and ethnically alienated when participating in the leisure facility because there was a lack of understanding by the broader group of patrons.

MacDonnell and colleagues (2012) recommended that health promotion strategies for immigrant women should:

(1) build on knowledges, processes, and resources that immigrant women have created,

(2) take account of the ways that knowledge about the mental health promotion of diverse populations is created, and

(3) encompass comprehensive strategies such as creating supportive environments and enhancing participatory processes for policy changes that are needed to foster the mental health and well-being of diverse groups of immigrant women (p. 9).

In the next chapter, the methodology used in this study is discussed.
Chapter 3: Methodology

In this chapter, I first provide an overview of the community where this study took place. I then discuss participant recruitment and data collection methods. Subsequently, I discuss ethical considerations, as well as my process of analyzing the data, including my experiences learning about intersectional data analysis. I also discuss reflexivity and methodological challenges encountered in this study.

Research site

My project was part of a larger research study (Frisby, PI) funded by the Social Sciences and Humanities Research Council. The study took place in one community in the Metro Vancouver Area in British Columbia with a total population of 132,608 residents in 2011 (Statistics Canada, 2012a, 2012b), including the urban downtown core that is surrounded by a suburban district. Unfortunately, with changes to the 2011 Census data collection methods, more detailed community profile information was unavailable.¹

According to the National Household Survey (NHS), approximately 6% of the total population of the study community is considered to be recent immigrants, with 3760 (51%)...
being women (Statistics Canada, 2014a). Statistics Canada uses the term ‘recent immigrant’ to identify individuals who immigrated to Canada within the five years prior to data collection (Chui, 2011). NHS data also showed that 61% of recent immigrant residents in the study community held post-secondary credentials, but recent immigrants reported median income from employment, wages and salaries as being less than $24,000, meaning that half made an income of less than this amount. This was approximately two-thirds of the median income reported by their Canadian-born counterparts that same year (approximately $37,000) (Statistics Canada, 2014b). According to the 2011 Census, the top non-English or -French languages spoken at home in this community included Persian, German, Korean, Spanish, and Tagalog (Statistics Canada, 2012a, 2012b). However, as the study began before 2011 Census data was available, 2006 Census data indicated that the top non-English or -French languages spoken at home in the study community included Korean, Persian, and Mandarin (BC Stats, 2010).

The local recreation department in the study community operated eleven recreation centres, four public swimming pools, and three public ice arenas. The department also oversaw numerous outdoor sport fields, tennis courts, and public parks. The community was also within close proximity to two provincial parks with a vast hiking trail network and several skiing facilities.

At the time the study was conducted, basic Leisure Guides were available online and in facilities to explain how to register for recreation programs and how to apply for financial assistance. The Leisure Guides had been translated into eight different languages, including Farsi, Chinese (simplified and traditional characters), Japanese, Tagalog, French, Spanish and
Russian. The department’s website also featured several introductory videos about community recreation filmed in English, Farsi, Korean, Mandarin, and Tagalog.

**Participant recruitment**

A purposive sampling method was utilized because in order to collect data that would be relevant to the research questions, interviewees needed to meet specific inclusion criteria (Bryman, 2004). The inclusion criteria included women: i) who were between the ages of 18 and 64, ii) who had moved to Canada within the last 5 years and resided in the study community, iii) who had immigrated under the skilled worker category, either as primary applicants and spousal applicants, and iv) who could speak English, Farsi, Korean or Mandarin. The age range was selected to ensure study participants were women of typical working age, and skilled worker immigrants were selected because few studies have focused on this group. Focusing on recent immigrant women allowed me to focus on the process of migration more readily than if they had lived in Canada for longer periods of time. The language criteria reflected the languages spoken by research assistants who were supported by the SSHRC research grant.

Participant recruitment was conducted in multiple ways. First, local recreation department staff facilitated recruitment by posting multi-lingual posters in various community recreation centres, and the Leisure Access coordinator distributed multi-lingual information leaflets to patrons who identified themselves as recent immigrants. Posters advertising the research project were also posted at the local immigrant service agency, and throughout libraries, faith organizations, and local ethnic food markets located in the city core area. As well, I visited community programs (e.g., library, community school, non-profit housing complex, and women’s walking groups) to distribute information leaflets.
Thirty participants contacted the research team via the phone number or email address provided on the poster or information leaflet. Eighteen of them met my study criteria, and the remainder participated in the larger study. Participants had the option to be interviewed in their language of their choice, which included Farsi (9), English (8), and Korean (1). Interviews in Mandarin were also offered, though all Mandarin-speaking participants (4) chose to be interviewed in English. The eight women who chose to be interviewed in English spoke a variety of languages as their mother tongues, including Mandarin (4), Czechoslovakian (1), French (1), German (1), and Malayalam, an Indian dialect (1). This diversity was intentional to avoid conflating experiences and views of individuals with a specific ethnic group (Meadows et al., 2001) and to more adequately reflect the diversity among recent immigrant women living in this particular community. As Reimer Kirkham and Anderson (2002) explained, “the easy classification of people into cultural and ethnic groups itself is evidence of a racialized application of culture, based on the assumption that discrete groups exist and can be used for explanatory purposes” (p. 5). Furthermore, MacDonnell et al. (2012) argued that a diverse sample of immigrant women can generate understanding of common processes and experiences across ethnoracial groups.

Data collection

Qualitative research methods that were influenced by critical and postcolonial feminist traditions were used to better understand the perspectives of recent immigrant women about the influences on their health and physical activity participation, and how “individual experience [links] with the social forces that structure that experience” (Meadows et al., 2001; Reimer-Kirkham & Anderson, 2010, p. 199). The data collection methods included semi-structured qualitative interviews and a background survey.
Semi-structured qualitative interviews

Qualitative interviews were chosen because of the ability to gather data directly from recent immigrant women about how the migration process, gender and socioeconomic status affected their own health and physical activity participation. As Kelly (2010) explained, “qualitative interviews are used when the researcher wishes to gain an understanding of how participants view, experience, or conceptualize an aspect of social life” (p. 309). In a 2001 study by Meadows and colleagues, immigrant women generally discussed health in terms of physical ailments, and aspects of mental health were only revealed through discussion of their broader social context after migration. In light of this insight, interview questions were designed to query women about SDH and physical activity in two ways. First, some questions asked directly about their health status and physical activity before and after migration, and if women felt either had changed after migration. They were also asked directly whether they felt changes in either health or physical activity (if any) were due to pressures related to migration. This garnered discussions that shed light on how these women felt migration overlapped with the SDH of socioeconomic status and gender. Second, indirect questioning as suggested by Meadows et al. (2001) asked about family, work, and living conditions before and after migration. This also provided an avenue for the women to discuss what was important to them about their migration experiences and to frame health and physical activity in those terms (see Appendix I for the interview guide).

Following informed consent from participants, all interviews were audio recorded with a digital MP3 recorder. Interviews were conducted over the course of sixteen months from August 2011 through to November 2012 and lasted on average one hour. Interviewees were reassured that they could share as much or as little about their experiences as they would like.
during the interview. English interviews were conducted and transcribed by the author. Farsi and Korean language interviews were conducted, transcribed and translated by bilingual research assistants working on the larger grant.

The interview questions were provided to participants prior to and during interviews to promote transparency in the interview process. In this way, participants had an opportunity to better understand what they would be asked to discuss. I believe this was particularly helpful in some of the interviews I conducted in English, which is my primary language, but was not the primary language for most of the women being interviewed. Semi-structured interviews are characterized by flexibility in discussion topics and responsiveness by the interviewer to adjust the conversation based on the interviewee’s direction as well as the research questions (Bryman, 2004). In contrast, structured interviews are meant to be conducted in a standardized manner in terms of wording, order, as well as responses, given that most structured interviews provide a fixed range of responses to questions (Kelly, 2010). However, providing interview questions ahead of time could have led to more of a structured interviewing situation in some cases, as some women referred often to the discussion guide to gauge progress in the interview.

On the whole, the interviews did follow a general pattern of the researcher asking a question and the participant providing a response, but the conversations were far from rigid in format and the focus remained on exploring the women’s points of view. Women were reassured that we were not looking for any type of ‘right response’ and were encouraged to freely discuss thoughts and perspectives that were prompted by the interview questions.

In reviewing the translated transcripts from the interviews conducted by the other research assistants, it was apparent that a similar freedom was also encouraged, though all researchers also probed based on the interview guide. For example, on the interview guide, a
probe to the question, “Have any pressures during immigration affected i) your health, and ii) participation in physical activity?” involved asking this follow-up question: “Do you think any changes in your health since coming to Canada are related to changes in physical activity? How so?” In other cases, probes occurred conversationally as part of the partner interaction between interviewer and respondent as the researcher was seeking to clarify and gain understanding (Kelly, 2010).

**Background survey**

Participants also completed a background survey after the interview that provided background socio-demographic data (see Appendix II). The background survey collected information including the women’s age, primary language, educational attainment, reasons for migrating to Canada, current employment and income situation, living situation, and existing health conditions.

Much of the information collected on the background survey was discussed in more depth during the interviews, but it aided data collection by enabling me to collect information of a more sensitive or specific nature, such as personal and household income (socioeconomic status), marital and family status (gender), and whether women migrated as primary or spousal applicants, and why they chose to migrate (migration). During the interviews income was discussed in very general terms and specific income amounts were not asked for or mentioned, but the background survey provided four ranges in income levels that women could select, providing additional detail that would not have arisen conversationally. The background survey was also helpful in collecting information consistently. It is possible that if only interviews were conducted, some background information may be missed or discussed with little specificity due to the semi-structured and conversational nature of the interviews.
Ethical considerations

Ethical approval was received from the University of British Columbia’s Behavioural Research Ethics Board for the larger research study entitled, “Learning from the local: Examining a sport and physical activity inclusion initiative for immigrant women” of which I was a student investigator. Prior to interviews, an information meeting was conducted by the researcher in English, or by a research assistant who could speak Farsi, Mandarin, or Korean, either in person or over the telephone with interested study participants. During the information meeting, an overview of the research project was provided and questions about the research process were discussed. The researchers clearly identified themselves as graduate students and research assistants with the University of British Columbia who were not affiliated with the local recreation department.

Women were reassured that their participation in the study would be kept confidential and would not jeopardize their participation in programs and services at the recreation centres where some of the interviews took place. They were also encouraged to share as much or as little information as they felt comfortable discussing during the interview and providing on the background survey. They were informed that all information would be kept anonymous as the interview transcripts would be assigned a participant code, and the background survey included a space for them to provide a pseudonym that would be used instead of their real names. To further ensure anonymity of participants, the data collected on the background survey is presented in this thesis in separate aggregated tables, rather than as one large table that is sorted by the women’s pseudonyms. This is because it would still be possible for some women to be identified based on a combination of identifiers such as place of origin, occupation, educational background, marital status, number of children, or years living in Canada.
The recruitment materials, information letter, consent form, background survey, and interview guide were available in English, Farsi, Korean, and simplified and classic Chinese. This was to ensure women had the opportunity to read about the ethical protocols in their language of choice, and keep a copy for their own records. The signed consent form was collected prior to conducting the interviews.

A $25 gift card for recreation services or groceries was given at the end of each interview as a token of thanks to participants for their time. As well, women were reassured that should they wish to end the interview or not answer specific questions, they could do so at any time without forfeiting the gift card.

Data analysis

Data analysis occurred through multiple methods and numerous iterations. Digital copies of transcripts were uploaded onto ATLAS.ti, a qualitative data analysis software package, and quotations were electronically coded through multiple readings. First, a code book was developed based on themes from the research questions and literature review (e.g. migration, socioeconomic status, gender, health, physical activity). Also known as structural coding, this type of coding was used to identify data that directly related to a specific research question and was useful in organizing data from multiple participants and a semi-structured data gathering format for further analysis (Saldana, 2009). Second, open codes were identified through multiple readings of the transcripts that reflected the women’s experiences (e.g., family separation, mental health, social isolation, intercultural encounters). Also known as initial coding, this process involved inductively coding the transcripts with the goal of generating numerous codes that could later be grouped to form categories that were not identified through structural coding (Saldana, 2009). Analytic memos were written to denote
how codes were defined, and to note connections with literature and other codes. I also 
conducted some content analysis in the form of counting types of responses for ease of 
reporting certain findings. For example, in a separate spreadsheet I created tables that 
documented how many women defined health as: 1) balanced/holistic, 2) lifestyle/avoidance of 
chronic disease, and 3) did not answer.

I found that the data analysis process was much messier and challenging than I initially 
expected, and it involved a great deal of learning about how to apply theoretical concepts 
related to an intersectional analysis. I found coding to be helpful with the identification and 
grouping of similar discussion themes. However, I found the resulting codes to be more 
descriptive than analytical, and the linear aspect of laying out themes in a code book did not 
effectively allow me to visualize the intersecting issues and overlapping complexities discussed 
by many of the women. I first attempted to remedy this by entering preliminary codes into a 
visual data map using the presentation software called Prezi. The visual data map assisted in 
conceptualizing the interconnected nature of experiences and SDH discussed by study 
participants, but still ultimately only resulted in a descriptive diagram. Saldana (2009) 
described the need in data analysis to develop “a strategy for progressing from topic to 
concept, from the real to the abstract, and from the particular to general” (p. 187). I found that 
once I began processing the data through writing I was able to move to more conceptual 
analysis. For example, in discussing the differing employment situations of the women I was 
able to explore the interrelated processes that helped or hindered their situations, and how their 
employment status affected their mental health or desire to engage in physical activity.

However, a particular challenge for me was learning how to write in a way that 
reflected consideration of both individual situations and how the intersecting SDH of
migration, gender and socioeconomic status patterned women’s health and physical activity without getting mired in individual detail. In my early drafts it was very difficult for me to know how to balance individual stories with broader patterns in the research because each woman’s situation was different and I was perhaps overly cautious of not conflating each account into a generalization about ‘immigrant women’. I found it helpful to review how other researchers had presented their findings in ways that demonstrated intersectional analysis, and in particular, I found inspiration in Dossa’s (2004) and Lee and Sum’s (2011) writings.

Data analysis took a great deal of time for me, and did not happen in one discrete step, but rather, as others have found (Cuadraz & Uttal, 1998), it was an iterative process that involved a combination of coding transcripts, identifying themes, reviewing related literature, writing, grouping and regrouping themes and subthemes, and returning not just to the quotations that had been coded, but also re-reading the transcripts in large sections, if not their entirety, to ensure I was not taking quotations out of context. I also kept my research questions in mind as it was not possible to write about everything that the women were talking about. Much like Mauthner and Doucet (2003), returning to the transcripts was a step in considering how I was making sense of and theorizing these women’s accounts, and paying attention to the conditions and constraints under which their accounts were produced. For example, as I re-read quotations in the context of the transcripts, I paid attention to the line of discussion that led to a given quotation, including my role in the discussion, and assessing whether my interpretation of its meaning was relevant to the broader discussion. That is, I checked that I had not taken a quotation out of context and presented it in a way that did not reflect the woman’s meaning, as I understood it to be. This cycle happened numerous times, and not always in the order specified above.
Further considerations that I kept at the forefront throughout my data analysis and writing process were words of caution from Mohanty (2003). She warned writers to be careful not to unwittingly represent women, especially racialized women, as powerless victims. This often happens when women are written about “in terms of their object status (the way in which they are affected or not affected by certain institutions and systems)” (p. 54). Furthermore, Mohanty cautioned not to assume that all women of a particular culture or category have a coherent group identity, nor to position the category of ‘woman’ to be already marked by powerlessness or disadvantage as these practices taint one’s analysis with binary conceptions at the outset. In addition, while I acknowledge that race and ethnicity are crucial SDH for immigrant women, I had chosen to focus and limit my study to an intersectional analysis of migration, gender and socioeconomic status for the reasons discussed earlier. When women touched on other SDH, this helped me develop recommendations for future research that appear in Chapter 5. Thus I endeavoured to demonstrate the complexity of each woman’s situation while keeping the focus of my study in mind, and to do my best not to perpetuate these practices in my representations of the women through my writing of their situations.

**Reflexivity and positioning myself in the research**

Reflexivity refers to the critical self-examination of a researcher’s own knowledge claims and imbalances of power inherent in the research context (Frisby, 2013), and I sought to do this by taking field notes about my researcher role as the study unfolded. In terms of my own positionality, I recognized my privilege as an educated, partnered, professional, heterosexual, able-bodied, middle-class, Canadian-born woman of Chinese heritage. I also do not have an accent that marks me as different or ‘less than’ (Creese & Kambere, 2003), because I am a native speaker of English and can communicate in the dominant language. I
have not resettled into a new country nor had to restart a career and life in a different language where my education and experience may be questioned. I also currently do not have children and have not faced gendered expectations that many women do of prioritizing family over my own personal goals. I feel that I am very privileged in many ways because my Canadian credentials and work experience are valued, and Canadian social norms are not foreign to me.

On the other hand, I also live as a racialized woman in a society that is deeply rooted in colonial-Anglo-Christian traditions. I have experienced discrimination and racism, both overtly and passively. As my parents were immigrants to Canada, I have also had to negotiate what it meant to me to be a Canadian female while trying to meet the expectations of my parents regarding maintaining some linguistic and cultural connection to my Chinese heritage. Growing up it was very clear to me that I was different from my white Canadian-born friends, but also not the same as other Chinese people who were born in Hong Kong or Taiwan. This concept of ‘living in between’ is known as liminality (Lee & Sum, 2005). Growing up with immigrant family members has sensitized me to the difficulties that many immigrants face during their process of settling in Canada. For my mother, I saw that learning a new language has been a long-term challenge for her, and though she has lived in Canada exclusively since 1974 and has worked in English-speaking environments, she still is not comfortable communicating in English. As Richardson wrote, “No textual staging is ever innocent…” (1998, p. 350), and I do acknowledge that my interest in the topic of migrant women’s experiences and my perspectives on the data have been informed in part by my own positionality.

For the most part, the interviews I conducted were very friendly and I felt I had the ability to build rapport with the women very quickly. In one case, however, I thought the
interview participant was distant. This was one of the last interviews and I felt this to be a very different interview scenario compared to others. While the participant was not unfriendly, I thought I needed to do something to reach a more personal level in our interactions. Quite early on in the interview, I had shared something about myself that I believed was often seen as a social norm in Chinese households. While less common in Western households, in Chinese families grandparents often live as part of the family unit in the household of one of their children. When this more reserved participant, Tracy (from China), mentioned that her mother currently resided in her home, I seized the opportunity to demonstrate some similarity and shared that my grandmother also lived with my family while I was growing up. In hindsight after reviewing the transcript, I do not believe this made a difference in how she interacted with me, as she had actually been quite forthcoming already in discussing her divorce and the need to rebuild her relationship with her son after moving to Canada. However, later in the interview I again felt the need to build rapport by discussing the benefit of recreation facility staff who could speak a language other than English, while mentioning that I understood Cantonese and some Mandarin. As I reviewed these interactions, it seemed that with Tracy I felt the need to perform impression management to win her approval via demonstrating my ‘Chinese-ness’ (Hurd Clarke, 2003). In other interviews this was not necessary because many of the women actively asked questions about my ethnicity, my family, my ability to speak another language, my thoughts on being a second-generation immigrant, as well as other topics that were more related to our similar ages and life-stage, such as whether I had children or were planning to have children, and my experiences with home ownership in the region.

While with Tracy I apparently felt I needed to ‘prove’ my ethnicity, some women referred to a similarity they noted between them and me, and used ‘we’ or ‘our’ as they
discussed items pertaining to being Chinese. For example, Fia (from Indonesia) had mentioned how “we are the minority there [in Indonesia].” I had to ask for clarification about what she meant when she said “we”, to which she responded, “Like the Chinese. We, the Chinese, are minority there.” Fia went on to explain that she thought there is resentment among native Indonesian people because the business class is predominantly comprised of Chinese people, and there is a significant gap between the minority Chinese business class and the majority of native Indonesian people. In this case, I questioned whether my ethnicity played a role in Fia disclosing her feelings that society in Indonesia was corrupt and that one of the reasons she left was that wealthy Chinese families were often targets for extortion schemes. She mentioned that she sought to migrate in part for reasons of personal safety, though this was due to the fact that she was part of the wealthy elite. It made me wonder if she thought I would be more understanding because of our shared Chinese background, though I found it curious that she seemed to equate being Chinese with being privileged. I thought about this interaction a great deal as I analyzed the data and wrote about the findings because I was concerned about how I was presenting women who I thought were more privileged than others in my writing. In both of the examples discussed above, I was reminded of De Andrade’s (2000) point that ethnic and racial identity is constantly being defined and redefined through research interactions between researchers and participants. This is also certainly applicable to how aspects of gender, socioeconomic status, and migrant identity can be defined and redefined through the research interaction, as well as how I as the researcher have interpreted and represented them. While I have made my best attempt to heed Mohanty’s (2003) words and be conscientious of presenting the complexity in these women’s accounts, I recognize that multiple dimensions of one’s identity become salient (or remain invisible or misinterpreted) to each individual at different times throughout the research process.
Methodological challenges and limitations

In this research project, conducting interviews with multiple interviewers in multiple languages was a double-edged sword. On the one hand, there is a dearth of research conducted with immigrants in their primary languages, thereby limiting the extent to which they can participate in knowledge production. For example, Creese, Huang, Frisby, and Kambere (2011) explained that the ability of Chinese immigrant women to speak in their mother tongues enhanced their ability to discuss their issues and concerns as research participants, especially when researchers had also migrated to Canada. In addition to being able to communicate more smoothly and directly with interviewers, participants may have felt less isolated because they assumed the researchers understood their situations better (ibid).

In my study, it was valuable to have access to the translated transcripts of interviews conducted in Farsi and Korean by other graduate students who were research assistants on the larger grant. Particularly in the Farsi language interviews, the women expressed very critical opinions of the Canadian government and openly discussed the many challenges they had experienced with community institutions, such as with English language schools and the local recreation department. In comparison, the interviews I had conducted in English the women rarely shared critical observations about any of the institutions here in Canada. While the concept of matching researchers with participants is problematic because it assumes similarities in values, beliefs and experiences based on racial and ethnic characteristics (Wray & Bartholomew, 2010), there can be an increased level of comfort, rapport and an ease of communicating complex ideas between individuals who share a common primary language and some similar understandings of pre-migration situations. Whether the research participants who elected to conduct their interviews in English did not experience challenges to the same degree
as women who chose to be interviewed in another language, or if they felt they could not openly criticize Canadian institutions is not known.

On the other hand, it was challenging to me as a new researcher to rely on the translated transcripts without the ability to understand the audio recordings or read the untranslated transcripts, so I could ensure as much accuracy in meaning as possible. I did review the translated transcripts, and subsequently met with the research assistants to discuss anything that was unclear to me. However, I am aware that I was working with documents that had not only been translated, but also meanings had already been interpreted for me when there was no literal translation in English or when I did not share the same social and historical reference points. As McWilliam, Dooley, McArdle and Tan (2009) wrote upon reflection of in-depth interviews conducted with an interpreter: “We wondered – but will never know – how much was filtered through the translation” (p. 71). Furthermore, when one is farther removed from the research context, it takes more time to become familiar with the content of the interviews, and the recall of details was more difficult. To partially remedy this, I spent much more time reading and re-reading the translated transcripts, both before and after coding, than was needed for the transcripts of the interviews I had personally conducted.

Debriefing meetings with the two research assistants who conducted interviews in Farsi and Korean were held after I reviewed the translated transcripts. Similar practices were noted in the literature in order to seek linguistic and cultural input from interpreters, and to gain their perspective of the research interaction (McWilliam et al., 2009). Since I had relatively little understanding and no personal experience with the social, political, or historical situations in those countries, my colleagues’ insights were valuable in providing context for parts of the discussions. However, working with translated transcripts sometimes felt like I was a third
party listening in on a conversation. I was not able to interact with the woman speaking, and could not seek clarification from her about any questions I had, and clarification provided by my colleagues were most often a ‘best guess’ at the woman’s meaning. One limitation of this process is that if another researcher who is fluent in, for example, Farsi was analyzing the Farsi-language transcripts, she may find other compelling themes that I had overlooked due to my lack of understanding of the language or socio-historical context.

As well, misunderstandings across languages in the interviews I had conducted happened with some of the women whose primary language was not English. Below is an excerpt of an interview I had conducted with a woman whose primary language was Mandarin. She had difficulty fully expressing her meaning in English, and at the time I had difficulty understanding her key point that was quite obvious in the clarifying questions I was asking.

Donna: Yeah… and so, yeah and I guess you talked about this, so how is your health now? And has anything changed about your health since you immigrated?

Jenny: I’m still healthy, uh… ‘cause I’m always thinking in positive way, and I’m also doing a little bit, tiny bit, exercise. But compared to the before, I’m reduced.

Donna: And so when you say compared to before, you’re reduced, did you do a lot of exercise before?

Jenny: No.

Donna: No?

Jenny: Not much as here.

Donna: Not as much as here?

Jenny: Yeah. ‘Cause before in our country I just, you know, work. I didn’t realize I have… I have trouble.
Donna: You had trouble?

Jenny: I didn’t realize I have trouble. I don’t have trouble ‘cause I didn’t realize, I didn’t think I have trouble.

Donna: Okay…

Jenny: So that means I think I don’t have trouble, right?

Donna: Okay, yes… you don’t think you have trouble… in China?

Jenny: Yeah, ‘cause everything just go-go-go-go-go! It’s all fine! And then here, I found I need more energy but I cannot have it.

Donna: So that’s you’re trouble?

Jenny: I don’t know… it’s because of age or because of…? …I don’t know.

Through further discussion I realized that when she referred to “trouble” she had meant problems with her health. When she was in China she seemed to have no trouble with her health because she was working and busy, and felt no lack of energy. Jenny mentioned that since migrating she needed more energy, and this precipitated the discussion of how she must expend a great deal of energy in Canada due to the need for constant mental focus to complete tasks done in English. In China, she had rarely participated in physical activity and felt fine, yet after migration she felt she needed physical activity in order to restore the energy she lost through daily interactions. This interview with Jenny was my longest interview at 1 hour and 45 minutes. The length was due in part to her willingness to discuss her responses in depth, but also it was due to exchanges similar to the above where we were trying to clear up misunderstandings in communication. As Richardson (1998) explained:

Language is not the result of one’s individuality; rather, language constructs the individual’s subjectivity in ways that are historically and locally specific. What
something means to individuals is dependent on the discourses available to them (p. 349).

When a research participant does not have the ability to communicate in her first language, the discourses available to her are much more limited.

In spite of these challenges, I do not suggest that cross-linguistic research should be avoided, for I believe the findings in this study are compelling and contribute to filling a gap in the literature about the importance of the SDH, health and physical activity opportunities for recent migrants, especially those who are not fluent in English as they are often excluded from research.
Chapter 4: Findings and Discussion

In the findings and discussion, I will present how women in this study negotiated migration through their new positionality as newcomers, and how the changes that occurred in gender roles and socio-economic status influenced their relationships with others, their material conditions, their health, and their physical activity participation. To better understand the process of being differentiated as an immigrant, I drew on Brah’s (1996) writing about difference as a social relation that “refers to the ways in which difference is constituted and organized into systematic relations through economic, cultural and political discourses and institutional practices” (p. 117, emphasis in original). In other words, these systematic relations serve to organize and differentiate people into groups based on dominant discourses and representations that have been repeated over time. The ways that the women were differentiated through class, gender, and migration operated at the macro and micro levels. At the micro level interpersonal relations within institutions such as the household, workplace, and public recreation centres reinforced differences in how people interacted with one another. Interpersonal relations are influenced by macro level systems including historical and popular discourses about immigrants, and gendered norms that persist over time. According to Dhamoon (2011), an intersectional analysis does not necessarily mean examining the intersection of different identities or categories, but rather involves examining how processes of differentiation bring issues of power into focus.

The following sections will present findings and discussion in response to my two research questions. I first present the background of study participants, including information about the women’s lives, health and physical activity participation. Next, I consider different aspects of health as discussed by these women and how it was influenced by the SDH of
migration, socioeconomic status, and gender. Finally, I address how the women saw community physical activity playing a role in their lives after migration. Interwoven in the discussion are factors that either facilitated or challenged their participation.

**Background on participants**

I begin by providing background on the women who took part in this study and include interview quotations to illustrate, in these women’s own words, their reasons for migration, their perspectives on their own health, and their past physical activity experiences. This set the stage for better understanding the women’s situations after moving to Canada.

**Participant backgrounds**

The data in Table 1 illustrates that half of the women were between 30-39 years of age and the other half were 40-49. Nine originated from Iran, three from China, and one each from the Czech Republic, France, Germany, India, Indonesia, and South Korea. They had been living in Canada from two months up to five years. Eleven entered the country as primary applicants and seven were spousal applicants. The names provided in the table reflect how each woman chose to be identified in the study, except for three cases where only initials were provided. In these cases, pseudonyms were provided by the author.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age (years)</th>
<th>Place of Origin</th>
<th>Time living in Canada</th>
<th>Skilled Worker Primary/Spousal Applicant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anisa</td>
<td>40 - 49</td>
<td>Iran</td>
<td>2 years</td>
<td>Spousal</td>
</tr>
<tr>
<td>Esther</td>
<td>40 - 49</td>
<td>South Korea</td>
<td>2 years</td>
<td>Spousal</td>
</tr>
<tr>
<td>Farzaneh</td>
<td>40 - 49</td>
<td>Iran</td>
<td>6 months</td>
<td>Primary</td>
</tr>
<tr>
<td>Fia</td>
<td>30 - 39</td>
<td>Indonesia</td>
<td>2 months</td>
<td>Primary</td>
</tr>
<tr>
<td>Jacqueline</td>
<td>n/a</td>
<td>France</td>
<td>10 months</td>
<td>Primary</td>
</tr>
<tr>
<td>Jennifer</td>
<td>40 - 49</td>
<td>China</td>
<td>2 years</td>
<td>Primary</td>
</tr>
<tr>
<td>Jenny</td>
<td>30 - 39</td>
<td>China</td>
<td>2 years</td>
<td>Primary</td>
</tr>
<tr>
<td>Maha</td>
<td>40 - 49</td>
<td>Iran</td>
<td>5 years</td>
<td>Primary</td>
</tr>
<tr>
<td>Mali</td>
<td>30 - 39</td>
<td>Iran</td>
<td>5 years</td>
<td>Spousal</td>
</tr>
<tr>
<td>Mina</td>
<td>40 - 49</td>
<td>Iran</td>
<td>3 years</td>
<td>Spousal</td>
</tr>
<tr>
<td>Monika</td>
<td>30 - 39</td>
<td>Czech Republic</td>
<td>3 years</td>
<td>Primary</td>
</tr>
<tr>
<td>Nadia</td>
<td>30 - 39</td>
<td>Iran</td>
<td>5 years</td>
<td>Spousal</td>
</tr>
<tr>
<td>Nazila</td>
<td>40 - 49</td>
<td>Iran</td>
<td>1 year</td>
<td>Spousal</td>
</tr>
<tr>
<td>Noushin</td>
<td>30 - 39</td>
<td>Iran</td>
<td>3 months</td>
<td>Primary</td>
</tr>
<tr>
<td>Parvaneh</td>
<td>30 - 39</td>
<td>Iran (via France)</td>
<td>1 year</td>
<td>Primary</td>
</tr>
<tr>
<td>Radhika</td>
<td>30 - 39</td>
<td>India (via United Arab Emirates)</td>
<td>5 years</td>
<td>Spousal</td>
</tr>
<tr>
<td>Tanya</td>
<td>30 - 39</td>
<td>Germany</td>
<td>4 years</td>
<td>Primary</td>
</tr>
<tr>
<td>Tracy</td>
<td>40 - 49</td>
<td>China</td>
<td>5 years</td>
<td>Primary</td>
</tr>
</tbody>
</table>

Study participants were highly educated, as 17 out of 18 of the women held credentials beyond high school graduation, including seven women with graduate degrees, nine with bachelor degrees, and one with a college diploma (see Table 2). Prior to migrating, participants reported the following occupations: management positions in corporate or municipal finance and administration (5), academics and researchers (3), office administration or bookkeeping staff (3), marketing and communications (1), and professionals including educators (2), a physiotherapist (1), and a computer programmer (1). Two women were not employed prior to migration: one was a housewife but had trained as a dental hygienist; another had worked in research and development but was a student immediately before migration. As well, one of the
three women who had worked in office administration prior had training and experience in
social work.

Table 2: Education and previous employment

<table>
<thead>
<tr>
<th>Educational attainment</th>
<th>Pre-migration field of employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate degree (7)</td>
<td>Finance &amp; administration management (5)</td>
</tr>
<tr>
<td>Bachelor degree (9)</td>
<td>Academic/ Researcher (3)</td>
</tr>
<tr>
<td>College diploma (1)</td>
<td>Office administration/ bookkeeping (3)</td>
</tr>
<tr>
<td>High school (1)</td>
<td>Educator (2)</td>
</tr>
<tr>
<td></td>
<td>Marketing &amp; communications (1)</td>
</tr>
<tr>
<td></td>
<td>Physiotherapist (1)</td>
</tr>
<tr>
<td></td>
<td>Computer programmer (1)</td>
</tr>
<tr>
<td></td>
<td>Unemployed (housewife, student) (1)</td>
</tr>
</tbody>
</table>

Several women described the positions they had held previously as being relatively
high level where they played a leadership role in the organization and many of them spoke
favourably about their occupational status prior to migrating to Canada. For example, one
woman spoke of how she was just starting to “bloom out” in her career in academia, while
another woman noted that she was well known among her colleagues and recognized by
organizational leaders. Thus, in the pre-migration context many of the women felt that they had
led successful lives as they were highly educated and most had a career.

Reasons for migration

Moving to a new country generally meant a considered decision to trade personal
successes and relative stability for new possibilities. The main reasons women identified for
emigrating included a combination of push and pull factors such as: opportunities for their
children; economic and work opportunities; gaining new life experiences; a sense of safety for
self and family; and personal learning. Better social and political conditions were also cited
often including personal freedom, less materialistic definitions of success, more gender
equality and less corruption. Fifteen of the women identified better living conditions for their families as a key reason for migrating, but at the same time, most saw moving to Canada as a sacrifice that created a disjuncture in their professional and social lives, particularly for those who migrated with children. Migration was thought to be a way to provide a better life primarily for their children at the expense of their own careers and comforts, as the quotation below indicates.

Yeah, I… hard working. And single mom. And the reason I just decide to immigrate to Canada and the move to [main city], just like half a year after divorced I feel like life is kind of hard for me. At that time my son was ten years old, I think it’s good time to have the North American education system. So I give up lots of thing… like before in China, I work as like very high position in multi-national company, so… I have to give up some thing to have the life balance. So that’s the reason I came to Canada. (Tracy, from China)

While providing for family was the most common reason for migrating, many of the women also did so as a way to improve their own lives, not just those of their children and partners. Ten women (eight with children) specified that their decisions were also self-oriented, such as for career opportunities, new life experiences, and stretching one’s personal horizons. For some, migration was seen as an opportunity to leave social systems that were institutionally oppressive for women, or that prioritized work and a materialistic lifestyle over well-being. However, for some, moving to Canada did not necessarily mean exclusion was left behind, but it was experienced in a different manner. For example, Noushin felt she had hit a glass ceiling and that there was little job security in Iran, so she was attracted to Canada by the pull factors of personal freedom and greater gender equality. However, after moving to
Canada, these feelings were moderated by difficulties she encountered finding work and communicating in English, which are discussed in more depth later on in this chapter.

**Perspectives on health**

Table 3: Perspectives on health

<table>
<thead>
<tr>
<th>Definition of health</th>
<th># of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balanced/holistic perspective</td>
<td>12</td>
</tr>
<tr>
<td>Lifestyle/avoidance of chronic disease perspective</td>
<td>5</td>
</tr>
<tr>
<td>Did not answer</td>
<td>1</td>
</tr>
</tbody>
</table>

In order to better understand how women viewed health, each was asked to define what health meant to her. Consistent with the literature (Dean & Wilson, 2010; Elliott & Gillie, 1998; Meadows et al., 2001), a majority of women in this study ($n = 12$) defined health in a holistic way that incorporated both physical and mental aspects, and in some cases emotional, social, and spiritual aspects as well. Very few women discussed chronic conditions or illnesses, while most discussed mental health. Physical health was often described as being influenced by or dependent upon mental health. Mental health was often discussed as being comprised of interrelated aspects of emotional, social, psychological and spiritual well-being. Although the different components that comprised health differed slightly, all of the women with this holistic perspective discussed the importance of balance among the different components, as illustrated in the following quotation.

…physically and mentally peaceful, like without medication. You know, in a balance. You feel unhealthy with so many stuff… if you are stressful with everything you feel unhealthy, so healthy means everything in a balance. (Radhika, from India via the United Arab Emirates)
While physical aspects of health did feature into the definitions provided by each woman, for the majority caring for the body was only part of the puzzle. These women understood health in ways like those advanced by the World Health Organization (1948) that has defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (p. 100).

The twelve women who espoused a holistic view of health described positive mental health in terms of peace of mind, feeling optimistic, the ability to relax, sleeping, having social support, or feeling refreshed or happy. For some of these women \((n = 3)\), mental health also included a spiritual element. This was not always in relation to organized religion, but rather to their sense of morale and the ability to have a positive outlook on life, as indicated in the following quotation.

I think I prefer healthy mind than healthy body. If a person keeps herself from spiritual and mental perspective as a healthy one, surely her body could be so. But if conversely, and whatever body is strong, it would decompose under effects of soul and spirit. In my opinion, the important thing is having good morale and way of thought. With good morale and thought, many things could be made, but otherwise not. (Maha, from Iran)

Symptoms of poor mental health were described as anxiety, depression, tension, headaches, sleeplessness, and sweating. Stress and poor mental health often brought on feelings of worry, frustration, irritation, and unhappiness. Several women who experienced depression were forthcoming and openly discussed their situations as well as the need for medication. For women who define health holistically, maintaining overall health depended on feeling physically well, having good mental health, and for some, spiritual and emotional well-being.
Five women defined health specifically in terms of lifestyle factors, such as healthy diets, physical fitness, and getting enough sleep in order to stave off future chronic illness. In relation to diet, some women discussed the importance of eating organic or less processed foods, and cutting down their intake of sugar, soft drinks, and fried foods. Some of these women felt that the increased level of knowledge around healthy lifestyles was a positive aspect of life in Canada. For example, Tanya mentioned that in Germany there was not much public health education that was easily accessible to the average person, for example, information on how to manage diabetes. But after moving to Canada she found that the local media played a significant role in raising her awareness of health information. However, her discussion sometimes bordered on healthism (Petersen et al., 2010), as Tanya explained that she had completely cut sugar out of her diet, exercised six times a week, and felt healthier than before. “Yeah, [health information] it’s more pushed in Canada, I’d say, to get people’s attention so they actually can make a choice,” noted Tanya. Other women explained that it was much easier to live a healthy lifestyle after migration because physical activity and healthier food options were more accessible, there were more recreation facilities, less work pressure, and the local community provided a conducive social environment. For example, some participants mentioned that the active lifestyles they observed among local residents had influenced them to participate and become more physically active.

Although Jacqueline defined health in terms of diet and exercise, she emphasized the need for moderation and expressed a concern that lifestyle factors were prioritized too much in her new community.
We practice sport [in France] but it’s not the most important things of our life. Here, especially in [main city] …people are crazy about their bodies and too much sport!

(Jacqueline, from France)

Later in the interview, she continued:

You have this extreme, just eat pills, don’t care about the quality of the foods, and running… do-do-do-do-do-do-do-do, like a hamster. (Jacqueline, from France)

Radhika also provided an example from her husband’s workplace, which she noted had a culture of calorie counting at lunch. In the ‘new public health’ discourse, everyone is called upon to “play their part in advancing ‘the public’s’ health through attention to lifestyle, healthy eating, attention to exercise…” and establishing control over one’s own life to achieve freedom and well-being (Petersen et al., 2010, p. 394). Individuals are called upon to assist in the task of governance by acting responsibly, taking appropriate preventative action and exercising informed choice (ibid).

However, it is important to note that although these five women responded relatively narrowly when asked directly about how they defined health, it was often the case that through the interview other aspects of health surfaced reflecting a broader understanding of health. For example, when asked directly Farzaneh defined health as healthy food habits and regular exercise, but at other points in the interview she also explained that the stress caused by lack of employment and financial security after migration affected her health by causing insomnia, fatigue and feelings of depression. Thus, although women responded to a direct question in one manner, it is important to recognize that a single response may not reflect the entirety of how they conceived of a given concept.
Physical activity experience prior to migration

As outlined in the data presented in Table 4, prior to migration, physical activity was practiced regularly by 13 women, with ten of them reporting 2-5 days a week of regular physical activity, and three reporting that they were participating one day a week or “regularly.” Three women stated that they generally participated one or two times a month or “not regularly”. As well, two women noted that they did not participate in physical activity at all prior to migration.

Table 4: Pre-migration physical activity frequency

<table>
<thead>
<tr>
<th>Frequency of Physical Activity</th>
<th># of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-5 days a week</td>
<td>10</td>
</tr>
<tr>
<td>1 day a week</td>
<td>3</td>
</tr>
<tr>
<td>monthly or not regularly</td>
<td>3</td>
</tr>
<tr>
<td>none</td>
<td>2</td>
</tr>
</tbody>
</table>

Although study participants were asked to discuss their physical activity before and after migration, the purpose was not to obtain a precise measure of the intensity or duration of self-reported physical activity. Rather the purpose was to better understand the women’s pre-migration engagement in physical activity, to provide a general comparison in terms of how physical activity did or did not fit into their lives after migration. Common activities previously practiced by these women included: swimming (6), aerobics and group fitness (5), walking and hiking (5), yoga (4), using gym equipment (4), running (3), and team sports (3) such as badminton, soccer, and volleyball. Two women from Europe also enjoyed skiing. It should be acknowledged that participation was likely higher in my sample because those who were more predisposed to being physically active would have been more likely to respond to recruitment notices for this study.
Some of the women noted that they were very active as children and youth, and that being physically active was a habit from childhood. For example, Jacqueline (from France) had been involved in competitive athletics and basketball, as well as dance through her teenage years, though into adulthood she tended to go hiking or walking for daily transportation. Two women had been involved in sport at a high level, as Anisa (from Iran) had been a professional table tennis player in her youth, and Nadia (from Iran) had been a volleyball coach.

Physical activity was also possible for a number of women prior to migration because there had been a convenient location nearby, which also made it conducive to building physical activity into their work schedules or travel routes.

I went to a pool every second day because it was so close to our house. I went to an Aerobics class and the next day to a pool. I went to class every day after school [she was a teacher]. I really like physical activity. (Mali, from Iran)

Other women, particularly from China, noted their workplaces encouraged physical activity and provided opportunities by sponsoring instructors to lead classes in the workplace. In addition to the proximity of facilities, a number of them mentioned that there were options that did not require them to spend much money, and where they had local knowledge of regular activities. For example, one woman from China noted that people would gather at her neighbourhood park every Tuesday night to run or walk from 7:00-9:00pm. As well, other women noted the existence of facilities where they did not need to worry about following a time schedule. For example, there were ample public badminton courts even in small towns in Korea that were well lit, allowing people to participate all hours of the day for free. Overall, these women did not feel financial pressures prior to migration, and they had social support networks and local knowledge that facilitated their participation.
For some, having a demanding work schedule did not allow them time to be physically active even though they had the financial means to participate. Tracy (from China) and Tanya (from Germany) were not able to achieve a work/life balance given the long hours and odd schedules they worked. Prior to migration, Tracy was a Chief Financial Officer in a multinational corporation that required her to participate in international conference calls at all hours of the day and to travel a great deal, while Tanya worked in special event marketing with evenings and weekends functions.

Though motherhood was fulfilling for many of the women, childcare responsibilities generally fell upon them and this limited physical activity participation. For example, Noushin had participated in yoga and aerobics regularly, but her activity level dropped after giving birth to her daughter. For those who did participate regularly while also having children, family support to help with childcare made a difference. For example, Monika explained that given her work and childcare roles, physical activity was only possible with family support.

…[I]t took me almost eight years to go get to the gym regularly and not feel guilty about it because I’ve always worked full-time so, kind of asking my parents, “Oh, could you look after [the kids] for an extra hour and a half because I want to go [workout]…”

(Monika, from the Czech Republic)

Additionally, for some there were more opportunities to participate in physical activity together as a family prior to migration or it was seen as a time to be social with friends. Some women identified limitations in the types of activities that were socially acceptable or even possible because of social or environmental conditions such as fears about personal safety, transgressing gender roles and pollution, even though they enjoyed physical activity.
I do physical activity comfortably here [in Canada], but in Iran you can’t run in the street. If you wanted to go to a gym it has lots of pressure and troubles. Recreation [was] so limited for women. Nowadays social security is even less [in Iran]. It was scary for me to go out of my home at 6 a.m. and I couldn’t even walk to the metro station. (Nazila, from Iran)

However, even in countries where physical activity among women was not socially acceptable in public places, many women noted that they were able to be physically active because facilities offered women-only hours for swimming, aerobics, and fitness. Some women also participated in physical activity in their homes with treadmills or swimming pools.

While the majority of women were physically active prior to migration, a few noted that they were not regularly active and two women were inactive because they had not been health conscious before migration. For example, Radhika and Anisa noted that they spent their leisure time going to parties and it was not common in their social spheres to participate in physical activity. However, as will be discussed in a future section about self-reported physical activity, some women increased their physical activity levels after moving to Canada, while others who had been regularly active decreased their levels of activity.

**How migration intersects with socioeconomic status and gender**

International migration involved a great deal of change in the lives of these women who migrated as skilled workers, even though most had resources and an opportunity to plan for the transition. Because previous studies have shown that immigrant women often situate discussions of health within their broader life situations before and after migration (Dean & Wilson, 2009; Jafari et al., 2010; Meadows et al., 2001), interview questions were structured to
first ask about how their health may or may not have changed since moving to Canada, and then to consider if and how any of those changes were related to migration. I begin with a brief summary of how women described their health prior to migration and then provide an overview of how their health had changed after migration. Though few women discussed having physical illness or symptoms, these findings are discussed next. Following this, data related to their mental health concerns, primarily stress and feelings of depression, and how this was related to the three SDH of migration, socioeconomic status, and gender are presented. I elected not to discuss each social determinant individually because it was impossible to trace the causes of declining or improved health to one single determinant. Furthermore, this is not my goal since one of the key arguments underpinning an intersectional approach is that social determinants are interconnected and bound together by mutually reinforced, socially accepted hierarchies of power, and that shift depending on one’s social location and the broader context (Collins, 2009; Hankivsky & Christofferson, 2008). In other words, social determinants of health are complex and integrated with one another; they cannot be easily separated and examined in isolation, as demonstrated by these women’s accounts.

Health following migration

To provide context to this section on the women’s health after migrating to Canada, I begin with a brief summary of how they described their health prior to migration. Half of the women \( (n = 9) \) indicated that they had no problems with their physical health prior to migration. Some of these women referred to physical indicators that they were healthy, for example, because they did not need to see a doctor, did not need to take pills, had no major health issues diagnosed, and one noted that she felt she had more energy. Several women attributed this to being younger, and one specifically noted that she had social support prior to
migration. While their physical health was generally described as being good, some women noted that they were less health conscious before migration, some previously had less access to healthy foods, and a few mentioned that their work situations caused stress. Two women responded to this question by discussing diagnosed chronic health conditions (high cholesterol and arthritis). However, it was not surprising that most of the women did not have major health concerns because part of the immigration process involved submitting to a medical examination by a CIC authorized doctor to verify their health status. This was in large part a precaution taken by the federal government to ensure that those given permanent residency in Canada will not become a burden on the health care system (Gushulak & MacPherson, 2011).

When women were asked if their health had changed after migration, most expressed appreciation for the improved air quality and a cleaner urban environment and, for a few, a new awareness about the importance of healthy lifestyles. Three women noted that they felt healthier since moving to Canada primarily because they led more balanced lifestyles that included more physical activity, healthy foods, and the ability to relax. Much like women in Elliott and Gillie’s (1998) study, two other women noted that they experienced no change in their own health status, but the health of their family members had improved as evidenced by accounts of fewer colds, milder allergy symptoms, and again, access to healthier foods. In contrast, another woman felt her health had declined because of a poorer diet in Canada. This was attributed to the high prices, limited availability and low quality of organic foods compared to France, and the low prices and ease of accessibility of processed foods in grocery stores. However, by far the most common response was that they felt little had changed in terms of their physical health, but many discussed concerns regarding their mental health (see Table 5).
Table 5: Health after migration

<table>
<thead>
<tr>
<th>Women’s description of health after migration</th>
<th># of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less healthy: Directly discussed mental health connection to physical health</td>
<td>7</td>
</tr>
<tr>
<td>Less healthy: Indirectly discussed stressful situations that caused health concerns (e.g. fatigue, weakness, insomnia, neck pain, depression)</td>
<td>5</td>
</tr>
<tr>
<td>More healthy</td>
<td>3</td>
</tr>
<tr>
<td>No change in health</td>
<td>2</td>
</tr>
<tr>
<td>Less healthy: Lifestyle</td>
<td>1</td>
</tr>
</tbody>
</table>

During data analysis, I coded statements that related to bodily conditions as physical health. This included physical conditions such as chronic illnesses, allergies, colds and flus, as well as lifestyle factors such as physical fitness and diet. As already mentioned, only two women had chronic health conditions prior to migration. The woman with high cholesterol discussed the need to manage her condition through physical activity after migration. Physical health also included physical ailments that women closely related to mental health, for example, when women discussed experiencing symptoms such as difficulty breathing, fatigue, weakness, lack of energy, neck pain, insomnia, and nervous energy. When such physical ailments were discussed, many thought there was a direct relationship between mental and physical health, namely that when their mental health was affected, their physical health would also be affected.

The concept of mental health included aspects such as “the realization of one’s abilities, the capacity to cope with daily stressors, participate in fulfilling relationships with others, work productively and fruitfully, and contribute to community life” (Parry, 2013, p. 217). The women attributed positive mental health to situations such as having less pressure in the work environment (after being able to secure employment), a balanced life, a better sense of equality for women, a feeling of personal safety, and the ability to enjoy physical activity. Only two
women referred to mental illness or disorder when they discussed their use of medication to alleviate depression and anxiety.

Though data were coded separately as physical health and mental health, I do not intend to set up a dichotomy between the two. Rather, as described by many of the women, I see physical and mental health as part and parcel of one’s overall health. Many women discussed how their mental health was negatively affected after migrating to Canada, though the extent and duration varied from person to person, and was largely based on each woman’s social and economic circumstances. Many women described physical symptoms of poor mental health such as difficulty breathing, fatigue, low energy, weakness, crying, loneliness, and feeling homesick. These were often accompanied by feelings of stress, anxiety, social isolation and uncertainty while adapting to a new environment. This stress and anxiety may have been felt more acutely by some women in this study because they migrated as skilled workers with the expectation and need to be employed after moving to Canada.

When asked if they felt migration had affected their health, seven women directly discussed stressors in their lives in relation to health, while five more discussed stressors at great length at other points in their interviews, but did not directly acknowledge stress as a health concern. These stressors were multifaceted and combined to affect life and health in different ways. Similar to women in Meadows et al.’s (2001) study, health was discussed more as a physical experience in relation to what was going on in their lives rather than as a result of an identified illness. Fatigue and lack of energy was related to the need for constant mental focus in order to avoid making social mistakes such as communication errors. Some women also felt anxiety from fear of making errors in judgment because they had limited access to information and lacked local knowledge that could help them make informed decisions. As
well, insomnia and nervous energy were tied to stress and worries about unemployment, financial insecurity, challenges with communication, family concerns, and ultimately wondering whether migration had been a good decision or not. These women’s explanations exemplify how physical and mental health are closely tied together.

Although anyone may experience times of uncertainty or isolation, difficulty finding a job, having to face bureaucratic red tape, or instances of miscommunication, many of these immigrant women encountered these issues concurrently and intensely on a daily basis, over an extended period of time, and in a new environment. They often did not have opportunities to resolve these issues through communication in their dominant languages. For skilled workers who had the expectation and need to find gainful employment, these challenges compounded the pressure of financial insecurity. As well, some needed to balance childcare and household responsibilities with their need to secure employment and income. Furthermore, most of these women were also learning to navigate a new social system, one that had been slow to respond to changing population demographics that have come about due to the increased diversity of source countries from which skilled immigrants originate. For example, when asked about influences on her health since moving to Canada, rather than answer directly about her health, Anisa discussed her situation after migration that exacerbated her depression.

Immigrants who come here as skilled workers do not have as much money and sometimes Canada does not accept their certificates. It takes money and time to get a new certificate and start working. …People who are skilled workers and come here have problems because Canada does not accept their certificate and they have to go back and work in their own countries. This country should use their skills; a dentist should not work in McDonald’s. (Anisa, from Iran)
Numerous women discussed the long-term stress that resulted from the lack of financial security many of them faced when they or their partners could not secure employment, and worried about how long they would be able to stretch their savings. Thus, aspects of migration, socioeconomic status and gender emerged as important social determinants in these women’s health. Below I present how intersecting SDH of socioeconomic status, gender and migration affected mental health, both positively and negatively, by examining the women’s varying situations of employment status, financial (in)security, English language ability, and social support or isolation.

**Employment status**

Employment status was a key issue that either caused or dissipated stress. One’s occupation is often considered to be one aspect of socioeconomic status (Reid, 2007), and as will be discussed, it is also often affected by gender and one’s status as an immigrant. Over two-thirds of the women \((n = 13)\) reported experiencing a downgrade in professional status and an accompanying situation of financial insecurity, as outlined in Table 6.
Table 6: Post-migration employment status

<table>
<thead>
<tr>
<th>Currently employed</th>
<th>Current occupation</th>
<th>Hours of Employment (FT / PT / Temp)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No (12)</td>
<td>Study English (5)</td>
<td>Full-time (30+ hrs/wk) (2)</td>
</tr>
<tr>
<td>Yes (6)</td>
<td>Homemaker (3)</td>
<td>Part-time (&lt;30 hrs/wk) (4)</td>
</tr>
<tr>
<td></td>
<td>Accountant (2)</td>
<td>No answer (12)</td>
</tr>
<tr>
<td></td>
<td>Cashier (2 – Safeway, bakery)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actively seeking work (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skill retraining (2 – payroll certification, hairdressing school)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Working in Canada” (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commission sales (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cook (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Volunteering (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not working nor seeking work (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No answer (1)</td>
<td></td>
</tr>
</tbody>
</table>

*Note: some women identified more than one occupation

Many of the women expressed their frustrations at an immigration system that did not adequately account for the difference between immigration screening and the actual requirements of employers, and the precarious situation this placed many women in. For example, in order to become a permanent resident through the Federal Skilled Worker program, participants had been screened and selected according to their mix of educational credentials, work experience, their English language skills, their adaptability as assessed by a CIC officer, and their health status. As explained by a number of women, it mattered that they migrated to Canada under the Federal Skilled Workers program because they had arrived with the expectation and financial need to find work. As a result of the application process, the women expected that they would be able to contribute and participate in their new country of residence, as Mina explained.
I think the big problem that newcomers have here is work. It means skill workers all have knowledge, experience and are well educated and here they don’t use their proficiency. And they need to put in extra energy in order to study again. I did study, I did work, I have experience and I really don’t have energy to start over again and I need to work here. Not low level work, because my physical health doesn’t let me do all kinds of work. Yeah … work is the biggest problem for newcomers. If this problem were solved, mental health, physical health and other things would be good afterward.

(Mina, from Iran)

Mina, who had twenty years of experience in accounting and municipal finance in Tehran, discussed her feelings of mental pressure and stress from worrying about her family’s unemployment situation in Canada. Furthermore, because she had a pre-existing condition of arthritis, this limited the types of employment she could take on. Eventually, her husband returned to Iran to resume his career in order that the family would have an income.

Many found that there was a disjuncture between requirements of the federal immigration program and how potential employers viewed international experience and credentials that were overlooked or discredited in favour of Canadian work experience. For example, Nazila (from Iran) had been unable to gain professional certification as a physiotherapist even though she had over twenty years of experience working in a Tehran hospital.

You can’t work, you can’t do many works [types of occupations] and as you go to start working they ask you “what is your Canadian work experience?” which you don’t have any. A newcomer has lots of tensions. (Nazila, from Iran)
The tensions Nazila was referring to were related to the situation that both she and her husband could no longer practice physiotherapy as their profession. Though she had migrated with the expectation that she would experience hardship, Nazila’s difficulty in securing her professional status caused stress and a situation of uncertainty that did not allow her to manage her high cholesterol through physical activity as the family had made a decision to cut costs. Professional certifying bodies often require applicants to enroll in Canadian courses to upgrade their educational credentials, as well as have Canadian work experience before granting Canadian credentials (OHRC, 2013; Shan & Guo, 2013). However, in order to gain Canadian work experience as a physiotherapist Nazila needed to be certified to practice professionally. At the heart of the matter, the Canadian work experience requirement emphasized a migrant’s social location as ‘not Canadian’, devalued their existing work experience, and created an artificial barrier that structurally streamed immigrants into lower skilled and lower paid positions (Shan & Guo, 2013). The Ontario Human Rights Commission (OHRC) (2013) announced its policy that the onus would be on employers to prove that Canadian work experience is a *bona fide* job requirement. This is an important step in addressing health and economic concerns of skilled immigrants as it counters the dominant rationale that has long upheld the negation of international work experience and credentials and systematically “distinguishes immigrants as the others who are different and by default deficient” (Shan and Guo, 2013, p. 36).

Many of the women expressed concerns about the need to find stable employment because they had sold their assets prior to immigrating, and therefore did not have a home or job to return to in case life did not work out in Canada. A number of them worked in survival jobs unrelated to their training that were often low-waged positions with little job security, such as seasonal work, commission-based sales, or menial jobs such as cashiering. Others
sought unpaid volunteer or short-term positions to gain Canadian work experience. In several cases, the need to seek employment as skilled workers involved multiple arrivals and departures to and from other nations prior to Canada, or movements to and from different cities after arriving in Canada. For example, after the first year living in British Columbia, Radhika and her husband moved to Calgary in search of a job for him, and then after another year they moved back to British Columbia because conditions were no better there.

So initially, after that one year we moved to Calgary to try and it was again the same situation, again the same survival jobs. We don’t say odd jobs, because I think it’s the wrong usage, “odd job”. People say odd jobs, but it’s not odd jobs because you took this decision and you came, so you know, anything to survive. (Radhika, from India via UAE)

Radhika was educated as a social worker and had work experience in office administration and her husband had previously worked in the oil and gas industry in the United Arab Emirates, but they accepted part-time jobs at Walmart and Best Buy. Relocating in search of appropriate work often meant expending already limited resources, delaying settlement in one community, and adding to their already elevated stress levels. Thus migration and socioeconomic status in these situations intersected to put strain on women who migrate and need employment. It has been documented in other studies that the loss of employment status and skills over an extended period of time has created stress and negative health outcomes for skilled workers (Dean & Wilson, 2009).

Some women also negotiated new gendered identities as they shifted from a work orientation to a family orientation due to the lack of employment opportunities. For example, Jenny (from China), who was formerly an academic and after migration became a self-
proclaimed homemaker, relayed a conversation with her daughter who felt that Daddy was more important because he earned an income, while Mommy’s job was easier because she was just taking care of children. Jenny noted that she tried to reframe this perception and explained to her daughter that, “I have to be a tutor, driver, cook, gardener, …[and] financial supervisor in our family. …Those jobs are very expensive to pay me!” Though Jenny shared this story with levity during the interview, it demonstrated that some women not only had to negotiate their new identities internally, but often with those who were closest to them. This was noted in Liversage’s (2009) study where skilled immigrant women lamented the loss of their professional identities and resisted adopting the role of housewife. Yet, Jenny demonstrated her agency through her attempt to reframe gendered ways of valuing occupational roles. Her story continued when she noted:

…but I feel like [being a] professor still is big challenge for me and I have two young kids, one is preteen now and the other is still very young, so I need to spend lots of time with them. I don’t want lose my family. For me, family always be the first priority. I probably will give up my career and try to find some easy career for living. (Jenny, from China)

Similarly, Chinese immigrant women in Australia who had limited access to their previous occupations refocused their priorities on family and household responsibilities (Ho, 2006). This reframing of life goals and ‘turning lemons into lemonade’ was likely a coping strategy (Graham & Thurston, 2005; Vaillant, 2012) for Jenny, as she quoted that euphemism and mentioned several times throughout the interview that though she physically felt a great deal of exhaustion and fatigue, she intentionally tried to keep a positive attitude so that she did not feel like a failure. While migrant women like Jenny worked productively and fruitfully to ease the
transition for their family members despite their own internal turmoil, their efforts may not have been valued as such because they are often measured against the greater value assigned to the male wage earner. Indeed, other women also discussed the intellectual conflict they faced when they realized they could no longer work in their own professions.

Only two women were able to leverage their past education and work experience to secure occupations in the same professional fields held prior to migration. Even though their initial situations were uncertain to begin with, after securing well-paying jobs their descriptions of life seemed relatively unproblematic.

At the beginning maybe four months looking for job I kind of struggle, but as soon as I got a job, everything’s so easy! (Tracy, from China)

These women noted that they felt healthy, balanced, refreshed and had leisure time for themselves and their families. Only Monika mentioned that she occasionally felt stress when work was busy. Prior to migration, these two women had worked in multinational companies in China and the Czech Republic including IKEA and PricewaterhouseCoopers in high-level positions as a director of finance and a financial controller. Tracy (from China) had registered with a recruitment company enabling her to secure a senior accountant position with an international mining company within months of arriving in Canada. Though Monika (from the Czech Republic) did not discuss her job search activities, she had secured a position at a boutique accounting firm within two months, and her husband found work with his previous company after six months. Both women were accounting professionals who had prior experience working in multinational corporations and were comfortable communicating in English. This made the transition to working in a Canadian company much easier for them and migration less of a stressor.
Echoing Parry’s (2013) key aspects of mental health, after migrating to Canada many of the women felt they had limited opportunities to realize their abilities, to work productively and fruitfully, and to contribute to their new society and economy. As Liversage (2009, p. 123) explained, “social status in the Western world today is strongly tied to labour market position, [thus] the inability to use former credentials holds critical implications for who immigrants are able to ‘become’ after migration.” Immigrants have been known to adopt strategies that could ease mental health concerns such as lowering expectations, targeting low and seeking lower status positions simply to earn an income to get by or to accept a volunteer position to get a ‘foot in the door’ (Anderson et al., 2010; Shan and Guo, 2013). However, it is important to be critical of such a system. For instance, volunteering may be reflective of an individual act of agency whereby volunteering provides opportunities to learn and gain local knowledge (Maitra & Shan, 2007; Shan & Guo, 2013). Alternatively, volunteer work or probationary jobs may also be seen as upholding a system that takes advantage of skilled immigrants and their professional labour for free or at a low wage (Chun & Cheong, 2011). Similarly, it is important to question whether short-term programs such as the federal government Canadian work experience program for newcomers, that Jennifer (from China) participated in, merely legitimizes and reinforces institutionalized discrimination adopted by many Canadian employers. Ultimately, many of these women migrated with the intention of being employed full-time after migration because they had skills and knowledge that allowed them into Canada in the first place. Migration, socioeconomic status and gender combined in different ways to affect these women’s ability to secure employment, often creating an unpredictable situation that took a toll on their physical and mental health. For those who could no longer do what they had been recognized for in the past, this not only caused an existential crisis, but it also had a material impact when women were unable to find gainful employment.
Financial (in)security

Another situation that negatively affected mental health for women was the lack of financial security. Income is another aspect of socioeconomic status (Reid, 2007), and much like employment status, can be further influenced by gender and migration status. Over half of the women ($n = 11$) reported a family income of less than $50,000$ per year (see Table 7), and a majority of the women ($n = 14$) discussed being concerned about their financial situations at some point after moving to Canada. While this had lessened for a few women over time as they or their partners found employment, it was still a persistent concern for over half of the women.

Table 7: Post-migration family income (before tax)

<table>
<thead>
<tr>
<th>Family's before-tax income</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; $20,000</td>
<td>(4)</td>
</tr>
<tr>
<td>$20,000-$50,000</td>
<td>(7)</td>
</tr>
<tr>
<td>$50,000-$100,000</td>
<td>(3)</td>
</tr>
<tr>
<td>&gt; $100,000</td>
<td>(1)</td>
</tr>
<tr>
<td>No answer</td>
<td>(3)</td>
</tr>
</tbody>
</table>

Living in financially insecure situations meant that many women were constantly concerned about having the means to pay for the basics including housing and food. As skilled workers they were allowed to bring an initial lump sum of money tax-free upon entry into Canada, but this quickly dwindled when economic exclusion persisted. Numerous women discussed insomnia, constantly worrying about how finances would be rationed, feeling a nervous energy, and one woman expressed a sense of fear. As Dean and Wilson (2009) found, the compounding effect of a lack of income, loss of employment-related skills, and the loss of social status affected the health of immigrants by inducing physical health problems related to
stress. One participant noted the disparity in income levels between immigrants and Canadian-born individuals when she noted that:

…work opportunity is less here and I think the government is responsible for this. They should make job opportunities and not discriminate between Canadians and immigrants. As far as I investigated, the wage level is so different. Even recently I read that there is close to a 40% difference between the wages that Canadians get compared to immigrants. And I think it causes immigrants to get depressed. …It means, how to say, this is a negative point for Canadian society. From a social point of view it could have mental pressure on your spirit. (Mina, from Iran)

For immigrant women the wage gap is not only based on migration, but it is also gendered as one study showed that they tended to earn 30% less than Canadian-born women and 22% less than immigrant men (Chui, 2011).

Financial strain was sometimes caused by the need for women to divide both their time and financial resources in order to pay for professional and language training that could put them in a position to generate more income, especially following separation or divorce.

When we immigrated we were not rich, we only brought $13,000 with us. We had to work here. One of the issues that caused our separation was that he could not find a good enough job. I myself got a job three months after our immigration. He did not search for jobs. I worked 7 days a week from 7am to 10pm. In order to have $3000 to pay my expenses, rent, and etc…. I had to work very hard. (Nadia, from Iran)

Through her interview Nadia noted that she worked multiple jobs in order to make ends meet, while being the primary caregiver for her son, and concurrently dealing with the dissolution of her marriage. She explained that her husband, who had been a physical educator at a university
in Iran, could not find employment in his field and essentially gave up due to the prospect of costly retraining, leading to their marital break down. Nadia discussed going through a period of depression after her divorce, but she continued to improve her situation through part-time work, attending English language classes, and re-training as a hairdresser. In seeking to alleviate financial insecurity, a number of women noted how busy and full their days were even though they did not work full time.

Many women who were experiencing financial pressures discussed feeling stressed, fatigued, and tired even though they were not working full-time as they were before migration.

Now our mind is so busy with a thought that the money that we brought here is going to be spent in the next four months. Probably some of our remaining money will be spent on getting a course, some for daily life and what if we couldn’t find a job afterwards?

(Noushin, from Iran)

Noushin discussed how she felt she had a lower social position after migrating to Canada, and spoke of the stress, self-doubt and worry she had over the family’s financial situation. She had attended courses on job searching, resume writing and English language courses, but Noushin also had to fit these in based on when she needed to pick up her daughter from school. The SDH of migration and gender intersected with socioeconomic status as women strove to balance their time and resources to take English language classes, enroll in educational courses to receive Canadian credentials, search for jobs and attend employment workshops. At the same time many were responsible for childcare responsibilities, concurrently placing pressure on them and reducing the time they could spend on health promoting activities for themselves. Migrant women in a study conducted by Elliott and Gillie (1998) often experienced fatigue due to overwork from employment and household responsibilities, as well as stress due to a lack of
work and having limited income. Banerjee and Phan (2015) found that gendered familial roles often led skilled immigrant women to prioritize their husbands’ economic integration over their own, preventing them from capitalizing on their own skills and qualifications after moving to Canada.

Finances also affected health because some limited their food budgets by purchasing lower-cost frozen foods and not purchasing organic vegetables. Although one woman noted that she could no longer afford luxuries like soda pop, for many of the women making a healthy choice was only possible after securing a regular income. Some women chose to forego leisure activities such as art or physical activity for themselves, which will be discussed in a later section.

Although only two women discussed challenges with the health care system, their respective differences in access to resources demonstrated how health outcomes were influenced by the intersecting SDH. Esther felt that the public health care system in Canada was inefficient due to the long wait times required to see medical specialists. She explained that rather than having to be first assessed by a family doctor before to being referred to a specialist, in Korea patients were able to book appointments directly with specialists. When her husband became ill, rather than endure the wait time to see a specialist in Canada, they opted to pay for his travel to Korea so that he could see a specialist immediately. In contrast, Anisa explained additional challenges she faced with the health care system.

The health care card took one month to arrive. And before getting the health care, one night I was feeling really depressed and I felt that I could not breathe. However, I could not go to the hospital because it was really expensive for me. It would have cost me around $60 which was 70,000 Toman in Iranian money at that time. Although I had
[private] insurance, they said that they couldn’t cover these costs, since I was a little depressed before [migrating] and I was taking pills as well. So I was feeling really bad and could not go to the hospital because I couldn’t afford it. (Anisa, from Iran)

Anisa’s dominant language was Farsi and although she was working to improve her English language skills, she had difficulty communicating on the telephone and could not follow up with the health care and insurance providers to determine how to address this gap. Interpretation support was available through the multicultural society, but she could only book an appointment there ten days later. Highlighting the intersecting challenges she experienced, Anisa asked, “Can you imagine a person who does not have health care and cannot speak fluent English had to wait 10 days to get an appointment?” As Crenshaw (1991) pointed out, existing institutional systems that do not account for differing needs can perpetuate health inequalities, in this case as related to class and place of origin, as seen in the gaps between public and private health care insurance, as well as the under resourcing of not for profit interpretation services. This highlights how health can be put at risk due to systemic issues that do not account for socioeconomic and migrant diversity, and how individual choices are influenced by intersecting SDH.

**English language ability**

English language ability was another challenge for many of the women that added stress, particularly when combined with the challenges of securing employment and gendered role expectations. Seven women were enrolled in English as a Second Language (ESL) classes, while another two were actively seeking opportunities to practice communicating in English. Five women did not appear to require ESL services. Two women worked in part-time service
jobs and had a functional use of English, and a final two women stated they did not know any English.

Although most of the women had studied English prior to migration, some discovered after coming to Canada that, on an interpersonal level, their English level was not sufficient for daily interactions due to the gap between a technical understanding and functional ability in the use of a non-dominant language. For example, Jenny (from China) explained that though her English language skills were assessed to be equivalent to high school Grade 10 English, she still experienced a great deal of difficulty using English on a day to day basis.

You know the word meaning, every word in the sentence you know, but put in a whole sentence, you’re lost! And when people talking with me, I know every word, I just don’t know what they’re saying! (Jenny, from China)

Another woman, speaking of her efforts to learn English, noted that she felt immigrants who have less proficiency with English hold a lower social position than before because they can no longer communicate effectively. Language acquisition can be limited by some immigrants’ lack of opportunity to interact with native English speakers due to isolation, non-participation in the workforce, or work in an occupation that does not require communication in English (Adamuti-Trache, 2013).

Yet for many, the language gap was a key reason for non-participation in the workforce when their assessed English language skills did not match the level expected by employers. In Jennifer’s account of job interview experiences, she described interactions with potential employers as “funny”, meaning strange or questionable. For instance, she was invited for a job interview but, after only a brief discussion, was told that she was overqualified because she held a Master of Business Administration (MBA). Jennifer found this questionable because her
MBA was listed on her resume, so it should not have been a surprise to the interviewer. She did not overtly suggest that she was being judged by her accent, though this story was reminiscent of accounts in other studies where qualifications on one’s resume were discounted due to one’s accent (Chun & Cheong, 2011; Creese & Kambere, 2003). This caused her to subsequently remove her MBA credential from her resume in order to be eligible for entry level positions, even though this devalued her actual skills and experience and could preclude her from higher level jobs that she was qualified for. She admitted that finding work after migration to Canada was:

…much more tough, difficult than I expected. Earlier, I thought, oh yeah, it’s not that big problem because apparently I can speak English and also I had experience study overseas [in the UK], so it should be OK. …But however, after immigrate here I felt it’s very challenge. …It was really frustrate for a new immigrant to find a new job… I mean a decent job. (Jennifer, from China)

Unfortunately, national belonging of immigrants is often marked by aspects such as language fluency and lack of or type of accent (Creese & Kambere, 2003). As Han (2012) demonstrated, immigrants often arrive to Canada with the pride of being selected to migrate based on their achievements. However, if they cannot communicate as the educated professionals they once were and their status is delegitimized, Han found that language became “an important terrain where socioeconomic inequality and immigrant identity are negotiated, resisted but reproduced” (2012, p. 147). Cervatiuc (2009) is a proponent of intercultural exchanges that encourage more opportunities for communication so that individuals from dominant Canadian society become more aware of the difficulties and hardships of learning a second language. As well, language markers are important for participation in not only economic life, but can also
constrain the types of social interactions and civic participation immigrants engage in
(Adamuti-Trache, 2013).

While migrant men also experience challenges when they can no longer communicate
primarily in their first language, this situation can be compounded for women when they face
gendered expectations about responsibility for their families and household.

My first problem was the language and I was alone. I wasn’t familiar with the culture
here and the school system and finding a job. Without knowing English it was so hard
for me with all of this. Being alone and getting home sick …I had all of this. But, I
passed those days and now I’m here [laughs]. (Mina, from Iran)

In Mina’s situation, sole responsibility for settling her family and household affairs after
migration was left to her because her partner needed to return to Iran in order to earn an
income. Navigating the public education system, health care system, setting up household
utilities, organizing transportation, and generally getting to know one’s community and
neighbours were all situations that women discussed as particularly challenging without the
ability to communicate in their dominant language, especially when they had limited social
support. Furthermore, as discussed earlier, these responsibilities sometimes forced women to
choose between childcare and household responsibilities and English language lessons.

Since many of the women could no longer use their dominant language to communicate
in daily life, this took a toll on their health directly and indirectly as they experienced isolation
and difficulty learning about a new community and social system. Jenny explained how she felt
challenges with language and communication affected her health when she said:

…[L]anguage cost me a lot of energy. And I was once read a newspaper they says
second language will make you… will drive you crazy or like a depression ‘cause they
takes lots of energy out. So I think that’s why before immigrate I’m much healthier.

(Jenny, from China)

Isolated incidents of miscommunication can happen to anyone, but for many immigrant women the overall tension caused by daily communication challenges compounded over time when they were not sure if they understood information correctly, or had difficulty communicating their needs or expectations. This made them question whether they had the vocabulary to self-advocate as they would have in their primary language. Indirectly, as discussed earlier in this section limited language abilities, whether real or perceived by employers, can exacerbate the stress and anxiety of being unemployed, underemployed and financially insecure. Challenges in communication can lead to isolation, marginalization, anxiety and other mental health issues, particularly when it creates difficulties securing employment and developing meaningful relationships with others (Jafari et al., 2010). Pottie and colleagues (2008) found that the correlation between lower dominant language proficiency and lower self-reported health was particularly strong among immigrant women in Canada, and suggested that this limited access to health and social services, health information, and affected their economic success. Key aspects of Parry’s (2013) definition of mental health that can be eroded when opportunities to communicate were limited include the realization of one’s capabilities, fulfilling relationships with others, working productively, and contributing to community life. Once again, migration intersects with socioeconomic status and gender to influence important aspects of immigrant women’s mental health.

**Social support and isolation**

As seen in Table 8, half of the women lived with their immediate family units after moving to Canada, while five separated their families in order to make financial ends meet
when one partner remained in or moved back to their country of origin to earn a stable income. Two were single at time of migration, and two women divorced their partners, one shortly before and the other shortly after migration.

Table 8: Post-migration family status

<table>
<thead>
<tr>
<th>Family status</th>
<th># of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with partner and children</td>
<td>9</td>
</tr>
<tr>
<td>Separated (“astronaut”)</td>
<td>5</td>
</tr>
<tr>
<td>Not partnered at migration</td>
<td>2</td>
</tr>
<tr>
<td>Divorced before migration</td>
<td>1</td>
</tr>
<tr>
<td>Divorced after migration</td>
<td>1</td>
</tr>
</tbody>
</table>

For most of the women, the availability or lack of social support was an important factor in their mental health. Similar to Parry’s (2013) definition, social support was often framed as a resource that could assist the women in coping with daily stressors to make the most of their abilities. Some women did specifically identify the protective effects on mental health of having close family and friends after migrating to Canada.

Because my situation at home and also my connection situations were good, I’ve had some good friends and they did support me and gave me positive feedback. But, those that have problems at home and don’t have any support they don’t like to go out of home and make connections with others but that hasn’t happened for me. (Nazila, from Iran)

Some women’s families were able to secure visitor visas, such as Tracy’s (from China) mother who had been visiting for two years and helped with daily household duties and child care, and actively enabled her to participate in work and leisure. Another woman, Tanya (from Germany), connected online with German immigrants living in the study community before she relocated, and lived her first several months in the house of a friend she met online. Her
new friend helped Tanya transition to life in Canada by providing a place to stay free of charge, introducing her to friends, and helping her navigate a new social system. In both cases, social support was integral in easing these women’s socioeconomic situations upon migration. In addition, Tanya explained that even though she did not have immediate family in Canada, knowing that she had family support back home was a relief because if life did not work out, her parents would be supportive and help her get re-established in Germany, relieving some of the pressure of migration that many other women faced. Tanya said of her parents “…they are my anchor, so …if that [migrating to Canada] wouldn’t have worked out I always, there was always a place to come back to and start fresh.”

However, living with immediate family provided limited social support for some women and did not necessarily guarantee social and emotional health, particularly in the face of traditional gender norms. For example, Mali developed depression after giving birth in Canada.

I didn’t know anyone here. All my family, friends and my supportive people were in Iran. I was suddenly shocked. My husband got a job and all the responsibilities of shopping, taking care of children, were on my shoulders. The feeling of anxiety caused me to get depressed. (Mali, from Iran)

To remedy this, her doctor suggested visiting Iran for several months to be near family and friends. While this did help Mali address her depression, travelling back to visit friends and family was not a viable option for other women if they did not have the socioeconomic means to do so.
Furthermore, several women revealed that not only did they feel isolated, but they also needed to put on a brave face for the sake of their families by not showing the strain they felt to their children.

So I really care about my health psychologically and physically. Although I am really in debt, I try to be healthy psychologically because of my child. I really care about his mental health as well as mine. I try to stay happy, although staying happy is expensive. It is really hard for me, though I am really strong. (Nadia, from Iran)

Another woman explained that she did not want to concern her partner and so she did not tell him when she could not sleep through the night because she worried about their financial situation. These interrelated effects of migration, gender and socioeconomic status meant women had to carry the burden of worry without being able to release the concern, and this took a toll on one’s health. For example, Monika explained that she realized she needed to take care of her health because her social support network was back home in the Czech Republic, so if anything were to happen to her or her husband, her children would be left on their own.

Five of the families lived in separated situations becoming what is known as ‘astronaut’ families where one partner, usually a husband, remained in the country of origin to earn an income while the other partner, usually a woman, migrated with the children to settle the family in Canada (Ho & Bedford, 2008). Maha explained how this affected her mental health.

…[L]oneliness problem because I didn't think my husband would return to Iran so soon… My loneliness is most likely because I had separated from my family suddenly and also, my husband was not here and my dependence to him is very much. (Maha, from Iran)
Maha discussed the loneliness and depression she felt after they decided her husband needed to move back to Iran in order to work, prompting her to question her initial decision to migrate. She decided to remain in Canada for the benefit of her daughters and their future, but was unhappy about having to be separated. Compounding the stress of adapting to a new community and society while using a new language, five women needed to adjust to life as lone caregivers. Though such decisions were made with the best interests of the family in mind, transitioning into lone parenthood exacerbated the stresses associated with migration. As Jenny explained, “I’m quite proud of myself! I’m settling here with two kids without my husband ‘cause he’s traveling back and forth… so far so good!” But upon further probing, she continued discussing her experience, “I cried! But cry is good, emotion out! I feel so lonely, you know you have to carry everything, right? …But depress, and lonely, that will be most part of it.” For participants with no family relations or social network in Canada, the pressure to be self-sufficient was great given their responsibility for children and the household.

A few of the women noted that since moving to Canada, they had enjoyed the opportunity to spend more time with their families. However, this was only possible when income and employment were not an issue. Esther explained that she had worked full-time in Korea, but after moving to Canada she chose to work part-time instead, as her husband had secure employment as a pastor. She did not feel that migration was related to how much time she was able to spend with her children, but rather it was her choice to work less that enabled this. On the other hand, Tracy (from China) felt that moving to a new environment was a key reason for her closer relationship with her son. After divorcing her husband and moving to Canada, she had more time and opportunity to develop her relationship with her son because she chose to work in a job that demanded less time and she no longer needed to send him to boarding school.
Finally, several study participants discussed how daily life had generally proven difficult because of their new environment. For example, Maha explained that in her home country she did not need to rely on the advice of other people to determine what is “right and wrong”, but since moving to Canada:

Personally since I came here I focus to avoid mistakes. Since it’s a new environment and I’m not familiar with anything here, whatever I do I feel the fear of making mistakes, which is suffering me. (Maha, from Iran)

Those with limited social support to help them understand new social and bureaucratic systems felt apprehension and constant hesitation in decision-making. In part this was due to lack of familiarity with the new environment, such as not knowing which ESL classes would be the most benefit professionally, not knowing who to call to help with home repairs, and not knowing how to register one’s child for school. As well, some women expressed worry that they would make a bad decision because they did not have access to local knowledge. Several women expressed a deeper concern related to being able to trust their new community. For example, Noushin (from Iran) struggled with whether she should seek work and trust the care of her daughter to people in her new community, or if she should stay home to care for her child herself while watching the family savings dwindle. Much like women in Suto’s (2013) study, some of the women found that actions that were “fulfilled easily in a known environment had become, and for many migrants remained, unexpectedly challenging” (p. 54), including routine interactions with teachers, health care providers and neighbours. Clearly, social support and isolation are influenced by the intertwining SDH of migration, socioeconomic status and gender that affected immigrant women’s mental health in a variety of ways.
In summary, the social location of immigrant women influenced their ability to access employment, earn an income, opportunities to communicate, and sometimes, social support. A ‘blame the victim’ discourse might question why an immigrant would choose to leave a secure job and income for a life of potential hardship, and would expect immigrants to more thoroughly research job requirements prior to moving to Canada. Some may also argue that these women needed to improve their English skills before migrating and that if not, they should not expect to attain the same type of profession they had before. Such assumptions can create difficulties for most of the skilled workers that affected their mental health. Jennifer summed up the interconnected challenges in getting re-established in Canada and her mental health in this way:

Yeah, after moving here. And very stressful because you away from your family, your friends, your husband, and I’m here alone to be with my son and we need adapt a new life, and looking for new job, and also feel very uncertain. And still language is a problem because language is fine for me and for the daily life, but for some deep conversation or for some, you know, you need high-level language communication and it can be a problem. So I feel very frustrated and I feel my value is decreased here, so that affect my health condition. Typically, mentally I feel very unhealthy… (Jennifer, from China)

As these women’s accounts demonstrated, many of the choices available to them, the decisions they made, and ultimately how their situations affected their health were influenced by intersecting social determinants of migration, socioeconomic status and gender.

While racial and ethnic discrimination were seldom overtly discussed by study participants, a majority of the women who did struggle to find a place in Canadian society that
matched their potential contributions were women of colour from countries where English is not a primary or secondary language. This aligns with the growing body of literature examining the links between the growing racialized and gendered aspects of downward socioeconomic status that is faced by many immigrants to Canada (Wallis & Kwok, 2008).

Despite the challenges that many women faced, most made an effort to project a positive outlook and expressed a belief that their situations would improve. Although a few seriously considered returning to their countries of origin, others thought their hardships would be temporary. As discussed in the next section, many of the women sought to address their mental health concerns through physical activity.

How community-based physical activity fit into the women’s lives

In this section, I discuss findings related to my second research question about how community-based physical activity fit (or not) into the lives of the women after migrating to Canada. Many of these women saw physical activity as a way to promote their physical health, mental health, as well as a potential means of developing social connections in their new community. While some women were successful at integrating physical activity into their lives after moving to Canada, many were not able to do so. Again, the reasons why women sought out physical activity or not, and whether or not it was possible for them, were situated within their social and economic circumstances as migrant women who were skilled workers. In Table 9 the types of physical activity the women participated in before and after migration, and whether they felt their participation increased, decreased or stayed the same are summarized.
Table 9: Pre- and post-migration physical activity participation

<table>
<thead>
<tr>
<th>Name</th>
<th>Physical activity</th>
<th>Before migration</th>
<th>After migration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esther</td>
<td>Badminton or running/ 2 days</td>
<td></td>
<td>Less - none (prioritize kids)</td>
</tr>
<tr>
<td>Mali</td>
<td>Swimming, aerobics, fitness/ &quot;a lot&quot; 5 days</td>
<td></td>
<td>Less - none (limited women-only hours, no childcare)</td>
</tr>
<tr>
<td>Mina</td>
<td>Gym/ 3 days</td>
<td></td>
<td>Less - building gym/ not regular, when she can</td>
</tr>
<tr>
<td>Nadia</td>
<td>Aerobics/ 4 days (coached volleyball)</td>
<td></td>
<td>Less - no time because of work/ knows about $1, but cannot go</td>
</tr>
<tr>
<td>Parvaneh</td>
<td>Fitness, swimming, family soccer/ 3 days</td>
<td></td>
<td>Less - due to cost, wants social opportunities</td>
</tr>
<tr>
<td>Jacqueline</td>
<td>Hiking, walking or swimming (athletics &amp; sports in youth)/ 2-4 days</td>
<td></td>
<td>Less - walking, snowshoeing, hiking, community centre</td>
</tr>
<tr>
<td>Nazila</td>
<td>Aerobics/ 3 days</td>
<td></td>
<td>Less - $1 fitness, walking/ 2 days</td>
</tr>
<tr>
<td>Anisa</td>
<td>None (played professional ping pong when younger)</td>
<td></td>
<td>Same – some swimming, occasional walking/ &quot;do not exercise specifically&quot;</td>
</tr>
<tr>
<td>Farzaneh</td>
<td>Walking or swimming/ 1 day</td>
<td></td>
<td>Same - building gym/ 1 day (forces herself to be healthy)</td>
</tr>
<tr>
<td>Fia</td>
<td>Yoga or aerobics/ 3 days</td>
<td></td>
<td>Same - walking, cycling/ 3 days</td>
</tr>
<tr>
<td>Maha</td>
<td>Yoga, swimming, hiking or treadmill/ 3-4 days</td>
<td></td>
<td>Same - building gym/ 3-5 days</td>
</tr>
<tr>
<td>Radhika</td>
<td>None</td>
<td></td>
<td>More - walking</td>
</tr>
<tr>
<td>Jennifer</td>
<td>Walking, running or swimming/ 1 day</td>
<td></td>
<td>More - walking, hiking or swimming/ 3 days - almost everyday</td>
</tr>
<tr>
<td>Jenny</td>
<td>Walking, badminton or volleyball/ not regular</td>
<td></td>
<td>More - aerobics (step)/ 3 days (forces herself)</td>
</tr>
<tr>
<td>Monika</td>
<td>Gym, skiing/ &quot;regular basis&quot;</td>
<td></td>
<td>More - Zumba, skiing/ 3 days &quot;More than I used to&quot;</td>
</tr>
<tr>
<td>Tracy</td>
<td>Yoga/ 1-2 days per month</td>
<td></td>
<td>More - yoga, skiing/ 3+ days</td>
</tr>
<tr>
<td>Noushin</td>
<td>Aerobics or yoga - less after baby</td>
<td></td>
<td>More - yoga, aerobics or swimming/ 3-5 days (most days)</td>
</tr>
<tr>
<td>Tanya</td>
<td>Gym, running, biking/ 3 days</td>
<td></td>
<td>More - running, yoga, fitness/ 5+ days</td>
</tr>
</tbody>
</table>

**Self-reported physical activity after migration**

In this study, seven women reported they were more physically active since migrating, while four maintained the same physical activity level, and seven reported less physical activity (see Table 10). The types of physical activities the women were familiar with were swimming, yoga, going to the gym, aerobics, and walking or jogging. A few women also
played sports such as badminton or volleyball. That these women were already familiar with many activities popular in Canada may be due to the method of recruitment as many learned of this study through the local recreation department via brochures distributed by staff members or posters posted in recreation facilities. It is likely that women who did not participate or participated only in other forms of physical activity, would not have seen the recruitment materials.

Table 10: Self-reported post-migration physical activity levels

<table>
<thead>
<tr>
<th>Physical Activity Level</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>More physically active</td>
<td>7</td>
</tr>
<tr>
<td>Same level of physical activity</td>
<td>4</td>
</tr>
<tr>
<td>Less physically active</td>
<td>7</td>
</tr>
</tbody>
</table>

This means that within this group of 18 individuals, those who were regularly physically active may be over represented. However, given that the goal of this study was not to generate generalizable data, but rather to explore different reasons why recent immigrant women do or do not participate in physical activity, the insight provided by women who are inclined to be physically active is of key importance.

**Reasons for participation**

**Physical health.**

One third of the women discussed engaging in physical activity in order to improve or maintain their physical health. Only one woman noted that she needed to be physically active in order to manage her pre-existing health condition of high cholesterol. Generally among this group, being physically active equated to living a healthy lifestyle or it was positioned as a necessity in life to stave off illness. For some, being physically active to maintain health was in
the best interest of their families. Monika (from the Czech Republic) indicated that since she worked in a sedentary occupation, it was important to maintain her physical health by being physically active because she was now separated from her social support network and did not have anyone to rely on in case of an emergency. Similarly, Fia (from Indonesia) stated that she stayed active in order to keep her “heart pumping” for the “necessary times”.

At times, the discussion around the importance of physical activity for health verged on healthism (Petersen et al., 2010), as it was sometimes positioned as an action that one simply had to force on oneself to be healthy, and was not done for enjoyment or pleasure.

I’d say I work out at least five times a week, sometimes more often, and actually I do exercise or I work out not to socialize, I do it for my health… (Tanya, from Germany)

Tanya spoke at great length about how she now felt the healthiest ever because she had become more physically active, paid strict attention to her diet, and constantly sought out health information. However, some participants may have overemphasized the importance of physical activity for health during interviews because of the project title, as they may have thought they should discuss the connection.

As well, I am cautious of oversimplifying these women’s perspectives and recognize their discussions around health and physical activity were multidimensional. For example, although Tanya’s comments at times referenced the ideology of healthism, she described her situation prior to migration when she had no time to participate in physical activity due to a high-pressure marketing profession in Germany. Since moving to Canada, Tanya had consciously chosen a lower-stress lifestyle so that she could have more life balance and gain a sense of well-being. Similarly, while Noushin (from Iran) stated that, “No, I’m not very sporty, and just do sport to be healthy.” She also discussed the importance of daily physical activity for
relieving stress after migration, even if it only had a temporary effect. Generally, the ways women discussed why they participated in physical activity were multifaceted and they spoke not only of benefits to their physical health, but also their mental health.

Mental health and physical activity.

Physical activity was often discussed as way for women to improve their mental health, such as feelings of nervousness, anxiety or sadness, as well as alleviate some of the physical ailments that they associated with poor mental health, such as tension or lack of energy. As identified earlier, the women discussed how migration influenced their mental health due to increased levels of stress related to employment, income, communication, and the loss of social support. Many women stated that despite the stressful situation of resettling, physical activity helped them to “feel better”. Many women explained that physical activity was a way to release the stresses of daily life and relax or a diversion from their feelings of self-doubt, loneliness and isolation. When Jennifer (from China) was asked if she felt her health was influenced by physical activity, she initially responded “No,” but then reflected:

…if I really feel bad, feel depression, why not I just go to swimming and then I will feel better… sometimes yes, if you really feel very stressful sitting in front of computer doing [employment] research or if you’re very depressed, if I was going out have a walk in the forest then I feel better. Yeah, so that is the way I feel, it’s kind of a very good way to help me to decrease the anxious level. (Jennifer, from China)

For Jennifer, physical activity was an opportunity to calm her mind, manage stress, and reduce feelings of tension and anxiety that accumulated in her body from worrying over her situation.

Some women also discussed how physical activity was important to help relax their minds because daily life took much more mental focus and energy, especially when
commonplace communications were not done in their first language. Other women discussed feeling a sense of fear and doubt, constantly needing to be on guard so as not to make a mistake. For example, Jenny (from China) discussed at length how in this new environment, in order to understand basic interactions like chatting with her neighbours, or to process her two and a half hour English lesson class, she constantly had to translate the words and meanings in her head and try to formulate an appropriate response. She found this to be mentally and physically exhausting by the end of the day, and physical activity such as swimming provided some relaxation.

…health means to me a lot, both… mentally and physically. And they have to come together. …And now I find once a while you cannot, you know, always work like a machine, you have to get some entertainment for yourself. (Jenny, from China)

For Jenny, going for a swim and being by herself meant that she could be with her own thoughts and not have to worry about making communication or social errors. She acknowledged that it may seem contradictory to expend energy when feeling tired, but offered this explanation: “I know when you exercise you are tired at that moment, but your energy still build up after you relax”. Thus, she intentionally increased her physical activity in order to metaphorically recharge her batteries and have time for herself without her family by participating in the $1 swimming session at the local swimming pool.

Some women mentioned that because physical activity helped to manage their stress levels and emotions, they could deal more effectively with the challenges faced. Even Monika, who had relatively little difficulty securing employment and spoke English quite fluently, found migration to be stressful.
…I tend to worry quite a lot, so I’m trying to, you know, watch the inside of it, you know, not to stress about stuff that I can’t change… but at the same time, physical exercise definitely helps me along. …You feel better, you have more energy, you just feel physically and emotionally better, so it helps you deal with whatever I need to do. It’s very important. (Monika, from Czech Republic)

Monika emphasized that ensuring her own physical and emotional health was essential for taking care of her family.

However, I am cautious of overstating the importance of physical activity in addressing mental health concerns such as reducing stress and preventing depression. Many women acknowledged the benefits of physical activity, even though the effects were only temporary. For example, Maha (from Iran) used words such as “suffering” to describe her feelings of isolation and her coping mechanism was to keep herself busy by “doing exercise.” However, Maha admitted that during times when she felt depressed, “even exercise doesn’t make me happy.”

These different aspects of ‘feeling better’ through physical activity echoed Caldwell’s (2005) typology of the benefits of leisure time activities, including physical activity or active leisure. According to Caldwell, such activities provide people with opportunities for prevention in the form of stress relief and the reduction of anxiety and depression. Such activities were also coping mechanisms as they provided mood enhancement and palliative opportunities that temporarily diverted women’s attention away from their stressful situations (Caldwell, 2005). Suto (2013) also found that migrant women sought out leisure past times for relaxation and to improve their well-being.
Seeking social connection.

While some women found it beneficial to engage in physical activity on their own, others sought physical activity as a means for building social connections, including physical activity opportunities with family. For example, Parvaneh (from Iran via France) reminisced about when she and her family lived in France and had weekly soccer games with friends and their families. She sought to continue this ritual in Canada by setting a weekly time for herself, her husband, and son to be physically active together. For some women, migration actually afforded them more time to spend participating in physical activity with their children than they had prior to migration. In these cases, family participation was enabled due to less employment pressure since migrating. For example Esther (from Korea) now worked part-time, while Tracy (from China) worked in a smaller company, and Fia (from Indonesia) was waiting for her credentials to be evaluated before she could seek employment.

Some women sought out physical activity as a means to connect with new people outside of the family, referred to by Caldwell (2005) as leisure companionship. As discussed earlier, many of the women left their social support networks behind or had to live separated from their partners in to make financial ends meet. As Maha, who had been very physically active prior to migration, explained:

I like to use classes in recreation centres sometimes, just for leaving home and to communicate with people or even learn some new English words. (Maha, from Iran)

Much like Maha, many of the women wanted to meet other migrants and local residents to reduce their isolation, to practice their English language skills, and to learn more about the community in which they now lived. A number of women also discussed their observations that the local population was generally very physically active and how surprised they were to
see people jogging or walking outdoors even in the rain year round. This motivated some to participate in physical activity as a way to ‘fit in’ or learn how to adapt to their new community.

Although many of the women discussed their desire to meet new people through public physical activities, very few were successful in gaining leisure companionship (Caldwell, 2005). For example, when asked about the benefits Jacqueline had experienced from attending the local recreation centre, she responded:

Yeah, it’s more about my health and good friendship... But not really friends, not really friends, no. Not right now, not yet. Maybe later, but not… because it change. It not always the same people that I see here, but it’s difficult if you don’t see all time same person. It’s difficult to create a, some link, you know? (Jacqueline, from France)

As well, many women discussed communication difficulties and feeling self-conscious about their English language skills, and some explained that they were too shy to initiate conversation with others even though they wanted to practice speaking English. In Graham and Thurston’s (2005) study, some women responded to interview questions about their experiences of securing employment after migrating to Calgary in optimistic terms, but discussed what they hoped would happen, rather than what they actually experienced. Similarly, women in this study expressed the ideal of wanting to build social connections through community-based physical activity, but it was not usually something that actually came to pass.

Furthermore, a few of the women said it was difficult to bridge the divide between local residents and newcomers. Tanya noticed superficial interactions.
I guess people are interested in you and that you are not from Canada and about your history and where you come from and stuff, but that’s where it stops. It doesn’t go behind that. (Tanya, from Germany)

Tanya suggested that connections could be actively facilitated by community centre staff, but without this, only conversations in passing are likely to occur in physical activity settings. For some, even though they were happy to live in Canada, they did not feel a sense of belonging and still felt like strangers.

It is clear that many of women were able to participate in physical activity, both in informal activities such as walking and community-based activities offered by public recreation departments to improve their physical and mental health. However, for those wishing to leverage community-based physical activity opportunities to build social connections in their communities, the opportunities available simply did not facilitate this. That immigrant women sought out community-based physical activities in order to reduce isolation, build social networks and to address mental health concerns is an important finding in light of Keleher and Armstrong’s (2005) conclusion that physical activity done in isolation does not improve depression, and the emotional benefits of physical activity are more possible when environments ensure social interaction. Furthermore, this finding echoes those of previous studies that community-based physical activity opportunities are sought out by immigrant women as potential sites for building social relationships (Frisby, 2011).

In the next chapter, the conclusions and recommendations are discussed.
Chapter 5: Conclusions and Recommendations

This study drew on an intersectional approach to the social determinants of health to better understand changes in the health and physical activity participation of immigrant women after migrating to Canada. My first research question was “How did the migration process, as it intersects with socioeconomic status and gender, influence the health of recent immigrant women who migrated as skilled workers?”

For all of the women, the process of migration led to some stress, worry and upheaval in their lives. Women for the most part focused on how their mental health had been affected after migration, though some also did discuss physical health concerns as well, including physical ailments that were related to mental health, as well as chronic conditions such as arthritis and high cholesterol. Most of the women migrated with the desire and need to secure employment as skilled workers. While a few were able to maintain relative economic continuity in their lives, many had to negotiate various interruptions and barriers to being accepted as a skilled worker by employers in Canada.

Many definitions of health provided by the women reflected a holistic view that involved a close connection between one’s mental and physical health, although illness and spirituality were mentioned by a few. Some defined health only in relation to lifestyle factors such as diet and exercise. A majority of the women reported a positive state of mental health prior to migration. However, the primary ways that their mental health was negatively affected after migration were related to changing employment, income and financial situations, challenges in communication, changes in social support and gendered familial roles. It was evident that women discussed fewer or more short-term problems with mental health when they fit more easily into Canadian society due to i) higher socioeconomic status because they
and/or their partners held stable, well-paying employment; ii) English language facility; and iii) social supports that facilitated connections.

By applying an intersectional approach to viewing the SDH of migration, socioeconomic status and gender, it became clear that the persistence of declining mental health was often affected by how many of the women were categorized as different (Dhamoon & Hankivsky, 2011). This was particularly evident when their perceived value as skilled workers was influenced by attributes that marked them as ‘immigrant’ or ‘not Canadian’, such as their English language facility or their lack of Canadian work experience. Socioeconomic status combined with migration and often resulted in economic exclusion and professional closure (Shan & Guo, 2013). Some women took on part-time or survival jobs, while others volunteered or worked in short-term positions in order to gain Canadian work experience. Other women retrained in order to gain Canadian credentials or to access employment in an unrelated field. The economic exclusion that many of the women faced meant that their financial situations were precarious and caused stress for an indefinite length of time.

All of the women needed to learn how to rebuild their lives in their new communities, though this task was more difficult for some when challenges rooted in socioeconomic status and migration were further compounded by the need to negotiate different gendered patterns as partners and mothers. For many, sacrificing their careers for the sake of their children’s future was a key reason for migrating. They had to balance their time, energy and resources between family responsibilities and activities that they hoped would improve their access to gainful employment. Some continued or reframed their roles as wife and mother particularly when they could no longer access their previous careers, while others either did not have or left their partners. A number of women were managing their job seeking and family responsibilities with
little social support, particularly for ‘astronaut’ families who made the difficult decision to separate the family to ensure one partner made a steady income while the children benefited from the Canadian education system. These numerous and overlapping conditions influenced the ways in which these women discussed their health.

Though migration is not always considered to be a SDH, I join others in arguing it creates a situation where individuals experience significant life transitions that place numerous stressors on women that combine with other social determinants to affect health (Meadows et al, 2001; Vissandjee et al., 2007). My results clearly show how the process of migration intersected with the SDH of socioeconomic status and gender by creating a great deal of upheaval, change and uncertainty. My study also pointed to the importance of other SDH that require further attention, such as discrimination or exclusion based on race and ethno-cultural background.

Although the choices available to many of the women were constrained by the SDH of migration, socioeconomic status and gender, as Lee and Sum (2011, p. 148) stated, they “have the capacity and ability to act as conscious agents, creating and re-creating strategies of survival, negotiation and resistance in their everyday lives.” Despite social relations with potential employers that devalued the women’s skills, knowledge, abilities and foreign work experience, women sought out community resources to help with job searching and resume writing, and capitalized on opportunities to help them gain Canadian work experience. Despite their exclusion from the job market, some women made difficult decisions to ensure the well-being of their families, whether this meant working in survival jobs or separating the family in order to generate income. Despite the lack of opportunities to communicate in their dominant languages and for some with little social support, women enrolled their children in school,
sought out health care, and found a way to participate in a research project where they could voice their concerns. They also developed coping strategies that enabled them to address their mental health concerns.

As well, many of the women actively sought out community physical activity to address their physical and mental health concerns, although this was likely in part due to my sample who were likely predisposed to being active given pre-migration activity levels and their skilled worker status which provided some with financial means at least initially. This finding related to my second research question, “How did community physical activity fit into these women’s lives, if at all?” For about half of the women, migration meant having to discontinue physical activity given the challenges experienced during resettlement, while the other half were able to increase their physical activity participation after moving to Canada. Some were able to increase their physical activity due to stable financial situations, while others were able to be more physically active due to financial subsidies available through the recreation department and the feeling that increased physical activity would be beneficial.

Community-based physical activity was sought out as a way to maintain physical health, promote mental health by relieving stress and anxiety, and seek new social connections. This supports previous research, where leisure-based coping strategies included participation in active leisure for diversion, mood enhancement, companionship, and to “transcend negative life events” (Caldwell, 2005, p. 15; Iwasaki & Mannell, 2000). For many of the women, physical activity was a means to an end, that is, in order to live a healthy lifestyle and maintain their physical health so they could be there for their families. However, given the challenges related to migration, physical activity was also a way to address mental health concerns by providing an avenue for diversion, or an opportunity to relax and manage the anxiety caused by
their post-migration situations. Physical activity was also spoken of by some women in idealized terms, in that they envisioned or expressed the desire to develop social connections through community-based physical activity, though unfortunately this desire was not usually actualized.

It is important to note that many of the immigrant women in this study did seek out physical activity, regardless of the reason. This finding importantly counters assumptions by service providers that immigrant women are simply not interested in physical activity, or they prioritize other settlement concerns ahead of it (Dossa, 2004; Frisby, 2011). In a systematic review Allender, Hutchinson, and Foster (2008) identified five types of life-change events that disrupt physical activity participation including: changes in employment status, residence, physical status, relationships, and family structure. In many of the studies examined by Allender et al. (2008), these life-change events were considered as singular events in study participants’ lives. However, many immigrant women experienced these life changes simultaneously and for an extended period of time, in conjunction with other changes such as loss of their primary language of communication and the need to adjust to new social, cultural and employment situations. My study illustrated that what may at first glance appear to be a choice not to participate in physical activity quickly changes when one considers how the SDH of migration, socio-economic status and gender intersect to affect not only the overall health of immigrant women, but also how the ‘choice’ of physical activity participation can be affected as well.

**Recommendations for practice**

In addition to making the case that community physical activity is a priority for many immigrant women, this study shed light on why it is not always possible for them to
participate. This understanding is critically important for recreation departments that deliver community physical activity opportunities, because it is often assumed that the institution’s role is fulfilled by simply providing equal opportunities for participation. However, equal opportunities to participate do not necessarily translate into equal participation, as Scraton and Watson (1998) stated almost two decades ago when they wrote: “Leisure spaces and places can be both sites for the production and reproduction of structural relations and where counter and contradictory discourses are developed. They can be sites for inclusion and exclusion” (p. 135).

At this point, I return to the concept of liberal relativism, where individuals in liberal democratic societies are thought to have a universal right to pursue their own goals, as long as they fall within the often unspoken acceptable range of goals or morals of a dominant group (Bhabha, 1990). Many of the women in this study discussed how their participation was limited when their needs did not fall within the needs of the dominant majority, such as having sufficient opportunities for women-only physical activity opportunities, or that allowed them to communicate in their primary languages.

Below suggestions are provided by the women, myself, and from the literature that could make it more possible for them to participate. These suggestions are aimed at providers of community-based physical activity, such as local recreation departments, yet community organizations may also draw upon these recommendations in their own service delivery and advocacy, including multicultural societies, public health units, and neighbourhood houses. Through my personal experience in the recreation field as a recreation programmer, and coordinator of a provincial initiative aimed at promoting access and inclusion to physical activity for adults living on lower incomes, I recognize the need for broader awareness, advocacy and action by multiple community partners in order to achieve systemic change. It is
my hope that the findings and recommendations in this study will be translated in the future to influence policy and practice in the recreation, mental health, and social services fields. Some of the women in my study have already collaborated with the researchers in the larger grant (including multilingual graduate students acting as interpreters) to present findings and recommendations to several staff and managers in the community recreation department along with a number of community partners.

**Affordability.** Many of the women discussed situations of limited financial resources, especially for those who experienced difficulty finding gainful employment and had limited, low or no incomes, despite entering the country in the skilled worker category. While the local recreation department offered a financial subsidy program that provided a $200 credit for eligible community members, the unequal relationship whereby one party must assess another resulted in some applicants feeling stigmatized. Also known as financial assistance programs, these have been critically examined in academic literature, and though often well-meaning, the associated application and assessment process has been criticized for forcing individuals to ‘prove poverty’ (Taylor & Frisby, 2010; Cureton & Frisby, 2011). Some women did have savings, however with little or no means of earning an income in Canada, it was needed indefinitely to cover basic living expenses. This forced some to choose between participating in physical activity and living expenses because they did not qualify for a financial subsidy if they had savings. Low-cost drop-in opportunities such as ‘looney swims’ were also available, though very few were offered per week and they were not available at all swimming pools in the community. When women had limited flexibility in their daily schedules due to attendance in ESL classes, enrolment in professional upgrading courses, or part-time employment, they had to forego activity programs. Much like the situation described by Reid, Frisby and Ponic
(2002), lowering participation fees may address one barrier to participation, but does not adequately address other simultaneous challenges that newcomer women face.

**Gender-based differences.** One gender-based challenge grounded in tensions related to gender and migration that was particularly important in this community was the lack of women-only physical activity opportunities, especially for women who originated from Muslim majority countries. These women explained that prior to migration they were able to participate in physical activities, ranging from yoga to swimming to sports such as volleyball, because there were women-only options available at convenient times of the day. For some, the prospect of mixed-gender activities such as swimming was daunting and uncomfortable since their participation throughout their lives had been in single-gender environments due to social norms in their countries of origin. Rather than alleviating stress, it sometimes caused additional anxiety. Taylor and Toohey (1999) found that recreation professionals in Australia assumed that physical activity was not a cultural norm in some countries and therefore was not a priority for immigrant women. However, my main goal in shedding light on this issue was to provide the perspective that physical activity is practiced by women in Muslim-majority countries such as Iran and Indonesia. My findings revealed that there are women from these countries who would continue participating in Canada if the way they would like to practice it was respected and supported. There was one community centre that allowed limited times for women who wanted swim without men present in attire of their choosing, but these opportunities should be expanded. Social closure refers to a process whereby “access to certain spaces or positions in society is ‘closed against outsiders so far as… participation of certain persons is excluded, limited, or subjected to conditions’” (Weber, 1968, p. 139 as cited in Frank, 2013, p. 81). As recommended by the International Association of Physical Education and Sport for Girls and
Women, there is “…a need to ‘Accept and Respect’ diversity of Muslim women’s experiences in terms of how they choose to participate in physical activity” including those who prefer women-only settings (Benn, Dagkas & Jawad, 2011, p. 30, emphasis in original).

**Information and local knowledge gap.** Another issue is that the acquisition of language proficiency and local knowledge takes time, and it is recommended that measures to facilitate information exchange be implemented. Local knowledge is that which a person learns simply through daily life in a given place (Sandercock, 2003; Smith, 2010). Knowing how to get involved in society can often be taken for granted by people with local knowledge, and many of the women, particularly those with little experience in non-Western and non-English speaking countries, found the process of accessing information about physical activity participation very challenging. They suggested that information about how to access physical activity could be made more available to them through information sharing with agencies such as settlement services, schools and faith-based organizations. As well, more detailed information could be translated into languages other than English, and recreation staff and program instructors could be hired based on their ability to speak a second language. As discussed by Forde, Lee, Mills and Frisby (2015), this community already translates some basic information about how to register in recreation programs and how to apply for financial subsidy. However, the women noted that more detailed information would be useful in a translated format, such as the parameters for accessing financial subsidies or orientations to the facility and etiquette. They also recommended that multilingual staff or volunteers be made available to provide information in person. In line with recommendations from Lee and colleagues (2014), some of the women offered to take on a leadership role and suggested that they or their friends would happily volunteer to fulfill these roles, should they be asked. Simich and colleagues (2005) also
discussed the importance of follow up mechanisms after information has been distributed and this could help address gaps in knowledge around colloquial language. For example, local residents may know that ‘public’ in the context of recreation programs means that program participation is open to everyone, or that ‘drop in’ means that single visits are allowed and there is no need to register ahead of time or long term for the program. However, these terms were unknown to many of the women in this study, so it is important to remember that the acquisition of a new language is a long-term ongoing process.

**Facilitated social and physical activity opportunities for intercultural learning.**

This recommendation mirrors findings from the broader group of immigrant women who were interviewed in this study, as reported by Lee and colleagues (2014). As Meer and Modood (2012) explained, the goal of interculturalism is to develop cohesive societies through communication and dialogue that allows the development of an understanding and respect for differences and similarities within and across cultures. As stated earlier, an intercultural approach aims to break down essentialized and stereotypical notions of ethnicities or nationalities (ibid). Interculturalism calls on both newcomers and existing settlers to learn, change, and adjust to forge new ways of being and doing together. One way to do this is to ensure there are ongoing opportunities for immigrant women to voice their concerns and suggestions about public service delivery. Many also expressed how glad they were that this research project existed so they had a forum to share their experiences about the challenges encountered and to openly discuss why the existing public system of physical activity delivery may or may not serve their needs. The women discussed their critique of government immigration policy and the many challenges encountered with institutions in the community, to
shed light on the multiple barriers faced daily post migration, and to raise awareness about how these difficulties have affected their health, especially their mental health.

Another recommendation for service providers is to create facilitated activities or programs that fall outside of the dominant norm by promoting social connection across different groups of people (Lee et al., 2014). While many of the women valued existing practices, they had suggestions for adjustments that would make it more feasible for them to participate. Physical activity programs offered in their primary language or with an instructor who could speak their primary language would ease anxiety and make participation more enjoyable because they would not be worrying about what the instructor was saying. This suggestion was not meant to exclude people who could not speak a particular language, but to enable participants to feel less self-conscious and participate in physical activity in an environment that was temporarily free from stress. The women were often sensitive to budgetary constraints and this suggestion came with the qualification that such an opportunity would be beneficial even if offered just once per month.

Another suggestion involved the development of physical activity programs that were offered in English, but designed specifically for immigrant women. Again, the intention of such a class was not the exclusion of local or Canadian-born individuals, but rather to encourage and facilitate participation of immigrants by providing a social space where participants were not only physically active, but also able to provide moral support for one another while learning the dominant language. Several women felt somewhat cut-off from their previous lives, and that they could bond with other women who understood what that felt like. Furthermore, speaking English in this setting seemed to be less intimidating for some women, as they noted that most participants would be in the process of learning English, so if some
mistakes were made it would be less noticeable. It seemed the fear of judgment would be reduced when all participants in the class were on more equal footing in terms of language acquisition. Some women also suggested that migrant women themselves could play a leadership role in such classes by volunteering to interpret or seeking immigrant women who had experience leading fitness classes in order to minimize the cost of offering programs specifically for them. Stack and Iwasaki’s (2009) study found that Afghan immigrants to Winnipeg wanted to participate in leisure activities, including physically active leisure, when it was not only enjoyable, but also served a purpose, such as for education, learning, or personal development, and was meaningful, such as having time for making friends and building social connections.

Finally, a number of women noted that they would like to participate in physical activities that promoted intercultural mixing, both with migrants from other countries and with local Canadian-born individuals. Such programs would intentionally promote both physical activity as well as social interaction. Numerous women discussed wanting to learn more about Canada, including its physical culture, and several women shared similar sentiments that they did not move to Canada in order to meet people only from their own countries of origin. Several women also discussed their interest in meeting people from other countries and cultural backgrounds. As well, several women suggested that such programs and supports for newcomers could be time limited and offered to migrants only when they first arrived in Canada to help them to feel more integrated. The suggestion of time-limited support was also mentioned earlier in the discussion around financial subsidies for immigrants who had not yet found stable employment. Throughout the interviews when women were providing suggestions, they were overwhelmingly cognizant of the cost of delivering such programs.
They were careful to provide ideas that could help minimize costs, or work within existing schedules, or that were limited in duration. However, it is debatable whether time limited support is appropriate, as settlement in a new country requires lifelong adaptation (Omidvar & Richmond, 2005). Nonetheless, the women clearly wanted to put forth suggestions that they thought were feasible to implement and would not require a great deal of resources to realize.

**Future directions**

Although a number of studies have examined barriers to recreation and physical activity participation of immigrants and ethnic minorities, there are relatively few studies that contextualize this within the experience of migration (Dean & Wilson, 2010; Frisby, 2011). This study began to examine how health is influenced at the intersections of migration, socioeconomic status, and gender, and how community physical activity may play a role in the lives of recent immigrant women. It was meant to begin a conversation about the important role that publicly delivered community-level programs can play in the lives of individuals as they adapt and rebuild in their new communities.

Some limitations to my study included the relatively small number of interviews conducted in languages other than English, the narrow focus on women who migrated as skilled workers, and that other important SDH were not considered. Therefore, further research is needed to overcome these limitations and to examine intersections between other SDH that were not examined here.

Future studies examining health and physical activity participation among migrant women should build on the practice of conducting research in languages other than English, as was done in the larger study (Lee et al., 2014). Although this practice has its own set of
challenges (e.g., meanings are not always easily translated), it is important to ensure that community members who have been welcomed into Canada are included in knowledge production that is recognized by the academy, and that they have the opportunity to participate in their language of choice. It is of key importance to ensure that immigrant women have the ability to express the depth and complexity of their thoughts and experiences, as this can lead to better understanding of their situations, and hopefully will contribute to real world application of the knowledge generated.

Future studies could also engage different subgroups of migrants about their health and physical activity participation as there is a great deal of variation among and between individuals and groups. In terms of subgroups, I refer to different combinations of categories such as gender, race and ethnocultural background, age groups, migration categories, sexuality, length of time in Canada, urban size, geographic location, and source country, to name a few. Given the current refugee crisis where thousands of people are being displaced from their homes in Syria due to civil war (CBC News, 2015) and the federal government’s stated commitment to Canada’s humanitarian tradition of protecting refugees (CIC, 2014), this is another subgroup that requires attention. Migration intersects with other SDH that may be relevant in different situations, and therefore it is important to gain a broader understanding of how health and physical activity participation are affected in light of other intersections.

Finally, I acknowledge that intersectionality theory often begins with an analysis of race, class and gender relations, though my study examined migration instead of race. I was interested in exploring migration as a social determinant because it is not always recognized in SDH frameworks, yet my study still pointed to disparities in income, employment and health that could be related to race and ethno-cultural background. Furthermore, studies have found a
growing link among race, gender and poverty, especially among immigrants (Wallis & Kwok, 2008). Therefore, it would be important for future studies to further this line of enquiry, and how this relates to both health and physical activity participation.

In conclusion, Cervatiuc (2009) argued that while migrants are expected to learn English and how to adapt to life in Canada, local Canadian-born individuals or those who make up the dominant majority also have the responsibility to learn “about the hardships and realities of marginalization that immigrants experience” (ibid, p. 268) and to extend opportunities to build social networks, develop language skills, and generally live a healthy and prosperous life. As defined earlier, an intercultural approach aims to develop interdependent societies through communication, dialogue, and better understanding across both similarities and differences (Meer & Modood, 2012). Adopting an intercultural approach that places responsibility on all parties to communicate, learn and find a co-created way forward is one way to reframe relations between local and migrant residents, especially in communities experiencing tensions grounded in Canadian immigration policies. Such dialogue helps to break down simplistic notions of ethnicity or national belonging, and facilitates possibilities for the creation of a more understanding public and physical culture that ultimately contributes to health, broadly defined.
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Appendices

Appendix A: Interview questions

Thank you for participating in this interview. I will ask a series of questions around topics related to your experiences with physical activity and health before and after immigration. There are no right or wrong answers because we want to learn about your experiences.

1) When did you come to Canada and what city and country did you immigrate from?
2) What was your situation like before you immigrated?
   - Family, work, living conditions
   - What, if any, pressures did you face?
3) Why did you decide to immigrate?
   - How did the process go for you?
4) What is your situation like now after immigration?
   - What pressures do you face now?
5) What does health mean to you? How do you define health?
6) How was your health before you immigrated?
7) How is your health now?
   - What, if anything, has changed about your health?
8) How is physical activity delivered in [city of origin]?
9) How did physical activity fit into a typical week before you immigrated?
10) How does physical activity fit into a typical week now?
11) What do you think about how physical activity is delivered in Canada?
   • How does it compare to where you lived before immigration.
   • Are there any improvements you would like to see in how physical activity is offered to you and other newcomers?

12) Have any pressures during immigration affected i) your health, and ii) participation in physical activity?
   • Do you think any changes in your health since coming to Canada are related to changes in physical activity? How so?
   • Is there anything about your current participation in physical activity that you would like to change?

13) What are some customs that we should know about when organizing physical activity programs for women from [country of origin]?
   • Has there been anything that has stopped you from participating physical activity in Canada?

14) Is there anything else you think is important to say that we haven’t covered in the interview?
Appendix B: Background survey

Some participants wish to use a ‘made up’ name called a pseudonym when quotes are reported to keep things confidential, others prefer to use their real name. How would you like to be identified in this study? __________________________________________

City of Residence: _______________________________________________________

Gender:     Female ☐     Male ☐

Age:   <30 yrs ☐     30-39 ☐     40-49 ☐     50-59 ☐     60+ ☐

What language/dialect do you mainly speak at home? ______________________________
Please list any other languages/dialects spoken at home?_________________________

What is your highest level of educational achievement?
☐ High School Diploma     ☐ College Diploma or Degree
☐ Bachelor University Degree ☐ Graduate Degree (Masters or PhD) ☐
Other_______________

How long have you been living in Canada? ___________________________________
How long have you been living in the [Community Name] area? _______________________

Where did you immigrate from?  ___________________________________________

What were your main reasons for coming to Canada? (Check all that apply)
☐ Economic/work     ☐ Family Reunification     ☐ Education
☐ Opportunities for children     ☐ Other: Please specify: _______________________

Under what category did you immigrate?
☐ Business Class     ☐ Skilled Worker Class     ☐ Provincial Nomination     ☐ Refugee
☐ Family Class     ☐ International Adoption     ☐ Live-in Caregiver/Temporary Worker

It is very helpful for us to know the socio-economic status of study participants, so we are requesting the information below that will only be reported as a group or aggregate summary (not individually).

Are you on income assistance program?     ☐ Yes     ☐ No
Are you currently employed?     ☐ Yes     ☐ No
If yes, what is your job? __________________________________________

Do you work:     ☐ Full-time (30 or more hrs/week)     ☐ Part-time (less than 30 hrs/week)
□ Temporary (seasonal, on-call, casual)

What is your own total annual income before taxes?
☐ Under $20,000     ☐ $20,000—50,000     ☐ $50,000 —100,000     ☐ Over $100,000

What is your family’s total annual income before taxes?
☐ Under $20,000     ☐ $20,000—50,000     ☐ $50,000 —100,000     ☐ Over $100,000
How do you describe your living situation?
- Partnered or married with a: Male  Female
- Not partnered or married
- Self-identified as single
- With dependents (check all that apply below)
  - Children, # of children (male) ; # of children (female) 
  - Parents and Relatives, # of male ; # of female 
- With no dependents

Have you participated in the Health and Wellness Newcomer Project offered by [Local Recreation Department]? Yes  No
   If yes, how were you involved?
- Spoke with a volunteer host at recreation centre
- Participated in orientation tour at recreation centre
- Attended healthy living presentation series
- Used translated physical activity and wellness guides
- Participated in some of the sampler activities

Do you have any health conditions?  Yes  No
   If yes, please specify: 

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Please indicate if you would like:

1) To participate in further discussions with other women, and Newcomer Project staff and partners at a later date and receive another gift card:
   Yes  No

2) To receive a copy of the summary report of this study?  Yes  No

If you said Yes to 1 or 2 above, please provide your contact information. Data completed on this form will be separated from any identifying information (using the participant code & chosen pseudonym). This form, and your consent form, will be kept in a locked filing cabinet data away from all other data.

Name:
Address:
Phone Number:
Email: Thank you!