THOMPSON RIVERS UNIVERSITY

Health Literacy of Healthcare Providers and Mental Health Needs of Immigrant Perinatal Women

by

Conchitina I. Lluch

A THESIS SUBMITTED IN PARTIAL FULFILLMENT

OF THE REQUIREMENTS FOR THE DEGREE OF

Master of Nursing

KAMLOOPS, BRITISH COLUMBIA

December 2021

Dr. Joyce M. O'Mahony

Dr. Roula Hawa

Dr. Melba D'Souza

Monica Gola

ABSTRACT

Providing equitable and quality healthcare to all is a fundamental principle within all healthcare systems. Immigrant perinatal women are at greater risk for mental health problems yet face a myriad of challenges to access mental health services. Health literacy, which is the ability to access, understand, and apply basic health information and services needed to make appropriate health decisions, has become a public health concern with immigrants having significantly low health literacy levels compared to Canadian-born citizens. Healthcare providers are in a unique position to limit or build their clients' health literacy. They are expected to provide effective communication and ensure that health information is delivered and understood by their clients. The primary purpose of this study was to explore how healthcare providers negotiate the mental health needs of immigrant women during the perinatal period. In-depth interviews were used to obtain information about the perspectives of healthcare providers working with immigrant women and the contextual factors that influence immigrant women's mental health and their engagement. The study's findings will inform effective and culturally safe health literacy practices and development of future healthy public policy.

Keywords: immigrant women, healthcare providers, health literacy, perinatal period, mental health

ACKNOWLEDGEMENTS

Mommy and Daddy, the love, trust, understanding, and unwavering support that you have shown me since day one, all of these motivate me to accomplish what you have always believed I could achieve. In my highest of highs and lowest of lows, you have always been my number one cheer leaders. Ma, dad, my successes in life are yours as they are mine. You will always be the loves of my life! And I will always be your Kukuch even when I'm 64!

Cipi, Myko, Maita, Cathy, Maymay, Omaw, Maiah, Maui, Babba, Carissa, and Riri, I appreciate all that you do for me. Thank you for accepting (and not just tolerating!) me. I am blessed and honoured to have you as my family. You, my family, complete me.

My partners-in-crime, Polano and Naomi, thank you for understanding that I had to leave home to pursue my dreams. Thank you for always being there despite the time zones. My heart is full knowing that I have you two to come home to.

Tita Inday, Tito Dan, Jo-el, and my sweet Lisa, I would not have survived a pandemic in a foreign country if I didn't have family in Canada. Thank you for welcoming me into your home and for all the unconditional support you have given me.

Dr. Joyce O'Mahony, I do not think I will be able to thank you enough for your patience, guidance, and for believing that I can reach the finish line. There is no way I could have completed this without you. I am proud to be your mentee. This Filipino is forever grateful.

To the members of my supervisory committee, Dr. Roula Hawa, Dr. Melba D'Souza, and Monica Gola, thank you for sharing your knowledge and expertise with me and for cheering me on as I went through the process.

And most importantly, to Jesus Christ who continues to nourish, strengthen, and protect me… I am nothing without Him. To Him Be All the Glory!

DEDICATION

To the healthcare providers who continue to serve during these trying times...

To immigrant women who continue to live and fight through adversity…

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Chapter I: Introduction

Canada has been home to immigrants since the first European colonizers of the 16th century. As the country increases its admission of immigrant populations, with around 300,000 immigrants arriving annually (Statistics Canada, 2017), calls to provide quality health care to diverse groups has become more pronounced than ever. Studies revealed that immigrant women in Canada are at greater risk for perinatal mental health problems than their native-born counterparts (Anderson et al., 2017; Falah-Hassani et al., 2015; O'Mahony & Clark, 2018). However, due to a myriad of cultural, social, and structural factors, they have difficulties accessing mental health services that are purportedly available for them (Ganann et al., 2020; O'Mahony & Donnelly, 2007). In the quest to provide equitable care to all, health literacy has become a concept of interest due to its association with health outcomes and increased evidence revealing immigrants having lower health literacy than native-born citizens (Chakraverty et al., 2020; Durbin et al., 2015; Omariba & Ng, 2013). Concordantly, healthcare providers, as the smallest unit of health organisations, provide direct care to immigrant women, have an important role in bridging the gap between immigrants and quality healthcare by providing culturally competent care and ensuring effective communication.

I have particular interest in health literacy due to my clinical encounters with patients from marginalized sectors of society in the Philippines. Now as an international student in Canada, I have experienced life as a newcomer. The realization that the healthcare providers (HCP) role in improving the health literacy goes beyond relaying health information to a population group that is faced with additional challenges has motivated me to conduct this study. The purpose of this research is to explore how HCPs negotiate the mental health needs of immigrant perinatal women and the contextual factors that affect immigrant women's mental health and engagement.

Background

Providing equitable and quality care for all regardless of their race, gender, personal characteristics, and social status is a fundamental concern for healthcare systems (Marmot, 2014). Health literacy, which is defined as "the ability to access, understand, and apply basic health information and services needed to make appropriate health decisions" (Rootman Nielsen-Bohlman et al., 2000, p. 20), is widely considered a public health concern. This is due to the association of health literacy to health outcomes, including mental health, as well as higher medication and hospitalization costs (Coleman et al., 2017). In the context of immigrants, they are burdened to obtain and process new information about health services while experiencing resettlement stress and often new health needs (Urindwanayo, 2018). Moreover, immigrant women often experience an unequal share of mental health issues linked to contextual factors particularly during the perinatal period. Immigrant mothers experience significant mental health challenges due to precarious employment, gender roles, language, and literacy barriers during resettlement (O'Mahony & Clark, 2018; O'Mahony & Donnelly, 2013). Further, it has been shown that the reasons for observed higher rates of mental disorders among immigrant women during this period were related to social risk factors, including low income, unemployment, intimate partner violence, and poor social support networks (Bodolai et al., 2014; Vigod et al., 2016).

Healthcare providers (HCPs) play a critical role in providing understandable health information to the public, which can reduce health literacy (HL) demands on healthcare consumers (Chang et al., 2017; Coleman et al., 2017). Although how HL is practiced and the use of different HL techniques vary significantly across health disciplines, previous studies have shown inadequate ability of HCPs to recognize and be aware of HL (Coleman et al., 2017;

Lambert et al., 2014), communicate effectively with clients (Hersh et al., 2015) and skills (Coleman, 2017) in caring for those with low HL. HCPs may have difficulties in communicating important health information and this situates immigrant women at risk to receive mental health support. In addition, risk factors for mental ill health for immigrant women during the perinatal period are related to contextual factors such as immigrant status, social isolation, culture, systemic discrimination, poverty, and gender relations (Higginbottom et al., 2015; O'Mahony & Clark, 2021). These contextual factors also affect immigrant perinatal women's engagement and access to healthcare services (O'Mahony & Clark, 2021). For the purposes of this study, the definitions of contextual factors, immigrant, health literacy, healthcare provider, and mental health, negotiate, and perinatal period are presented to provide foundation to the study.

Definitions

Contextual Factors. In this study, contextual factors include cultural and social dimensions, and access to healthcare. Cultural factors shape how immigrant women respond to their mental health needs. Culture may influence immigrant women's help-seeking behaviour, decision-making, and communication with healthcare providers (Delara, 2016). Social factors include social support of immigrant women which may affect health-related beliefs and behaviours and social isolation that physically and culturally separates the immigrant woman from their support systems. Access to healthcare is influenced by multiple factors such as the stigma and shame of having mental health issues (Delara, 2016), lack of transportation (Ganann et al., 2020), and healthcare staff shortage (Higginbottom et al., 2015; Shafiei & Flood, 2019).

Immigrant. According to Statistics Canada, an immigrant is any person who is, or who has ever been, a landed immigrant or permanent resident. Such a person has been granted the right to live in Canada permanently by immigration authorities. Immigrants who have obtained Canadian citizenship by naturalization are included in this group (Statistics Canada, 2016).

Health Literacy. In this research, health literacy will be defined as "the degree to which people are able to access, understand, appraise and communicate information to engage with the demands of different health contexts in order to promote and maintain good health across the life-course" (Kwan et al., 2006, p.80).

Healthcare Provider. An interdisciplinary healthcare professional who works with immigrant women to provide health care and support services. This can include a family doctor or general practitioner, medical specialist, nurse practitioner, or social worker (Statistics Canada, 2017). In this study, the term healthcare provider can be used interchangeably with healthcare professional and health professional.

Mental Health. Mental health is viewed in this research as "shaped by various social, economic, and physical environments operating at different stages of life" (World Health Organization [WHO], 2014). Improving the conditions of individuals' everyday lives may improve their long-term mental health trajectory (WHO, 2014).

Negotiate. Negotiate in this study refers to how healthcare providers assess and communicate the mental health needs of immigrant women and arrive at shared decision-making about their care.

Perinatal Period. This period of time includes the pregnancy up to one year postpartum (Perinatal Services BC, 2014).

Study Purpose and Research Questions

The purpose of this research study is to explore the health literacy of health care providers working with immigrant women and their mental health needs in the perinatal period. A socioecological approach (McLeroy et al., 1988) aids in conceptualizing and understanding of the intrapersonal, interpersonal, organisational, community, and policy factors that may affect

active engagement of immigrant women. The research questions are: (1) How do healthcare providers understand and negotiate the mental health needs of immigrant women during the perinatal period? (2) What are the contextual factors that impact health literacy and immigrant women engagement?

Chapter II: Review of Literature

This literature review presents current research on the health literacy of healthcare providers and the mental health status and needs of immigrant women in the perinatal period. A search for peer-reviewed literature published from 2000-2021 was carried out in the electronic databases CINAHL, MEDLINE, and Springer Link. Grey literature including unpublished masters thesis and Ph.D. dissertations were reviewed. Searches were performed with the keywords immigrant, women, health literacy, healthcare provider, healthcare professional, health professional, nurse, physician, doctor, perinatal, and mental health. Inclusion criteria were (a) primary sources and secondary sources; (b) qualitative, quantitative, and mixed methods studies that included health literacy of healthcare providers and immigrant women, and mental health of immigrant women in the sample; (c) seminal works about immigrant women's mental health and health literacy of healthcare providers. Studies published in non-English languages were excluded. Screening of titles and abstracts left 185 manuscripts that met the inclusion criteria (See Appendix D). The following themes were found in the literature centered on health literacy, mental health of immigrant women during the perinatal period, and various contextual factors that affect immigrant women's engagement, HCPs, and health literacy. These themes are (1) health literacy and patient outcomes, (2) health literacy and healthcare providers, (3) health literacy and immigrants, (4) immigrant women's mental health, (5) cultural factors, (6) social factors, and (7) access to healthcare.

Health Literacy and Patient Outcomes. A growing number of studies link low health literacy (HL) with higher healthcare costs and poorer health outcomes (Berkman et al., 2011; McDonald & Shenkman, 2018; Yu & Mishra, 2019). At-risk groups for low HL levels identified are non-native speakers, older persons, and those with limited education. Moreover, limited HL

poses a significant economic burden to any healthcare system (Vernon et al., 2007). Health literacy levels are usually measured through a questionnaire. Many scales exist such as the Adult Health Literacy Scale, Short Assessment of Health Literacy, and Rapid Estimate of Adult Literacy in Medicine (Liu et al., 2018).

Delanoe et al. (2016) sought to explore the association between HL and pregnant women's intention to use a decision aid for prenatal screening. The researchers found a significant association between HL and pregnant women's decision to use a decision aid. The researchers added that the pregnant women's own perceptions of their self-confidence, reading comprehension, and social support may influence their intention to use a decision aid. Further, they postulated that objective outcomes in healthcare communications interventions do not always match outcomes perceived by the clients. The researchers recommended to assess pregnant women's HL levels to ensure that pregnant women can provide informed and value-based consent to prenatal screening.

Senol et al. (2019) showed that as the HL level increased in pregnant women, the rate of receiving sufficient prenatal care also increased. Additionally, they posited that the HL levels of pregnant women affected their ability to understand and use knowledge in order to protect and promote their health. The respondents' health literacy level was measured through a questionnaire that includes sociodemographic characteristics and questions on their pregnancy and prenatal care histories. The study concluded that HL has a direct effect on the mother and infant during pregnancy.

Similarly, in a study examining the effect of HL on prenatal checkup and pregnancy outcomes, it was stated that pregnant women with high HL levels received prenatal checkups earlier and more frequently (Kohan et al., 2007). The authors also reported that pregnant women

with high HL levels were different from those with low health literacy levels in respect to the subjects such as hematocrit levels, the use of iron and folic acid, delivery preferences, weight gain during pregnancy and breastfeeding.

Health Literacy and Healthcare Providers. In the past two decades, the concept of health literacy has evolved considerably. The role of HCPs in building or limiting patients' health literacy was highlighted for the first time in the 1990s (Lambert et al., 2014). Their part in communicating effectively and in improving the patient's health literacy continued to receive attention in the past two decades (Lambert et al., 2014). HCPs play a critical in providing understandable health information to the public. Scholars assert that the effective delivery of health information can reduce HL demands on healthcare consumers (Chang et al., 2017; Coleman et al., 2017; Johnson, 2015). Moreover, the health professional's ability to assess patients' HL levels may influence provider-patient interactions (Nesari et al., 2019).

Mackert et al. (2011) conducted a study with 166 participants that sought to gain information on the efficacy of a training program that aimed to increase the HCPs knowledge on health literacy. The results revealed that HCPs overestimated their knowledge on HL which suggests that HCPs may not be aware of the need for HL training. The researchers further showed that most HCPs in their study believed their experience equipped them with the necessary knowledge and skills. However, results indicated that experience is not a substitute for training. They concluded that health literacy training programs can improve HCPs perceived knowledge on HL and promote the use of effective communication techniques. The same conclusion was drawn by Coleman and Fromer (2015) in their study that analyzed HL training of physicians and other health professionals. They asserted that a modest educational intervention can positively affect HCPs self-perceived knowledge, skills, and behaviours about HL.

Schwartzberg et al. study (2007) involved physicians, nurses, and pharmacists that found significant differences in the self-reported use of various HL-oriented communication techniques among HCPs. They also noted that only a minority of schools and internal medicine programs appear to be teaching about HL. Similar results yielded in the study of Jukkala et al. (2009) involving HCPs wherein they found that the participants were not knowledgeable about the prevalence of limited HL. Further, Ali (2012) conducted a study to assess the teaching and evaluation methods around HL in community-based internal medicine residency programs. They also evaluated the teaching and evaluation practices used for physician-patient communication skills. The results showed that less than 50% of the programs provided any formal teaching on HL. The study suggested that HL is not consistently being addressed in the core residency curricula of community-based internal residency programs.

In order for professional organisations to improve patient outcomes, HL must be addressed as part of each clinical encounter (Yin et al., 2015). Healthcare providers need to have better training if they are to understand and effectively address patients' HL skills. This can be done through clear communication techniques (Yin et al., 2015). However, research has focused more on factors pertaining to patients than that of HCPs (Coleman, 2011). HL principles are relevant during every clinical encounter and in every public health communication (Coleman, 2017). For example, in the study of Castro et al. (2007), they showed that clinicians often use medical jargon during patient encounters. This can affect how information is communicated to patients and therefore can impact their compliance (Coleman, 2017). In the study of Al Sayah and Williams (2012), they noted that HCPs tend to overestimate patients' HL since health professionals have become accustomed to the medical field and medical jargons. They conjectured that some patients who have inadequate HL skills often deny or do not disclose the

deficit. Egbert and Nanna (2009) echoed the same conclusion, stating that many patients may be in denial as to their limitations in reading and understand health information. Additionally, the authors added that while other patients may acknowledge their HL limitations, they try very hard to hide them to avoid embarrassment.

Various studies involving HCPs have shown that health professionals do not feel equipped to adequately support women with perinatal mental health issues (Harsha & Acharya, 2019; Lau et al., 2015; Noonan et al., 2019; Ransing et al., 2020). Noonan et al. (2019) attributes this feeling of inadequacy to the fact that HCPs are required to develop a diverse range of skills to meet multiple client health needs making it difficult to focus on specific skills. Furthermore, Ransing et al. study (2020) highlighted that HCPs in their study had misconceptions on mental health disorders. For example, 71.52% of nursing practitioners in the study believed that perinatal depression is a normal part of pregnancy. The researchers conjectured that if HCPs are misinformed that depression is normal during pregnancy or depressed perinatal women are weak-willed, these women might not be referred to appropriate mental health services. The researchers recommended that health professionals should be adequately trained on perinatal mental health disorders so that proper screening and assessment can be done and effective health education can be provided. Similarly, Noonan et al. (2019) recommended that training be required to recognize and respond to different cultural manifestations of perinatal psychological distress to ensure equity of perinatal mental health services.

Health Literacy and Immigrants. The growing immigrant population is considered as part of the contributing factors to the low HL national profile in Canada (Canadian Council on Learning, 2008). The council also found that daily reading habits, educational attainment, parental education, concordance between respondent's mother tongue and place of birth were the

most important predictors of HL (Canadian Council on Learning, 2008). Moreover, in the same report, the council reported that 60% of immigrants fall below the literary competency level required for coping with daily life demands. This appears to be a trend in developed countries since surveys yield similar results, with immigrants scoring poorly in HL as compared to their native-born counterparts (Omariba & Ng, 2013; Simich, 2009; Yu & Mishra, 2019). The trend illustrates that recent immigrants have less knowledge of the healthcare delivery and are therefore less capable of advocating for their own health (Yu & Mishra, 2019). Consequently, this would make understanding health information a challenge, especially with having to accommodate different cultural views health and illness (Yu & Mishra, 2019).

Sentell and Braun (2012) studied the HL and English proficiency of Chinese, Vietnamese, Korean, Caucasians, and Latinos. They reported a prevalence of low HL among immigrants with limited English proficiency and their cultural health beliefs. Additionally, those who had both limited HL and limited English proficiency were more likely to have poorer health outcomes. A study undertaken by Shaw et al. (2009) showed that cultural beliefs also shape HL. They examined cultural influences on HL, cancer screening, and chronic disease morbidity. Their findings reveal immigrants' cultural beliefs can affect how they understand and behave in response to their care providers' instructions. They explained further that lower HL may hamper the doctor-patient communication and lead to poor chronic disease management. Finally, since cultural beliefs around health and illness are an integral part of a patient's ability to respond on his or her care plan, Shaw et al. (2009) asserted that HL interventions that fail to consider cultural beliefs are unlikely to succeed in improving HL levels of patients from non-Western cultures.

Durbin et al. (2015) conducted a matched population-based study to assess the likelihood of primary care, psychiatric care, and hospital care by immigrants. They reported that immigrants were less likely to access primary mental healthcare compared to their native-born counterparts. Additionally, in the study of Coleman et al. (2017), they reported that physicians have cited difficulty in communicating ideas of risky behaviour to some immigrants. For example, some cultures prefer traditional or alternative medicines to treat diseases rather than evidence-based treatments. These differences in cultural perception of health contributes to both low HL and rapid decline in new immigrant health (Yu & Mishra, 2019).

Zanchetta and Poureslami (2006) examined HL in the context of culture and linguistic diversity with new immigrants. They contended that the understanding of HL may be more complex for immigrants as literacy in Canada presumes knowledge of at least one of the two official Canadian languages. An immigrant may be highly educated in their home country yet labelled as illiterate when faced with communicating in one of the official languages in Canada. Moreover, the researchers reported that several factors such as health literacy rate, educational attainment, language, culture, beliefs, and implicit racial bias influenced immigrants' access to health services and immigrant women's health outcomes.

Critical health literacy, an emerging but underdeveloped domain of HL, is seen as empowerment of the people (Sykes et al., 2013). It is suggested that being critically health literate may mean acting individually or collectively to improve health through the political system or membership of social movements (Sykes et al., 2013). They added that critical HL is potentially a higher order process that could be developed through education to critically appraise information of relevance to health. Moreover, with its focus on community capacity to act on socioeconomic determinants of health, critical HL is suggestive of community

development (Sykes et al., 2013). Just like community development, critical HL is seen as a process in which citizens become aware of different issues, participate in critical discourse, and become involved in decision making for health. These aspects of HL are relevant to immigrant women and could foster their involvement in their care particularly their mental health as well as their empowerment (Sykes et al., 2013).

Immigrant Women's Mental Health. Immigrant groups make up a rapidly changing multicultural context in Canada, with 21.5% of its population being foreign-born as of 2020 (Statista, 2021). This percentage is projected to grow to at least 25% of the population by 2031. Additionally, in the past two decades, the proportion of women migrating from source countries such as the Philippines, India, Iran, Nigeria, Iraq, Columbia, and Eritrea has doubled (Statistics Canada, 2016). This signifies that a growing number of women coming into Canada are within prime childbearing age and fleeing stressful circumstances, such as chronic poverty (Gannan et al., 2020; Khanlou et al., 2016). These changing patterns of migration have implications for both the planning and the delivery of maternal health services, as well as programs that promote immigrant women's mental health (Khanlou et al., 2016).

Immigrant women often experience a disproportionate share of mental health issues (MacDonnell et al., 2017). This can occur despite arriving in good health and with considerable social resources (Khanlou et al., 2016). Additionally, immigrant women find themselves simultaneously experiencing a new environment, being unfamiliar with societal norms, and lacking the necessary social networks and as a result vulnerable to mental health problems (Urindwanayo, 2018). Likewise, gender bias and gender-specific risks also contribute to the disparities in women's mental health (O'Mahony et al., 2012). For example, women may be prone to the stresses of childcare, isolation, and biological changes that occur perinatally

(Ganann et al., 2020). MacDonnell et al. (2017) posited that diverse immigrant women often face several barriers to health including social isolation, unpaid and risky work, discrimination, altered family dynamics, and limited access to health services.

Miszkurka et al. (2012) reported that antenatal prevalence of depression was 32% among immigrant women. Moreover, immigrant women often experience a disproportionate share of mental health concerns and mental illness linked to social determinants of health (Chowdhury, 2017). Moreover, in the study by Vigod et al. (2016), they concluded that the reasons for observed higher rates of mental disorders among immigrant women were related to social risk factors, including low income, unemployment, intimate partner violence, and poor social support networks.

Cultural Factors. There are various pathways that cultural identities can shape immigrant women's responses to mental health and illness (Delara, 2016). Firstly, culture can influence immigrant women's perceptions and interpretations of symptoms, help-seeking behaviour, decision-making, and coping style and communication with health providers (Delara, 2016). Consequently, immigrant women's access to the health care system is also affected. Secondly, culture can determine the stigma immigrant women attach to mental illness (Delara, 2016; O'Mahony & Donnelly, 2007). O'Mahony and Donnelly's (2007) study showed that immigrant women dealing with a mental disorder meant denying and not accepting their illness, as well as concealing the disorder. Thirdly, culture may prescribe appropriate norms for behaviours associated with gender role (O'Mahony et al., 2012). For example, O'Mahony and Donnelly (2012) asserted that gender hierarchies in a familial context may play out as unequal power relationships affecting decision-making power between the partners. Additionally, the

literature suggests that language barrier affects immigrants' access to healthcare services (Baumeister et al., 2021; Hawkins et al., 2021).

In a systematic review conducted by Suphanchaimat et al. (2015), they showed that language and cultural challenges, along with a lack of knowledge on the host country's healthcare system critically impeded effective provider-client communication. Moreover, citing patriarchal norms of many Non-western cultures as the reason, HCPs had difficulties in providing holistic care to women (Fair et al., 2020). Care decisions are made solely by the male partner. Consequently, HCPs were reluctant to assess beyond the physical symptoms of immigrant women patients, leaving mental health problems such as anxiety, stress, and postnatal depression, unassessed (Suphanchaaimat et al., 2015).

Campbell et al. (2014) compared health care access between permanent residents, undocumented immigrants, and refugee claimants in Toronto. They found that all the participants found language as a major obstacle to seeking health care. Furthermore, they posited that language barriers were also linked to fear because of their inability to communicate with their HCP. Likewise, Hennebry et al. (2016) reported that about 75% of the study participants believed that not knowing the English language was detrimental to their health. The researchers added that the participants were forced to rely on interpreters to translate their health needs, especially with personal or sensitive health problems. This finding is similar to the study of O'Mahony and Clark (2018) which suggested that having a family member act in the role of the interpreter may be a cultural risk for women due to the stigma attached to mental and reproductive health. This stigma around mental illness, according to O'Mahony and Clark (2018), may hinder immigrant women from accessing mainstream mental health services.

Further, gender preferences in care providers resulted in challenges with care provision (Lyberg et al., 2012). The researchers explained that male interpreters do not understand the maternal health needs of women. As such, translation issues occur and distrust from women in disclosing their needs arise. Similarly, Mengesha et al., (2017) highlighted that some immigrant women refuse to share information with male interpreters. Correspondingly, male interpreters can also be uncomfortable and reluctant to interpret information regarding female reproductive issues. Moreover, Turin et al. (2020) underscored that the Bangaladeshi-Canadian women in their study also expressed their preference for a female doctor due to privacy and modesty concerns with exposing themselves to a male provider.

Social Factors. Social networks and connections have powerful effects on immigrant women's mental health (Hawkins et al., 2021; Iliadou et al., 2019; O'Mahony & Donnelly, 2012). Social support refers to the cognitive appraisal of being connected to others and knowing that support is available when needed (Delara, 2016), and this may affect health-related beliefs and behaviours (O'Mahony & Donnelly, 2012). This tangible support network affects mental health through the provision of various types of support, including emotional (e.g., listening, understanding, sharing feelings), informational (e.g., advice, suggestions, directives) and practical/instrumental (e.g., aid, money, labour) (Hawkins et al., 2021). In the context of immigrants, they may be at higher risk for social isolation because they are separated physically and culturally from their support systems (Delara, 2016; O'Mahony & Donnelly, 2007; McMorrow et al., 2017). Immigrant and refugee women recognise the importance of social support; however, they also acknowledge that there are challenges in maintaining it (McMorrow et al., 2017). Though circumstances may differ from person to person, many immigrant women are separated from their families and friends. This is a much-needed support especially during

the perinatal period and settling in a new country (Hawkins et al., 2021). Fellmeth et al. (2017) revealed that one of the most consistent risk factors for perinatal depression among immigrant women is a low level of social support. In the study of O'Mahony et al. (2012), support from family, friends, and the community were found to be salient factors in helping immigrant and refugee women to cope with challenges after childbirth. They further reported that the absence of family members, lack of social relationships, lack of connectedness within the social network, as well as loss of informational and emotional support were challenging for new migrant women. As such, O'Mahony et al. (2012) recommended that information on PPD be extended to family members because they often do not understand the seriousness of PPD or how to support someone who is depressed.

Similarly, in the study of Kim et al., (2017), immigrant women who gave birth shortly after migrating faced more physical and emotional difficulties. This is compounded by the fact that supports normally present in their home country were absent in the host country. Scholars suggest that without these social support networks, pregnant immigrant women are at a higher risk for isolation (O'Mahony & Clark, 2021), loneliness (Lephard & Haith-Cooper, 2016), hopelessness (Fair et al., 2020), and distress (Phillimore, 2016).

A study conducted by Glavin et al. (2016) with perinatal Somali women in Norway revealed that feelings of isolation in their new situation of being pregnant and giving birth in a new country. This is in contrast to Somali women who had family with them during the entire course of their pregnancy who described the help and support they received as very important. The family and friends of these women helped with household chores and gave them a respite by helping in caring for the newborn and other children.

While most immigrant women find relationships from family and friends supportive, this is not always the case. Gannan et al. (2020) have shown that some informal supports contributed to the postpartum depression of immigrant women. They informed that for the immigrant women in their study, the most important relationship and crucial to managing or worsening their PPD symptoms was their partner. How their partners show support and their ability to communicate with them was pivotal to the management of their mental health issues. Similarly, Mengesha et al. (2017) purported that HCPs found it challenging to provide perinatal and mental care to immigrant women when their partners were not supportive of the treatment.

Access to healthcare. In Canada, the stigma and shame of being labeled mentally ill was identified as one of the barriers to accessing postpartum mental health services (Bodolai et al., 2014). Salami et al. (2015) documented that in some cases, immigrants were deported back to their home country because they had signs and symptoms of mental illness. This policy is seen as a potential barrier for immigrant women to seek help when they have perinatal mental issues. Additionally, health system bureaucracy can serve as barrier for immigrant women from accessing or profiting from existing perinatal services (Urindwanayo, 2018). This includes circumventing multiple bureaucratic structures, filling out numerous paperwork, or searching for a family doctor which may take about a year (Higginbottom et al., 2016). This is similar to the findings of the study of Ganann et al. (2020) with immigrant women describing their struggles in navigating health services. They expressed difficulties to establish contact with HCPs by telephone and were uncomfortable with personal questions asked during intake. Lengthy wait times was also reported by the participants to access care providers and limited availability of family doctors.

Several studies have also informed that some immigrant women are not aware of available culturally appropriate services. In the Ontario-based study of Ahmed et al. (2017), they reported that half of immigrant and refugee first-time mothers in their study were not aware of the mental health services available to them. Donnelly et al. (2011) also had similar findings, whereby participants in their study revealed that the lack of professional interpretation services in healthcare disabled most of the participants in benefitting from available mental health counselling services including community-based health programs. Further, the immigrant women in the study called for professional interpretation services to ensure confidentiality. The women perceived confidentiality to be of utmost importance as they feared that their partners would use their mental health problems to exert more control and power over them.

O'Mahony et al. (2012) also related that immigrant and refugee women in their study were unfamiliar with, and unaware of available services in the community that could help them cope with their PPD. They also felt that healthcare services offered in their host country is different from their country of origin, which made it difficult for them to access mental health services available. This is in-keeping with the study of Mangesha et al. (2017) that showed immigrant women's experiences in their home country influenced uptake of health services in the host country. For example, some immigrant women did not have health promotion in their country of origin. As a result, the women did not think some perinatal services were important.

Significance of the Study

As health communication requires reciprocity, provider-patient interactions play an important role in care (Macabasco-O'Connell et al., 2011). Patients with low HL face challenges understanding the explanations of their conditions and their treatment options (Coleman et al., 2017). This breakdown in communication contributes to poorer health outcomes (Coleman et al.,

2017; Mackert et al., 2011). When HCPs think of HL in narrow terms of verbal skills during their interactions with immigrants, the social and cultural context of communication is neglected, and the meanings of important messages are lost (Simich, 2009). Despite the growing interest in HL, little research has been done around healthcare providers' health literacy skills in communicating with immigrant women, particularly regarding their mental health during the perinatal period. Additionally, the contextual factors that affect immigrant women's engagement and health literacy have not been fully explored. This study can inform the literature on how HCPs communicate with and negotiate the mental health needs of immigrant women during the perinatal period. Moreover, this study can provide deeper insights on the various contextual factors that affect their engagement and utilization of mental health services through the lens of healthcare providers.

Chapter III: Methodology

A qualitative approach was used to answer the research questions that form the purpose of the study. Critical qualitative research method emphasizes holistic human experience and its relationship to power and truth. From a health perspective, a critical approach offers opportunities to closely examine health challenges from the point of view of those who experience them on a daily basis (Harrowing et al., 2010). Scholars suggest that the method be congruent between the researcher's worldview and the research questions (Bradshaw et al., 2017; Wood & Haber, 2005). My worldview is acknowledging that reality is socially and culturally constructed and linked to wider power relations which privileges some, and disadvantages others. This perspective directed me to uncover the HCPs encounters with immigrant perinatal women to address their mental health needs.

Furthermore, engaging in critical ethnography requires engagement with one's positionality wherein one's vulnerability should be acknowledged, valued, and voiced. According to Deutsch (2004), highlighting positionality is key to recognizing the limits of objectivity. Positionality allows me to understand what frames my research choices; I am both a healthcare provider and an international student in Canada who can relate to the experiences of HCPs as well as newcomers. I acknowledge that this duality puts me in a unique position as it poses a challenge with the multiple complexities of insider-outsider position (Chaudry, 1997). I am navigating multiple positionalities; as an insider through my healthcare background and as an outsider through my current immigration status in Canada. As an HCP, I had to be mindful of my past experiences as a health professional who has negotiated the health needs of people from marginalized sectors in my country. As an international student, I needed to be mindful of my

line of questioning so as not to elicit answers the research participants think I would like to obtain.

Representation is seen as an important construct to address in critical ethnographic research (Chaudry, 1997). Therefore, in my construction and representation of the participants' voices, I played close and systematic attention to the complex relations between my analysis and the voices that I intended to represent. I was aware that meaning would be constructed through representation of my research which includes representing the HCPs practices, experiences, views, and values placed on data. Further, I was cognizant that my positionality as researcher would influence discourse, shape the dynamics of the HCP and immigrant women, and could affect the way in which knowledge is presented. Madison (2005) informs that social positionality is a form of ethical accountability and a moral responsibility. For me to justly represent and value the narratives of the HCPs, I maintained reflexivity as my own circumstances, experiences, cultural background, beliefs, and values influence the research process.

In-depth interviews were used to gain insightful data on HCPs experiences with immigrant perinatal women. Rich data was obtained by asking the participants certain questions concerning how they assess for and communicate the perinatal mental health needs of immigrant women. Exploring a variety of factors that influence the immigrant perinatal women's engagement with the participants brought to light the social, cultural, and structural influences that affect health service utilization. Throughout the collection and analysis of data, the study's theoretical underpinnings served as the guide to understand and describe the rich data and the context in which immigrant perinatal women exist.

Theoretical Framework

Recognizing the moral necessity to achieve health equity for everyone, healthcare professionals, public health workers, researchers, and community advocates have begun to explore and promote new and more integrated programs (Baron et al., 2014). The social ecological framework lends itself to the understanding of health within broader social and societal contexts (McCormack et al., 2017). The framework considers the interactions of health determinants within different contexts including individual, social, community-based, and broader societal aspects (Baron et al., 2014; Mccormack et al., 2017).

The proponent of the social ecological framework (SEF) for social sciences focuses on the assumption that individuals are influenced by interlocking external factors related to the physical and social environments (Brofenbrenner, 1977; Brofenbrenner, 2005). Building on the work of Brofenbrenner (1977), McLeroy et al. (1988) offered five levels of influence specific to health behaviour, namely, intrapersonal, interpersonal, organisational, community, and public policy. Socioecological models not only assume that multiple levels of influence exist but also that these levels are interactive (Golden et al., 2012). As such, the SEF proposes that individual-level behaviuor is formed by interactions between and among multiple environmental factors (Roder, 2018).

The adaptation of SEF in framing this research is significant as it has been widely acknowledged that using a multilevel approach in preventing and addressing adverse health outcomes is crucial (Hawkins et al., 2021). The SEF recognizes the importance of social, environmental, and biological factors that may foster or inhibit individual attitudes and behaviours (Hong et al., 2015). In the context of health literacy of HCPs, the SEF serves as a framework to identify, organize, systematize, and analyze their interaction with immigrant

women during the perinatal period. Additionally, the SEF concerns itself with the different contextual factors that impact HL and immigrant women's engagement (See Appendix F).

Levels of the Socioecological Framework

Intrapersonal. The intrapersonal level encompasses the immigrant women's knowledge, awareness, attitudes, beliefs, and perceptions. These attributes are influenced by immigrant women's physical and social environments. As well, the intrapersonal level includes immigrant women's demographic factors such as socio-economic standing, gender, age, and personal history, and lack of knowledge and understanding about mental health diseases as well as the stigma associated with mental illness (Higginbottom et al., 2012). For example, the perinatal experience may act as a trigger for women to recall previous traumatic events (Urindwanayo, 2018). Specific factors on the intrapersonal level concerning immigrant populations were identified in the literature. Pre- and during migration stressors included economic factors back in the country of origin and rigid migration process. Post migration stressors mentioned were acculturation factors as well as a lack of knowledge about available mental health care services (Salami et al., 2018; Thomson et al., 2015; Wohler & Dantas, 2017). In this study, the immigrant woman is situated at the center of all levels in the framework to exemplify her interaction with her surroundings such as family, support groups, HCPs, community, and the healthcare system.

Interpersonal. At the interpersonal level, social networks, both formal and informal, have a powerful effect on mental health of immigrant women and health service utilization (Delara, 2016). Support networks provide important social resources and support, including informational, instrumental, and practical supports. These networks are important mediators of life stressors and components of overall wellbeing (McLeroy et al., 1988). Thus, social relationships are influential in informing health and health-seeking behaviour.

In addition, provider-client relationship inherently informs utilization of health services (Sword, 1999). Numerous studies have shown the critical importance of a healthy relationship between providers and clients (Fair et al., 2020; Hawkins et al., 2021; O'Mahony & Donnelly, 2012) and how these relationships had been instrumental in facilitating access to mental health services and recovery of mental health illnesses among immigrant women (Ganann et al., 2020).

Organisational. The organisational level focuses on environmental determinants of behaviour and how organisational characteristics inform patient engagement and health services utilization (McLeroy et al., 1988). Specifically, this level looks at how formal and informal rules and regulations may promote or endanger mental health engagement and services utilization on an organisational level (McLeroy et al., 1988; Roder, 2018). It was postulated by McLeroy et al. (1988) that organisational settings, structures, protocols, and processes can substantially influence service utilization.

Structural barriers immigrant women encounter comprises lack of confidentiality, lack of professional and culturally sensitive interpretation as well as translation services, disintegrated services, and lack of suitable culturally sensitive and skilled personnel who outfit immigrant women's needs (Delara, 2016; Ganann et al., 2020; O'Mahony et al., 2012; Thomson et al., 2015). Likewise, healthcare systems or structures can create unequal access to mental health services among immigrants (McCormack et al., 2017). Health system structures can restrict immigrant women from receiving information and accessing existing perinatal services (Urindwanayo, 2018). For example, immigrant women may have to cross multiple bureaucratic obstacles, fill numerous paperwork, and search for a family doctor, and may take excessive amounts of time in some cases (Higginbottom et al., 2016).

Community. At the community level, community is defined as face-to-face primary groups to which individuals belong or relationships within a defined geographical or political area (McLeroy

et al., 1988). This level focuses on how various factors such as shared identities, cultural values, norms, and gender-related norms influence engagement between HCPs and patients. As such, community is viewed as a mediating structure that transmits certain values and norms to individuals which inform engagement (McLeroy et al., 1988). In mental health care provision, the most common community level factor shaping access is the stigma associated with mental illness among refugee and immigrant populations (Salami et al., 2018; Thomson et al., 2015; Wohler & Dantas, 2017). These cultural and societal beliefs and attitudes around mental health also shape help-seeking behaviour and therefore may adversely affect access to mental health care services (Salami et al., 2018).

Policy. The policy level is the use of regulatory policies, procedures, and laws to protect the mental health of the community (McLeroy et al., 1988). Such policies and procedures also regulate mental health care access for immigrants and may promote or prohibit access through eligibility criteria and entitlements according to national law and provisions. Additionally, national policies, laws and regulations also feed down into other layers of the SEF, such as local ordinances, spending allocations, education, and work experience of HCPs (Roder, 2018). Therefore, educational and social policies determine the utilization of mental health services as they can encourage or inhibit access to mental healthcare services through social and cultural norms (Roder, 2018).

The structure and complexity of the healthcare system may also affect access to mental health services, particularly for newcomers. For example, Ganann et al. (2020) have highlighted immigrant perinatal women's concerns with the three-month delay in eligibility for provincial health insurance. It is suggested that health services and systems also placed significant health literacy demands on patients through various factors including the design of these services and health systems, operational activities, and built environment (Lambert et al., 2014). Thus, health

systems are called to support HCPs in building clients' health literacy by promoting effective provider-client communication (Koh et al., 2013).

Critical Ethnography

Ethnography is a qualitative approach in which the researcher explores aspects and meanings of a group's culture, including values, behaviours, and beliefs (Harrowing et al., 2010). Critical ethnography is used to describe cultures or groups and to uncover social, political and economic factors, such as oppression, conflict, struggle, power, and praxis (Schwandt, 1997, p. 22). Critical ethnography differs from traditional ethnography in that it seeks to connect the behaviours, meanings, practices, and perspectives of cultural groups to socio-political and historical contexts (Parissopoulos, 2014). Rather than focusing on creating a description of the "other", critical ethnography focuses on the development of a dialogical relationship between the researcher and participants with the ultimate goal of social transformation (Schwandt, 1997). Moreover, this approach may expose social norms and representations which are oppressive and constrain a person's health and quality of life (Schwandt, 1997). Parissopoulos (2014) asserted that critical ethnography provides a "forum" in which HCPs can work together in order to understand and mentally restructure their clinical practice. He furthers a critical ethnographic approach bares numerous contextual factors that stems from an HCP's subjectivity.

Generally, critical ethnographers start by building an etic-outsider perspective to promote strong reflexivity and establish positionality of the researcher (Hardcastle et al., 2006). This often involves discrete observation of participants and reflection on the information gathered. However, restrictions imposed in light of the COVID-19 pandemic, interviews were conducted through Zoom Meetings. This limited my time in the field with participants. However, an integral part of the critical ethnographic process is critical reflection (Parissopoulos, 2014).

Reflexivity involves being self-aware about the one's beliefs and the influence of the study on the participants, and decisions on collecting, analysing and interpreting the data (Harrowing et al., 2010). Reflection shows how data was constructed, as well as allowing researchers to maintain the balance between being the analyst of data and being an advocate (Reimer-Kirkham & Anderson, 2010). Moreover, as with bias, emotional attachment to research participants also influences how the researcher presents the study's findings (Reimer-Kirkham & Anderson, 2010). My etic perspective was built through engaging in critical reflection after each interview by journaling.

The study adopted a qualitative critical ethnographic approach to critically analyze how healthcare providers negotiate the mental health needs of immigrant women in the perinatal period. The same approach was also used to investigate the social, cultural, and structural factors that impact health literacy and engagement of immigrant women. Moreover, the impacts of the pandemic on immigrant perinatal women's mental health and their access to health services was also investigated.

Setting

The study was conducted during the COVID-19 pandemic. Eight interviews were performed virtually through Zoom Meetings, a video teleconferencing software program. The participants included healthcare providers employed in the Interior region of BC, including Kamloops, Salmon Arm, Vernon, and Kelowna.

Study Participants

Eight participants were interviewed to gain insight about HCPs health literacy and immigrant women's mental health during the perinatal period. Several healthcare disciplines were included to have a better grasp on how HCPs negotiate the needs of immigrant perinatal

women. Participants were all female, including seven Caucasians and one Hispanic participant. The rationale for using eight health care providers was based on the supervisory committee recommendations due to time and financial restraints of a Master's thesis. The decision to interview eight healthcare providers was not to obtain data saturation, but to gain better understanding and insight on HCPs health literacy and immigrant perinatal women's mental health needs. Participant profile follows:

Pseudonym	Area of Practice	Years of Experience
1	Community Health outreach & counselling	>20 years
2	Community Outreach Worker	>20 years
3	Public Health Nurse	8 years
4	Immigration family counsellor	15 years
5	Community Health outreach & counselling	14 years
6	Community Health outreach & counselling	8 years
7	Family Support Consultant	8 years
8	Family Support Consultant	3 years

Entry into Site

With the aid of the research advisor, Dr. Joyce O'Mahony, email invitations to join the study with the information letter attached were sent to key informants from various health organisations within Interior B.C. Those who were interested were invited to send me an e-mail. In turn, I was able to screen for eligibility.

Criteria for Selection of Participants

The purposive sample consisted of eight healthcare providers that met the inclusion criteria of: a) English speaking; b) Healthcare provider (psychiatrist, psychologist, midwife, registered nurse, social worker, counsellor, community outreach) working in direct contact with

immigrant women in the perinatal period, and mental health issues in the community; c) Two years working experience or more.

Participants were selected carefully as the aim was to gain a rich perspective into the health literacy of HCPs and immigrant perinatal women's mental health needs. Participants had one semi-structured interview lasting 45-60 minutes. Purposive sampling was done and through conversations with key informants, chain referral sampling was also utilized resulting in a variety of HCPs.

Ethical Considerations

Critical ethnographic interviews examine comprehensive and in-depth information (Thomas, 1993). As such, there may be sensitive details the participants would divulge that may compromise their privacy. To protect the participants' privacy, specific measures were taken to ensure their safety and that their rights are upheld (Polit & Beck, 2017). This study was reviewed and approved by the Thompson Rivers University Research Ethics Board (REB) (See Appendix E). Recruitment of participants commenced only after approval to conduct the study was received. All interested participants were sent an information letter describing the study. An informed consent was also obtained from all participants. Participants were duly informed of the procedure, risks, and benefits, including their right to withdraw anytime during the course of the study. To protect the confidentiality of the participants, cases were assigned codes and the codes linked to the participants were stored and locked in a secure environment. Moreover, data such as transcripts and codebooks were encrypted and password protected. The interview recordings will be destroyed five years after the completion of this study.

Data Collection

Data collection occurred over a period of two months. In-depth semi-structured interviews of about 45-60 minutes were used in this study. Open-ended questions (See Appendix A) were used to encourage participants to explain their perspectives in their own words (Creswell & Creswell, 2018).

Trustworthiness

Credibility, according to Carspecken (1996), can be achieved via triangulation. Triangulation was used in the study to increase the credibility of the research findings. This required collection of sources of data (e.g. interviews and questionnaires). Additionally, I employed persistent observation of data, which meant constantly checking and rechecking the data while codes were generated. This process is crucial in avoiding "cognitive leaps" (Morse, 2000) and for improving the researchers' depth of insight (Korstjens & Moser, 2018). In addition to this, I sought to clarify responses which were unclear. Rephrasing questions was also done to ensure that the questions were understood.

Data contained in interview transcripts and final themes was recorded in my notes and softcopy versions of the codebook. These set of notes formed an audit trail which was used to evaluate the dependability and confirmability of the research findings (Korstjens & Moser, 2018). Dependability includes the aspect of consistency of the research over time while confirmability is concerned with the aspect of neutrality (Lincoln & Guba, 1985). To ensure transferability of research findings, a thick description of participants and the research process was provided (Korstjens & Moser, 2018). Moreover, broad social, cultural, and political factors that may have influenced their behaviours and experiences are also considered (Korstjens & Moser, 2018) and discussed in subsequent chapters.

Reflexivity in this research was achieved by using reflexive journals and interview notes to clarify feelings and intentions and to be aware of personal biases and prejudices. As an example, reflexive journaling helped me separate my personal biases being an HCP in my home country and an international student in Canada myself. There were times when I found it a challenge to separate my experiences as an HCP in my home country to that of the participants. It was revealed in this field note:

> Perhaps it is easier for them to be compassionate to "others" because they are valued and respected by the system. They are paid well, recognized, and given full benefits. HCPs in my country are severely underpaid, undervalued, underappreciated, overworked. They only see HCPs as mere dispensable units who only want to work abroad. Maybe it's easier to extend your patience with someone who doesn't speak their language because that is what's required of them. Or… maybe they just understand the power dynamics and just genuinely want to provide the best quality care. Does being underpaid, undervalued, overworked excuse a professional whose profession is tied to caring be uncompassionate and impatient?...

This note has made me aware of my feelings of helplessness towards the current situation of HCPs in my home country which may affect the tone of my questioning with subsequent participants. This allowed me to be more self-aware during the next interviews.

Data Analysis

The process of data analysis and data collection occurred concurrently. Braun and Clark's (2006) outline guided this study's data analysis. Braun and Clark (2006) asserted that analysis is not a linear process of moving from one step to the next. Instead, it is one that is recursive where

movement can go back and forth throughout the phases. Data analysis involved multiple steps: (1) The first step involved transcribing in verbatim the taped interviews as soon as possible following the interview. Transcripts were rechecked against the audiotapes and corrected to ensure data accuracy. (2) The next step involved coding the transcripts so that preliminary patterns and themes emerging from the data could be visualized. Furthermore, a list of code categories was formulated for organizing incoming data which was then encoded in a Microsoft Word document. This document became the study codebook. (3) The third step saw several coded data in one category to be relevant to other code categories. This analysis produced a set of interrelated themes and concepts. I employed a process involving a systematic and rigorous formulation of code categories and subcategories which was flexible and evolving. In this stage, I had regular consultations with my supervisor to discuss, review, and share reflections on the data gathered during the interview, and the quality of analytic descriptions. Themes and subthemes were continually refined. (4) To ensure that all data was accounted for and coded accordingly, transcripts were re-read. Data found was then added to identified themes and subthemes. I clustered the identified themes and subthemes around the research questions. (5) The final step involved comparing the themes, subthemes, and concepts within and across transcripts in the data set. This process also involved frequent review with my research supervisor. During this process, linkages were made between the coded data and the different contextual factors identified in the literature. The themes generated a higher level of data conceptualization and broader theoretical formulations.

The dominant themes that emerged from data analysis were healthcare provider role and health literacy, health literacy determinants of immigrant women's mental health, and impacts of the COVID-19 pandemic. Data revealed the HCPs health literacy in negotiating the mental

health needs of immigrant perinatal women, the contextual factors affecting immigrant women's HL, and the impact of the COVID-19 pandemic on immigrant women's mental health and their access to health services. In the subsequent chapters, the findings are presented in-depth with discussion of each theme.

Chapter IV: Findings and Discussion:

Healthcare Provider Role & Health Literacy

This chapter presents the findings regarding the role of the HCP's in improving the health literacy of immigrant mothers during the perinatal period. The role healthcare providers play in building or limiting patients' health literacy has been emphasized in the literature (Budhathoki et al., 2019; Chang et al., 2017; Lambert et al., 2014); a role which is most relevant in the areas of communication and delivery of health information (Coleman et al., 2017). The need to build and enhance trust, comfort, and communication highlights the two-way nature of HL as a social enterprise and a vehicle to assist in disintegrating structural and cultural barriers (Cornett, 2009; Simich, 2009). Moreover, assessment of the client's mental health status is identified as one of the primary roles of HCPs (Anderson et al., 2020; Iliadou, 2020), a vital function that requires both professional standards and provider creativity. Further, to ensure that health information is delivered effectively, HCPs are called to utilise health literacy practices (Schillinger, 2020). Finally, the role of the HCP as a collaborator of mental health services, support, and resources is pivotal in bolstering the health literacy of immigrant women. These roles of the HCP as identified by the participants were the following: (a) building trust through relationships, (b) assessment of mental health needs, (c) delivery of health information, and (d) the HCP's collective impacts on immigrant women's mental health.

Building Trust through Relationships

Client-centered approach. In communicating with immigrant women, the participants emphasized the importance of ensuring that the clients are receiving the care and information they want and need. Participant 2 stated:

> Every visit, the clients choose what information they want for the next visit, so it's client centered. So, for each visit the nurse brings a couple of topics that are part of the program and then the client picks what she wants to work on.

Additionally, the participants encouraged immigrant women clients to lead conversations, which enabled the women to talk about their experiences and exploring their feelings. Participant 1 stated:

> I've just started with another woman, dad's from Ireland and like huge trauma for mum and the first time kind of, um, opening up and so we're, we just said we'll just take it as slow as this needs to go and your body and you, can tell me when you've had enough and so we're just starting with slow things, you know. Inviting them to come to the group online, which they do with their little girl. And so, the next thing we said, well, how about do you guys have other recreation stuff, well we like swimming, awesome, okay, well let's get you signed up for a pass at the pool then and you can take her and we'll go over and do the forms together and, and little by little she shared a little bit more.

Participant 6 also added:

> …letting them guide the conversation and moving the conversation to where they are comfortable and circling back, uh, if we need to, because they can be crying. "I miss my mom" and "I miss that". So, you know, that's the conversation you have to go to in order for them to be open to hear anything about why you're calling.

Moreover, the participants purported that as HCPs, they need to be cognizant of their clients' pace in terms of opening about mental health. This includes checking if the rest of the care team are operating at the client's pace of understanding. Participant 7 stated:

> It's very difficult for them to recognize or accept that there may be some mental health concerns going on. Um, yeah, so we kind of dance or we're dancing around, like we kind of, we have to go gently - we sometimes have to go slow. And as a family support consultant, I often have to remind the therapists because they are very clinical. And so, yeah, it's always it's always trying to find that, yes, we, we recognize that mom is really struggling, but they're not there yet. And so, it's, as professionals, we, we have to remember to step back and wait for the mother.

In addition to encouraging the client to operate at their own pace, safety and confidentiality are emphasized to build trust. Participant 1 shared:

> They dictate kind of the pace. And, um, other safety, you know, we, we always, um, there's consent for release forms like explaining about, you know, I don't share what we've spoken about unless you give me specific consent to speak so we would sign a consent form or checking in to say, okay, you know, you mentioned that you worked with [name] at Immigrant Services, would it be alright if I touch base with her and I can see how much she's done… you'll be able to access the literacy, the language classes. . .

Though the participants recognise that they are health specialists, as HCPs they acknowledge that there needs to be balance and clients should be considered experts to their own mental health experiences. Participant 5 explained:

> …it's their own situation, and trying to draw that out, and how it is impacting them and understanding how this is for them. Like, these are the norm - these are what we would think like, I know what I would expect to see in a person with postpartum depression. So being aware of that, but then watching for that, and then asking some delicate questions carefully, caring for the client, after I built trust, where they might be willing to share something about that, and then building on that and expanding on that.

Establishing rapport/attending to immediate needs. Immigrant women do not proactively seek mental health consultations or services (Ahmed et al., 2017; O'Mahony & Clark, 2018). As such, HCP encounters with immigrant mothers are usually initially medical in nature. To establish rapport and foster trust, the participants purported that attending to their immigrant women clients' immediate concerns is important as this paves way for them to participate in dialogue about their mental health concerns. As Participant 4 stated:

> It's a two-stage process. You have to build trust first, you can't, you know, use the first session to do everything, you know, you do address, what their needs are, why they came to you and then they'll trust… and following up on what they ask me to, you know, to address first… In my experience with our clients and depending on the situation, let's say cultural shock, yes, settling in a new, settling in a new country, you know, is really tough. And [I tell them] so far you've been trying to manage with this too but I see and I notice that, you know, you seem to be having a- how do you feel?

Participant 7 also shared:

> It's like, we asked the client, what is the concern? What would you like to work on? And a lot of times too, if there's, like, you know, like, ten concerns coming at them, or, you know, with them, and it's like, okay, but "what, what is the main one here? What do you what do you want to focus on first? How can we best support you?" And so, we narrow it down to what the family wants.

Participant 8 commented that when immigrant mothers share about their mental health concerns, it happens during follow-up visits. She added that prenatal visits serve as jumping points for other potential health problems such as mental health concerns to arise. She expounded:

> Through a lot of just like, talking a lot of just comfortable chatting in living rooms, is where you get a lot of the— and also them just fully self-reporting that like, yeah, "I might have postpartum depression right now, I'm not sure." So, a lot of it is just being very comfortable and establishing that rapport. And I mean, really, primarily expressing concern for their health. And being - and that being a valuable thing for me to consider that like, I value you being healthy, and I want to do what I can.

Easing into the topic on mental health is one way of establishing rapport for one participant. It was also important to discuss the biological aspect, such as hormonal changes and nutritional needs during pregnancy, before embarking upon the conversation about mental health. Participant 3 stated:

> We kind of ease into things like we don't just start and say, you know, emotionally how are you feeling? We talk about their partner and about, you know, if they're working and then we get into family supports, who do they have around them. So that kind of thing just to kind of build that relationship. And then

based on kind of that information then we can take it into the mental health piece where we start talking about changes that happen with hormones and physically with our body and how that can affect our mood in different ways.

When establishing rapport with clients, it is important to be mindful of the clients' past experiences in connecting with HCPs. Thus, participants revealed that reinforcing to clients they are there to help them with their important concerns. Participant 7 stated:

> Being aware, too, that their experiences with healthcare providers might be, you know, more clinical, and the doctor who just prescribes things and tells them how to do things. This is like, no, we're not that. Let's just sit down here, let's have a conversation, what's working, what's not working, you know, how do you want to move forward and just kind of guiding them that way. And in order for healthcare providers to do that is to really, you know, spend time with them, get, get to know what their needs are. And from there, just build the trust.

Assessment of Mental Health Needs

Standardized checklist/tool. Standardized checklists are one of the tools utilized to assess immigrant women's mental health and well-being. Participant 4 stated:

> We have some checklists available and we also work with Interior Community Services and they also do assessments as to, you know, how are they doing, its called like a well-being check, you know, are you able to get around, how are you feeling today, you know, are you happy, is there anything that can be different on a scale of one to six [laughter] one being very happy, six being very unhappy, you know, what does that number look like?

Participant 8 acknowledged that in their organisation, a focus tool is utilized to assess the well-being of the immigrant mother and her health literacy such as parenting knowledge and skills and her community resource knowledge. They revise the tool from time to time to reflect best practices. She stated:

> So, we have a form in my program, we're editing it right now… So, it gives you a lot of different— it helps you understand where there may or may not be gaps in there, like best practices, parenting, understanding, you know— I mean, the one that we have now, it involves a lot of like, "Are you safe at home?" And like, "do you and your partner practice safe sex?", and those are very vacuous sort of ideas and also very personal...

The use of the Edinburgh Postnatal Depression Scale (EPDS) was also being used to assess client referral to a doctor. Participant 3 stated:

> It would move me to a more formal mental health assessment like an EPDS, that would be the main tool that we use. It's the only one that we would be technically using. I know that there are other resources out there but EPDS would be the assessment tool that we'd be using for mental health.

Interviews. Although the use of standardized tools is viewed an important aspect in mental health assessment, the participants believed the nursing/clinical interviews and conversations with immigrant women were best in the assessment of the immigrant mother's mental health status. Participant 1 stated:

> I would say its more talking, um, hearing stories, getting anecdotal information, um, talking and just saying, you know, these are some of the things that we may see from someone who is experiencing depression, even if I suspect possible

> anxiety, I would you say that that's something that, um, so really I, yeah, I would just say more by meeting and through the conversation or that kind of thing.

Participants also shared that they go by their nursing judgment and draw from their experiences with provider-patient interactions to assess if their client has mental health needs. Participant 5 stated:

> I guess it would be my experience because I've done this work for so long that I would already know if I was concerned about a client just based on the interactions that I'm having with them. And that starts from the first minute of my conversation. "How are you today?" "How are things for you?" "Can you tell me about that?" And it really would depend on what type of reactions and responses that I'm getting back from the client on how I would be maybe a little bit moving to a mental health assessment quicker, maybe, you know, just to determine if that is a factor.

As well, Participant 3 shared, "so we just kind of assess and go by our nursing judgment and how they're feeling…". Participant 6 noted, "and then also identifying— when you hear little things, to go explore that topic a little more if we need to for safety reasons".

Taking of patient history during interviews was also seen as an integral part of assessment. This includes checking if the client has a family physician, previous diagnosis, and medications. Participant 1 expounded:

> If I was working with someone and, and we talked about anxiety and, and, or, or whatever it was, mental health and we, you know, I would ask about do they have a family doctor, is there something that they've talked about at all or shared with a doctor, are they on any medication for it, you know, whatever, so what kinds of

> things they've tried, have they tried other things in the past, have they been successful.

Asking questions that would give the participants an idea on their client's mental health status helps them identify the need for support or referral. Participant 8 stated:

> Just through dialogue, and sort of following up with the client on like, "How are you feeling?" "Are you getting enough sleep?" You know, and if you see those yellow or orange flags regarding poor mental health to ask those hard questions, like, "Are you worried about hurting yourself?"

Participant 7 also noted:

> It's just kind of when meeting and interviewing, kind of getting a sense of what their general mental health is like. Some— in asking what, what is the struggles? Like what, you know, what, what would make things easier for you? What is you know, what's difficult for you?

Similarly, asking open-ended questions while reassuring confidentiality was also identified as an approach during assessment. Participant 1 shared:

> Comments that they might be making about at home or things, you know, that there may be more going on, um, or, or asking open ended questions like is there anything else you think that might be important for me to know? Or is there anything else that you'd like to share, you know, reaffirming the safety, the confidentiality, um, if there, if there is something, you know, like I said if they're, um, seeking postpartum depression.

Engaging in meaningful conversations rather than just asking a series of generic questions was also mentioned to make a difference. Participant 5 shared:

> …then adding those things in more in a conversational style rather than just direct interview. Like, "what about your mental health? What would you say your rate your blah, blah, blah", like, none of that, it's too formal, and you're not going to really get much information. So really making it personalized to their situation.

Becoming active listeners. Active listening is also an essential health literacy practice (Chang et al., 2017). According to Maraj et al. (2018), it is important to give special attention to the immigrant woman's voice and assuring that they are heard, thus, becoming active listeners during encounters with immigrant women is essential. Participant 1 expounded how she becomes an active listener during encounters:

> I would say its more talking, um, hearing stories, getting anecdotal information, um, talking with the patient, you know, and just saying, you know, I am here as a listening voice. I would just say more by meeting and through the conversation.

Understanding that mental health is a topic that not all cultures readily embrace, the participants make certain that conversations did not feel rushed. The participants have articulated that frequently, a warm atmosphere was provided during their encounters with immigrant women. Moreover, making sure that they understand the conversation is important. Participant 1 stated:

> If I don't understand, you know, active listening, rephrasing things so, um, would it be helpful for this or it sounds like this, if I, if I don't understand I'll say, em, you know, I'm not sure I understood can you, can you tell me that again. So making sure but knowing that I'm as many times as it takes for me to repeat something or say a different way or them, you know, and we might be using hand

> signals or whatever that, a sense that we have all the time in the world and I'm, I'm here for you…

The participants also have immigrant women lead the conversation and validating their feelings when talking about mental health. Participant 6 said:

> It's really, uhm, being active listening, open-ended questions, letting them guide the conversation and moving the conversation to where they are comfortable and circling back, uh, if we need to. And sort of really validating feelings, you know, for them.

Clients also stressed the importance of being in the conversation. Participant 6 stated:

> Because sometimes, the conversation can go silent, or they didn't hear what you said, or whatever. And you can really pick up on that. So, it's being mindful in the conversation. In those first couple of lines, they kind of know what we're gonna talk about, that they're free to ask us any questions.

Participant 7, who conducts telehealth consults with her clients, views conscious listening as crucial. She stated, "we have to be very conscious listeners for those subtle cues because we have no facial, uh, cues on to go along on what they're saying". As well, the demeanor of the client during encounters was seen as an indicator of a possible mental health concern. Participant 5 commented:

> If I notice that the mom is very, you know, like, maybe she's very subdued or looking very sad, or looking completely exhausted and just glazed, you know, I'd be doing a further assessmentand have initiated some of those contacts where I might follow up with them. I might create a file that I have for long-term follow-

> up with them because of that, you know, based on that initial assessment and providing of information.

Similarly, the body language and the comments posed was also thought to be an indicator for mental health needs. Participant 1 stated, “You can tell by, well, body posture, uh, and comments that they might be making about at home or things, you know, that there may be more going on”. Participant 4 added:

> When they participate in our program and we’re seeing that there’s a change in behaviour, they notify me. And keeping their confidentiality, I just do a welfare check like, hey, how are you doing, you know, it’s been a while since we talked”.

The participants asserted that most of their immigrant women clients see mental health as taboo. Subsequently, as part of becoming active listeners, they need to be more attentive to nonverbal and subtle cues during encounters even when the clients say they are doing fine. Participant 4 stated, “You know, some clients rather do magic than mental health. They’re scared of mental health. Yeah, they’re always fine, everything is but you can see their behaviour changes, you know, when you’re talking to them…”. This was also echoed by Participant 8 who said, “Yeah, I mean, a lot of what we do it, especially when it comes to mental health stuff, people will say, "Oh, no, I'm fine" and laughing to cover it up, but you can sort of see through that and know that they're like masking things”.

Creative ways of assessment. It has been revealed that many immigrants do not readily and openly talk about their mental health needs during the first few encounters with the participants. In fact, the participants have voiced uncertainty if some immigrant women know about what mental health entails. As the participants assess for nonverbal cues that may indicate the presence of mental health struggles, they also become creative in asking questions to

determine the immigrant woman's mental health status. This is consistent with the health literacy practices posited by Chang et al. (2017). Participant 3 stated:

> I'm not even sure if they really know the details about mental health like, you know, anxiety and depression and, and those kinds of things like postpartum depression like if they're even aware that… That's a thing, yeah, exactly. And then you have to kind of get more, you know, a little, um, creative, I guess, in exploring that like, do you feel sad, do you cry, um, you know, do you feel angry, how are you sleeping, are you eating like all of those things is what helps us to determine…

In some languages, there is often a lack of equivalent terms like depression or psychosis (Harsha &Acharya, 2019). Most participants recognized that there is a need for constant rewording and rephrasing questions and statements surrounding mental health When assessing for mental health needs. Participant 4 stated:

> So, we have to reword it. We're always true to the client, you know, we're not lying to the client, but we have to reword it in, in terms of, you know, assessing for that need. So we can help you have access to a person that you can talk to that can help you find tools so that you can manage your daily life and that you can cope with the situation that you are, you know, be that you are grieving, you lost your baby, you lost a family member and your, you know, you can't seem to get back to the, how you were before that incident happened…

For some of the participants, they would ask the same question in different ways to assess for the client's mental health. Participant 5 stated, "it might take a few more times of asking the same

question in different ways, perhaps to make sure that there is understanding". This was also echoed by Participant 8, who had an encounter with one of her immigrant clients:

> I had one of my clients, it was, you sort of had to ask the same question, like ten different ways to kind of get a full spectrum understanding of what the issue was. And whether that was her individually not understanding, like the difficulty she could have been having with mental health things or the red flags that I may have been seeing. So, you, you kind of had to attack, like read the situation from a lot of different places.

Their assessment also included exploring topics of interest for the immigrant women. Participant 4 stated:

> You have to find what makes, makes them tick, you know, how, what do they care about and approach it in that, in that way be it that, you know, you're not eating, you know, will affect the brain development of the baby.

Delivery of Health Information

Normalizing mental health. Cultural dimensions determine how much stigma immigrant women attach to mental illness (O'Mahony & Clark, 2021). Women generally do not proactively seek help for mental health concerns due to several factors including the stigma attached to mental health illness (Ahmed et al., 2017; O'Mahony & Clark, 2018). Kingston et al. (2015) have suggested that normalization of mental health problems is substantial in reducing barriers that discourage verbalization of mental and emotional concerns. Correspondingly, the participants suggested that likening mental health issues to other physical illnesses help in normalizing mental health. As Participant 4 stated:

> …mental health is like any other health, you know, some people have asthma, some people have diabetes, older people, you know, they suffer from anxiety and, and depression and that is something that can be managed the same way that we manage asthma. It's not going to go away but we have different ways where we can manage the daily life and carry on with our daily activities.

Participant 2 acknowledged that there might be some cultures that are not in favor of having women become independent and discourage speaking about mental health problems. She shared:

> It would be that de-stigmatizing the stigma but it's okay and it's quite common to experience these feelings around childbirth and, and, you know, normalizing some of that and in terms of encouraging them to access services and normalizing those services that are available and that it's without judgment.

Additionally, Participant 6 stated that educating the clients on the hormonal effects during pregnancy helps normalize mental health concerns. She explained:

> …then normalizing for them, uhm, the feelings that they are having. Uh, because it is normal to be up and down and all over the place in this first trimester with increasing hormones and so we always sort of say, "information is your power because it helps if you put the norms to how you might be feeling and understanding when, uh, you need support and when to reach out.

As such, the participants recognize that employing strategies geared towards normalizing mental health is vital. One participant stated, "creating a normal in some of the facts that that might exist, and that of the things that you're trying to assess for that it's very common for women to feel like they're on an emotional roller coaster. In addition, Participant 5 stated that statements such as, "lots of women find that they feel very tired and isolated at home after they come home

with a new baby, how is that for you?" and “have you felt any of those ups and downs?” help in normalizing mental health.

For many of the participants, sharing their personal experience on mental health during their own pregnancies with immigrant women helped normalize reaching out for mental health services. One participant stated:

> I sometimes bring my personal experience with mental health and postpartum in there as well, just to kind of normalize it and let them know that it's okay, you know, this is a moment where we're struggling in life, and it's okay to reach out for support and help. And you don't have to do this alone. And some of the feelings you're experiencing, or your thoughts that you're experiencing, are normal, and it's okay to let others know that you need help getting through this.

Participant 1 echoed the same sentiment when talking about mental health with immigrant women. She stated:

> I might share my own experience with anxiety or share about, you know, a co-worker or someone, yeah, just to really normalize it happens, its very common and one of the great ways to help feel better is by talking about it and, and here’s some of the other things that you can do and then presenting some programs or opportunities that would be helpful.

She then reassures her immigrant women clients that, “it is okay to ask for help and it is okay to talk about mental health”.

For one participant, how HCPs present information is important in normalizing mental health. She stated, “…in a way of trying to present so that its not stigmatizing, you know, that, mood

concerns would be something we commonly see in pregnancy or the postnatal period and it's not her fault".

Interestingly, O'Mahony et al. (2012) have reported that immigrant and refugee women in their study felt when HCPs attempted to normalize their depressive feelings, the seriousness of their condition is downgraded. This discouraged immigrant and refugee women from pursuing mental health help. Moreover, the participants also reported that some HCPs probe too intrusively into their vulnerable situation, which impaired their relationship with the HCP.

This could imply that while the intentions of HCP are pure, hidden power imbalances may still exist.

Using simple terms. Effective oral communication is crucial because it may be the most important method by which health information is obtained (Meares at al., 2020). As such, health education messages must be carefully designed to be effective (Kreps & Sparks, 2008). For Participant 7, she stressed the importance of using simple terms and avoiding medical jargon and making sure that the information is understood when communicating with patients. She shared:

> I let them know that at any time that I'm talking with you, if you're not understanding, please let me know. I also try to rephrase it as simple, simplified as possible. And then often check in, like, "Did you understand that?" Or "is that okay with you?" Just to make sure that I'm just not looking for words, and they're not understanding these words, and it doesn't work anyway.

Participant 5 also added that, "avoiding the use of medical terms, just trying to keep it as basic as possible, and build upon that, depending on what their understanding is, or how much impact that is playing in their life". This was also reiterated by Participant 2, stating: "Um, really like trying to make the information simple and not using lots of medical terminology".

A lot of emphasis was placed on the importance of using simple terminologies in discussing the plan of care and providing other pertinent information. Patient 7 stated:

> We try not to use that big jargon medical terms for all our families… It's just that we really try to simplify the language we use. So, when we provide information like visit records, or strategies, etc., we try to have the language very, very simplified.

In conversations involving immigrant women with challenges in English language proficiency, the participants purported that they need to be careful not to be condescending when using very simple terms. As Participant 6 stated, "…most of the time, there is some English language that they understand so keeping the language very simple sometimes which you don't wanna be demeaning, you know. But in terms of communication, can we keep it simple.

When discussing possible pregnancy complications, the participants make sure that the client has adequate background on a particular health concern. Consequently, if they have determined that there is a potential lack of understanding around the topic, they provide appropriate health education. Participant 6 stated:

> Lots of times the language around everything to do with pregnancy is new language for them and so lots of times you have to bring that wording down to what it means. So, for instance, uhm, we make all moms aware that, you know, twenty-six weeks they go for their routine blood work to check their iron levels before going into the last part of their pregnancy and at that time you'll have a gestational diabetes testing. Now, most people don't know what gestational diabetes testing is, let alone being in an English as a second language. So, we always clarify, you know, do you know what gestational diabetes is… And it's

> really going down to how it works in simple language for them. It's having the opportunity to go that next step to help them understand.

In some languages, there are no specific equivalent translations for mental illnesses (Simich, 2009). Many of the participants acknowledged the different angles of how different cultures view mental health. Thus, using layman's terms in explaining symptoms of mental illnesses such as anxiety attacks help with letting immigrant women understand, especially those who have limited English skills. Participant 1 stated:

> When I get a look… I will rephrase another way or simplify it, like, anxiety is really that, it just means that, um, you have these big feelings about things or big worries about things and sometimes it's stuff that's not even really a danger or a, you know, your mind is telling you this is something to be afraid of or this is something to protect yourself when actually that's not the case.

Providing support and positive reinforcement. Providing an avenue for immigrant women to share everyday life experiences such as celebrating small wins with their immigrant women clients is seen as a valuable way of providing support. Participant 1 stated:

> We had a mum from the Ukraine in the baby group and she said would you guys mind if I just take a minute, I painted my son's room and I can't, there's no-one else I can share it with, you know, and we can't have people into our houses right now, everybody was like, yeah, for sure, that's awesome. So, she could just pan around with her phone and we got to learn that she was a bit of an artist like she painted a whole wall and we were like holy smokes like that's amazing, you know, like just sharing these little parts of their lives…

Many immigrant women are away from their family during the prenatal period. As such, the participants posited that by giving positive reinforcement, they are giving support. Participant 1 stated:

> When a parent, when a baby is born a parent is also born and so just having information and support because so many are away from their family, don't have extended family here, um, just, just getting some reassurance, some positive reinforcement like, wow, what a great idea, you know, and they must have loved that.

Establishing mutual goals and making follow-up appointments is another way the participants provide support. As with the study of Molina-Mula and Gallo-Estrada (2020), they noted that nurses in their study recognized that involving the patient in care decisions yielded better health goals outcomes. Doing so would enable the HCP to monitor the progress of the client and provide positive reinforcement by celebrating goals that are met. Participant 4 stated:

> We go through a plan and we put it in writing and I share with the client and then we agree, okay, we're goanna follow up at this point, I'm goanna contact you or we're goanna meet in two weeks and we're goanna see, you know, have you gone to your appointments and follow up just to see the process, the progress and show the client, hey, you know, a month ago you were at this point. You're two steps, you know… away from your goal.

The participants added that recognizing these progresses and reminding the immigrant client of the same really helps in boosting their confidence. One participant stated:

> I had a meeting with a client today and I had an interpreter and, you know, he was giving the information himself and I was like wow, he came here, you don't have

> to say anything, he's telling me everything in English that is amazing and, you know, there's a lot of acknowledgment and praise because on a day to day basis when you're dealing with your own self you don't notice that progress. Especially, you know, when, when you are depressed or facing looking for a job, you have anxiety, you don't say that so, you know, it's important that other people around you recognize the progress that you have made and remind you that, yeah, you're, you're going forward.

For Participant 2, programs such as baby support groups where immigrant mothers get to connect with other mothers is another way of providing support. She recalled:

> We had one of the mums from India, she's done our infant massage three times, almost every single time so it's five sessions, five weeks… And we said [name] like don't you want to take the time and, and she said this is the only time in the week that I can connect with someone else, my husband works all day, we can't go out and so this is the one hour that I get to connect with other people and so she just, she sits and joins in with her cup of tea and I was like holy cow like even online this connection is so important.

Cultural humility. Migration brings people from different backgrounds together. It is thus essential that explicit attention be given to the cultural dimensions of the health and illness experience (Kirmayer et al., 2011). The participants are cognizant that culture has a major influence on how immigrant women respond to illness, and that as HCPs, they need to be mindful and make an effort to know about the clients' cultural background and beliefs. Participant 5 purported:

> … being curious about how their culture might impact them, like, with Chinese women and being isolated, not being able to have a bath for 30 days, and not being exposed to cold and all those things. Like, not putting them in a situation that's actually going to go against what their culture dictates for them, or how to explore, "Okay, we do need to get you out to the doctor, how can we do that in a way that still acknowledges the importance of your cultural practices? How would this look for you?".

Asking about the immigrant woman's culture was also seen as an integral part of engaging with them. One participant suggests:

> You can ask about their culture, you know, the interest and listen instead of, you know, making assumption, let's say, you know, Ramadan, what does Ramadan look for, for pregnant women, what are you allowed to do, how do you keep healthy, you know, do you have any friends that you have met that have been pregnant and then we provide the information…

The participants also touched on the importance of being humble in dealing with their clients, particularly those of different cultural backgrounds. Participant 6 stated:

> I don't think that the healthcare professional has to be the know-all, end-all, and be-all. There has to be a sense of humility that grounds us to be open to the differences and then learn from that and be humble because you can learn lots by being humble.

The participants acknowledge that different cultures have different cultural and social norms. As HCPs, they are determined to be cognizant of these differences in cultural background

of the client. Participant 8 shares that she usually does research on acceptable norms and practices of immigrant clients. She stated:

> If I have a client who is an immigrant, I will usually do sort of a cursory check of like, things to avoid that are offensive things that are you know, like gestures that she would impart to me that have a greater significance than they do in Canada.

She proceeded with providing an example during one of her encounters with an immigrant mother. She shared:

> We were trained, like you can't accept food, you can't accept drink, you can't like all of that is sort of crossing the line, it could be construed as bribery, all of those things. But in my current program, it's all about the client being comfortable. So, I had a client who came from Colombia who, in my little cursory search of like things that are, you know, like, important socially and culturally, it was like, it's a big cultural thing to offer food and drink. And so normally, I would have automatically like, "No, I'm okay, I don't need coffee." But knowing the importance of that to her when she offered, I was like, "Yes, that would be lovely."

For Participant 8, it is essential to find ways to make a health intervention work. She explained:

> It's about then finding ways to make it work. "Okay, baby can do tummy on your chest" or "baby can do tummy time on the bed with maybe a board under or something". Like, there's— you just want to make it work for the best. And, you know, I would really be remiss if I said, "this is the right way to do it". …It's about finding ways to make it work. "Okay, baby can do tummy on your chest"

or “baby can do tummy time on the bed with maybe a board under or something.

And, you know, I would really be remiss if I said, “this is the right way to do it”.

Moreover, Participant 4 added that the mother and the HCP have one goal, regardless of their cultural background. She explained, “all mothers love their children, there’s no right or wrong way, you know, we, you are safe, that is safe, you’re happy, you know, go ahead…”

Respecting the health beliefs and practices of multicultural clients is a must for all HCPs, as the goal is to provide the best care to the clients. Participant 3 stated:

> …when you reject things and say this is how we do it in Canada and this is how you have to do it, you are set for failure. When you are, how do you do it, oh, that’s interesting, that’s great, then you, its just a natural, its just that they’re goanna ask you how you do it in Canada and, you know, child raising and, they, they take what they like and then combine it.

For Participant 2, part of their job is to understand and acknowledge the different history and background of immigrant women and making them feel safe during encounters. She stated:

> Really acknowledging the complexity of many of these women’s lives and maybe what they’ve, they’ve come from and challenges around coming from countries there might have been a lot of poverty and, and world events like things that have happened that have brought them to Canada so that awareness of possible past trauma… Like really making it safe and welcoming, respectful in our interactions...

Collective Impacts

Interdisciplinary partnerships. Partnering with other health professionals and organisations to address the different health concerns are essential and important roles when working with immigrant women. Participant 1 stated:

> We have in-office counseling in our, within ICF and we also have a clinical supervisor and so at any time we're able to just go bounce things around or, you know, this is the situation. And also with our, our postpartum connections group was developed, um, as a result of the need in the community but we also partnered and kind of developed through the reproductive mental health person here [name] in Kamloops and Dr. [name] and so their skills and expertise so also at any time that we feel like there's more of an urgent need or a safety thing or we're just kind of like what is going on here, we, I guess, always have other people that we can (a) consult with or (b) bring in, if necessary . . .

Working together with other agencies and health professionals was seen as a necessity in order to provide the needs of the immigrant mother, as working independently would not be beneficial for the client. Participant 4 stated:

> Because I mean it takes a village and, you know, we're a small town and we can't operate in silos, you know. We cross refer all the time, we, I work with YWCA, the Childcare, Interior Community Services, there's another, the Pregnancy Care Center which is, of course, our agency so I work with the ladies and we do a quick intake and they can go in and select everything.

As collaborators with different organisations and health professionals, they needed to ensure that immigrant women feel safe. The participants pointed out that some immigrant

women may not be used to having different health professionals involved. Participant 2 stated:

> Probably even if there's someone recognizable from their own community or a greeter or someone who speaks the language to make them feel safe. If we had like a counselor or somebody working like it was multi disciplinary in terms of having an outreach worker and an interpreter that spoke the language, the physician or nurse, you know, and then the counselor available. But you had the people there but there was somebody who was kind of like a greeter or to ensure that safety.

Referrals to other agencies are made based on the assessment of the HCP and the need of the immigrant woman. As an example, Participant 6 stated that she would make a referral to public health if she determines that an immigrant mother needs further support in navigating different health services available to them. She explained:

> It is also helping the family understand that what public health nursing does for support during the pregnancy period and afterwards. Lots of them don't understand that the nurse does come to see them after baby is born. Uhm, that's very comforting for a lot of our immigrant moms because they like to know that the baby is being weighed and there is that support for breastfeeding or whatever that needs to be that the public health nurses that ongoing support for them as new parents, you know, in figuring things out.

The participants expressed that they do feel capable of providing mental health support to their clients. However, if they feel the client would benefit more from a trained professional, they make a referral. Participant 8 expounded:

> Usually, it is sort of through conversation that I pick up that something is an issue, or they, you know, profess, "this is a real issue." But they're so deep in the thick of it oftentimes that I sort of have to be the one like, "would you like me to refer you because this is an issue, and you shouldn't have to go through it". So primarily, it's I think, usually what the thing is that I'm in there early enough to see when it's low rumblings to monitor until it gets to a point and then we would do the referral. I mean, if it's a serious mental health concern, we would want her to be in touch with like a mental health professional.

Prenatal care for pregnant immigrant women should continue after birth. Some participants maintained that different health programs are available in their community to ensure that care is given throughout the pregnancy and in the postpartum period. Participant 4 stated:

> We collaborate… and now they have a lot of pregnant women support groups and after the pregnancy, you know, women support groups going on. And there was a big training [place] college started but, you know, we've been able to, to have these groups available in the community and we collaborate a lot with community, in their community services where they have several programs where they take this, you know, when they're pregnant until after they, they give birth, and their kid reaches the age of three there are different programs plus our programs.

It has been said that misunderstandings among HCPs happen especially when caring for multicultural clients. Thus, Participant 4 purported that the different organisations in their community have established close working relationships to ensure that the best care is delivered to their immigrant clients. She explained:

> I had a, a mum who they thought was very depressed and they were going to, you know, doing an intervention… When I spoke with the mum and it turns out that she had to go based on her beliefs on a quarantine like forty days which you will not go out of the house and try not to receive any visits because that's their cultural background and so there can be other misinterpretations in terms of, you know, diet and beliefs… And, you know, because we have this amazing communication with Interior Community Services and even Interior Health they know to call us before intervening with an immigrant mum…

The realization that immigrant women have special needs especially during the perinatal period has brought multiple organisations and various health professionals together. The literature suggests that conducting regular PPD screening is a shared responsibility among HCPs involved in the care of immigrant women (O'Mahony et al., 2021; Sword et al., 2008). This collaboration allows them to deliver care and assistance to the clients faster and more efficiently. Participant 1 informed:

> But I have an equity forum, the TRU Equity Forum, we started last year meeting quarterly and this is just for, for anybody who supports kind of underrepresented, you know, EDI's so equity, diversity, inclusion, all around Kamloops… I think its pushed professionals in their practices to find other ways and to make it work despite barriers and so there's been more collaboration… we've been able to call to a couple of community doctors or I connect a lot with the North Shore Health Clinic there to the, um, nurse practitioners.

She continued by sharing her experience with an immigrant mother who wanted to undergo a birth control method due to safety concerns. She shared:

> You know, we had one just recently who needed an IUD because already has a young child, just had a baby, um, is not in a really safe living situation with her partner and, and she wants to make sure she does not have any more children at this time. And so, you know, we were able to kind of really wrap services around her quickly, so the collaboration has been great…

Working with faith-based organisations and engagement of ethnic groups. The social support immigrant women receive can influence their mental well-being (Delara, 2015). The presence of welcoming ties within ethnic communities or religious groups can mitigate the effects of migration losses, isolation and discrimination (Kirmayer et al., 2011). As immigrants, women tend to rely on people from an ethically similar background, especially during the perinatal period (Urindwanayo, 2018). Additionally, soliciting support that is closer to home also includes tapping into resources such as faith-based organisations, and is viewed as a source of mental health support for immigrant women (O'Mahony & Clark, 2018). Many of the participants help their immigrant women clients in linking them to communities or organisations from their same cultural background. Participant 3 commented, "I try to find out if they're involved with anyone in the community already if, you know, they have a group or a church that they're attending or a temple or something where they have some kind of connection". Participant 4 also stated:

> If I see someone who comes from the Philippines, I always refer them to the Filipino group, the India group they have different temples and organisations and Mandarin speakers because it's nice to be around people from their community. The Spanish group I have a poster and I send them, you know, the poster and I, you know, if I know the organizer, I contact the organizer and say, hey, you

> know, this person is, is going your way so they know to welcome them and because in their language she can make friends.

Along with connecting the client to community organisations that share a cultural connection, the participants also inquire if the immigrant woman would like to be linked to other government support available to them. Participant 6 stated:

> So sometimes it might be, uhm, that they need that cultural connection so then it's, is there a multicultural society or supports or uh, like some of our communities have larger, uh like, Filipino family, you know like a large community that they can find comfort in or asking them if they made friendships in their community and sort of understanding where the gaps are. And seeing if we can plug in any supports that we know of. And then, overlapping that with what would be a perfect provincial support if they need it like with the BC nurse line... So, that there is a way for them to communicate and connect if they are wanting to.

However, it has been proven difficult to sustain engagement of immigrant clients (Maraj et al., 2018). Participants highlighted the importance of continuing support as needed by their clients. As Participant 5 explained, "…supportive groups, if that's something that a community has determined that they need, then providing that support and, and not just starting it and stopping it very quickly, …it is very important to make a commitment to follow through".

Participants also stressed that before connecting them to a group or organisation, they make certain this is the kind of support the immigrant woman wants and needs. Participant 8 explained:

> …we want to ensure that they have supports, and that those supports are coming from the places that they want. you might have a mum who really misses you know, speaking with people who, who come from a similar cultural background to her, and she would want to seek out — like, it would benefit her to arrange her being involved in like one of those community organisations in Kamloops. For another month, she might have fled her country and wants nothing to do with that. And she has chosen to, you know, put aside those cultural norms because they don't work the best for her. So, getting her in touch with a cultural organisation from her home country would be very not beneficial for her.

Use of translation services. In using translators during encounters with immigrant women, it was suggested that some understanding of the cultural background of the client be known, and not solely about the language. This is especially important for some languages that are almost similar but have different cultural connotation. Participant 4 expounded:

> On many occasions we do have to use interpreters and we make sure that its not only the language that they speak but they have an understanding of the cultural background for, you know, bringing back again the example of Syrians and we have our experience, we have Kurdish Syrians, we have Arabic from other Arabic speaking countries, African countries, you know, there are many and the language can be the same but they, it, it, there's a different connotation.

For the participants who conduct telehealth, having to use translation services means less time with the client over the phone. Participant 2 stated:

> So, mood is something we typically ask about, this is the other piece if you've got an interpreter on the phone doing the phone call it might, phone calls take twice as

> long, we might not get to all the same topics that if you're not using an interpreter because the nature of the visit just takes so long.

To remedy this, the telehealth providers book longer appointments than usual for clients who would need translation services and send them a summary via e-mail. Participant 2 explained:

> We do speak to them before we have our actual phone call because we call them in regard to the referral. So that way we can kind of judge how well their English is or whose going to translate or if we're going to need translation services… So that's kind of how we have our communication plan and then typically we arrange a phone call that, you know, we give ourselves more time like say we usually book sixty minutes for a client… We have to do our charting and all that kind of legal stuff and sending them an email so we might talk to them for thirty minutes and then we have thirty minutes for doing our nursing work.

Part of the assessment during encounters with immigrant women is gauging their proficiency in the English language. This helps in booking an interpreter in advance when they put out the referral. Participant 3 stated:

> …another piece of our nursing judgment like based on their, how good their English is like, you know, we definitely need to have a translator who is explaining, saying exactly what we're explaining and just, you know, what, kind of what the support looks like and how it can help them cope with their situation. And then, you know, either we'll contact the referral source that they may, we'll need translation services or putting it on the referral.

Providing safety and confidentiality cannot be understated for the participants. Accordingly, setting standards in hiring translators is a priority. Participant 4 stated:

> And the language, you know, if we can't find anyone to provide mental health in their language which is really hard to, you know, early access people who speak Punjabi… [We] provide services to assure them that, you know, the interpreter everything is confidential, we're super strict with our interpreters we only give one chance in terms of confidentiality and boundaries we, we are, you know, really, really strict with that and the criminal record checks that we do on all of our volunteers and interpreters.

Some immigrant women may not be agreeable in involving a translator, especially in matters concerning mental health. For this reason, consent to book a translator must be obtained, and confirm that they are comfortable bringing in a third person into the conversation. Participant 8 stated:

> But if it got to a point where I was, I was worried about a client who had—who didn't have as full a comprehension of English in order to fully be able to communicate those difficulties to me, I would ask them if they were comfortable with a translator and I know that Kamloops Immigrant Services has translators for a bunch of different language groups. And so, I would, because in those— if they were comfortable with that, too, because that's now a third person you are bringing into this difficult discussion, but ultimately, that's what I would have done hypothetically.

In cases where medical or therapy terminologies are difficult to translate, Kamloops Immigration Services is contacted to provide translation services. Participant 7 stated:

> It's a lot of medical terms and a lot of like therapy terms. So maybe, there's no way we could possibly have literature to provide service to all the different

> families. So, we rely heavily on Kamloops Immigrant Services to help try to bridge that barrier. So, when there's something specific that we need help with regarding a medical term or understanding for the family or therapies, then we will work with them for that.

Often, family members such as the husband or the child act as the translator for immigrant women. In such cases, verifying that what is said is translated correctly and adequately is important. For some participants, this is done by observing body language and facial expressions. Participant 8 stated:

> …her husband was very fluent. And so, he could come in, and sort of be like, act as a midway translator. And I also would, sort of, she would, she would kind of communicate to him based on what my question was, and he would sort of communicate that to her. And then she would give him her answer. And he would communicate whatever she had said to me, but I always wanted to check and read her body language to make sure that she was verifying through body language, that what he was saying was what she had wanted him to say, because, you know, I don't know what it's like behind closed doors, people are very good at hiding things.

Summary

This chapter discussed findings about the different roles of the participants to support immigrant women's health literacy. Building trust through relationships is seen as a necessary element prior to initiating conversations surrounding mental health. This included employing a client-centered approach in each encounter and establishing rapport, as well as attending to the client's immediate needs.

Assessing of mental health needs was done through a variety of methods. Although utilising standardized checklist or tools were still seen as essential, it was conducting interviews and engaging in conversations that facilitated better assessment of mental health status. The participants also paid attention to nonverbal and subtle cues and were creative in assessing mental health concerns.

Delivery of health information was denoted as one of the roles of the HCPs. The concept of mental health was normalized by explaining the physiological and hormonal changes during pregnancy and sharing their personal experiences on mental health struggles. Additionally, using simple terms and avoiding medical jargon was emphasized as an important health literacy practice to minimize confusion among immigrant clients. Further, offering support when needed and providing positive reinforcement were identified as important factors in sustaining health support to immigrant mothers. And lastly, it was thought to be vital to acknowledge the cultural differences between the participant and client and respect the client's culture during patient education.

Healthcare providers also revealed their collective impact on immigrant women's mental health during the perinatal period. They acknowledged that working with immigrant women should be a multi-pronged approach and concerns should not be addressed in silos. The participants included partnering with different health professionals, the use of translation services, and working with faith-based organisations and engaging with ethnic groups to better address the mental health needs of the immigrant woman.

The next chapter focuses on the health literacy determinants of immigrant women's mental health.

Chapter V: Findings and Discussion:

Health Literacy Determinants of Immigrant Women's Mental Health

This chapter presents the health literacy determinants of immigrant women's mental health during the perinatal period. Immigrant women have lower HL rates compared to their Canadian counterparts (Omariba & Ng, 2013). Their lower levels of HL can have a wide impact on information exchange about health and help-seeking as women play a pivotal role in child rearing and social networks (Gele et al., 2016; Simich, 2009). Moreover, culture is closely linked to HL because there are significant cultural differences in how people identify, explain, experience, and react to mental disorders (Omariba & Ng, 2013; Simich, 2009). The participants identified several immigrant women's health literacy determinants, namely, social support networks, gender roles, cultural influences, language constraints, and access to mental health services.

Social Support Networks

Mental illness is thought to be more prevalent during and following pregnancy due to several factors including lack of family and social supports (Gannan et al., 2021; Iliadou et al., 2019; Thomson et al., 2015). In general, social support is associated with immigrant health and well-being, with social support sources from nuclear and extended family identified as the most significant (Fair et al., 2020). Migration contributes to the disruption of family and cultural ties of newcomers (Stewart et al., 2010), which can lead to poor mental health outcomes (Fair et al., 2020; Lephard & Haith-Cooper, 2016; Phillimore et al., 2016). As such, social support is seen as a key determinant of health, especially for immigrants (O'Mahony et al., 2012; Delara, 2016).

A common and significant problem cited was the immigrant women's unfamiliarity and lack of access to mental health support in their country of origin. Participant 1 stated, "that's a

big one for sure. It's just their family being so far away, yeah, is definitely, definitely one of the main ones that I, um, see when I'm talking to immigrant women". Participant 3 also shared her observation:

> They struggle with that like, you know, they talk to them by Zoom or over the phone but its not the same and a lot of them culturally have different traditions that they tend to follow say, grandma takes care of the baby for the first kind of three months but they don't have that because they're in Canada and their family is not here… So, it's a little bit of, you know, a struggle that way and… for mental health as well, you know, because they're missing that piece and they don't have that support.

Aside from the lack of family support, having a limited social network was also seen as a concern. Participant 2 stated:

> …their family norms and roles at home, their limited network that might be around them, like they may not have any friends that could actually say, "hey, you're not really seeming like yourself", you know, they don't have those people around them to even just plant that idea. Like, "are you okay?", you know? They don't know what they don't know.

Isolation is especially magnified for immigrant women who lack social support during the perinatal period (Delara, 2016). Participant 5 stated:

> Sometimes, it's simply the isolation because they're on their own... So, you know, isolation is such a big thing, especially with maternity care and new babies, and that, that I mean, you're already isolated, no matter if you have a group of 50,

close friends, you're going to be at home with your baby. So yeah, the impact of that is going to be even greater if you don't have that network around you.

Participant 1 also shared the predicament of one of her immigrant clients, who had to spend more to get around the city because she does not know anyone in Kamloops.

> … that isolation of being alone and not knowing people… Like a mum that I had from Bangladesh when we first started, you know, she was in a great location… and she said well, how do I get to the campus and I said well you're in a great location you can just walk… And she's like well but how do I do that like how do I go across the street… because she was having a taxi kind of do all her which was costing her s much money to get things that she needed.

Recognizing that isolation is a common concern among immigrant mothers, it was raised that we need to ensure that support is offered to them. Participant 8 expounded:

> An issue for women from all over but especially for immigrant women, is isolation. And so that, that would be— usually that's a big one that we want to address, we want to ensure that they have supports, and that those supports are coming from the places that they want. Like, hypothetically, you might have a mum who really misses you know, speaking with people who, who come from a similar cultural background to her, and she would want to seek out.

Pregnancy is a challenging time for any woman, and the challenges are magnified for immigrant mothers who, aside from having no family members to support them during pregnancy, must also deal with different beliefs and practices of the new country as well as the pressures of being a new parent (O'Mahony & Clark, 2021). Participant shared her experience with an immigrant mother:

> A lot of [immigrant women] don't have that extended family to draw on support… To understand that it wouldn't be expected of them to be on their own, uh, if they were in their own primary country and it can be overwhelming for the majority of them and a scary time for them. Happy, uhm, they're excited to have a baby, sad because they're missing family. And unsure because they have no sense of norm for how this is going to go for them.

Cultural differences between immigrant women and Canadian-born women were also highlighted. Some cultures tend to depend heavily on extended social networks, especially familial support compared to other cultures (Simich, 2009). This was also highlighted by Participant 8:

> …a difficulty for immigrant women that if you know, if a Canadian woman experienced that same thing, it wouldn't affect them as negatively because they, you know, they would be more used to not having a huge support circle… It could add to their mental health needs.

Gender Role

Shifting roles. Many recent immigrant women are stay-at-home mothers to take care of their family members (Nichols & Tyyska, 2015). Their role and responsibilities at home can hinder them from accessing mental health services (O'Mahony & Clark, 2018). One participant remarked that some immigrant women she worked with have difficulties getting to appointments or to wellness clinics due to child rearing. Moreover, the time frame of when medical appointments or classes are offered could also be problematic for the mother. She stated, "if they can go to say drop in mental health… if they have a child, other children that they're looking after that can be a huge barrier". With these shifting roles, the needs of the husband and her

children tend to become the immigrant woman's priority. This signifies that the concerns, particularly, mental health concerns of the immigrant mother are sidelined. This was pointed out by Participant 4, stating:

> …because women think that they're not the priority, the priority are the children and the husband, the parents and its like I'll deal with myself after this is done and, in the meantime, we see that they are [laughter] deteriorating in front of our eyes.

Similarly, Participant 4 shared her observation that a lot of immigrant women put their families and communities before than their personal needs, including their health. Comparing them to women from North America, she stated:

> A lot of privacy things in North America here we just tend to phew everything out and talk about everything that's going on where they're, they're a lot more private. Where they're [immigrant women] a lot more, um, [focus on] the good of the whole community. It's not so much selfish and so not, feeling selfish about, um, putting themselves as a priority or putting their health as a, as a priority.

Moreover, while many immigrant mothers rely on their partners for financial support, a growing number of immigrant women work to help with the family's expenses. This added responsibility could place more burden on the mother, given that she also has to tend to her children. Participant 2 stated:

> … a lot of them are working really hard, they're working a lot of hours and they, it might be hard to access services because they are living marginalized and in poverty and maybe looking after children and its, its, its tough.

Relationship dominance. In a familial context, gender hierarchies may manifest as unequal power relationships affecting family well-being as well as creating economic challenges, adding new responsibilities and shifting roles, and influencing decision-making power between the husband and wife (Mengesha et al., 2017; O'Mahony & Clark, 2021). Consequently, the decision to seek mental support may rely heavily on the male partner. This resonated with one participant who recalled, "it's hard to know what status they have in the family if they would even be allowed to seek support on their own or if they have to get approval from a partner". Another participant also spoke about finding the balance between providing support to a woman and crossing cultural dynamics of the family. She stated:

> I'm speaking with a woman, and the husband isn't on board or accepting, etcetera. Yeah, that's really a tricky one. Because you don't want to cross any of those cultural aspects, like, you could give her all the information and stuff. But she's not feeling comfortable proceeding.

Decision-making in many immigrant families rely on the husband. This includes health decisions for the mother and child. Participant 6 recalled her experience with a South Asian family who came to their unit for breastfeeding support. The husband would not let the wife go to the clinic alone unless he had determined that it was a safe environment for both mother and child. She shared:

> A couple of times I had the dads come and bring the mom to weigh the baby. And sort of the check up would be dad and grandpa and mom and baby. And then, it's, I'd say, "okay, we need to have some time with you to see baby feeding 'cause baby's weight is down". So then, dad will recognize, "okay, this is a safe environment, it's okay for you to come a second time." And so, dad will bring

> mom a second time, like a couple of days later and dad will be sitting there, uh, with mom while she was feeding baby.

Living with extended families is common in many cultures. This living situation makes the immigrant mother vulnerable to abuse and become powerless to make her own decisions (O'Mahony & Donnelly, 2013; Suphanchaimat et al., 2015). Participant 3 stated:

> Say, they're living with their husband and his parents, you know, how is that on your relationship, do you have a good relationship with them right like is there possibly any, you know, intimate partner violence or violence, you know, coming from elsewhere or abuse…

Domestic violence is accepted as normal in numerous countries and many cases go unreported (Guruge et al., 2015; Mengesha et al., 2017). This norm and being immigrants in a new country may situate the immigrant women and the child in a powerless and dependent position. Participant 1 recalled her experience with an immigrant woman:

> A lot of women that are experiencing interpersonal violence in their relationship are immigrant women. I've had a long-term client who was experiencing violence in relationship and it wasn't until her baby was born and, and the baby became the target of some of that.

Participant 1 added:

> …[in some cultures], its okay that, that a husband slaps his wife or his, that that would be common and it wouldn't be something that, um, it would be common for the woman to have no financial, all monies are controlled by, um, the male or, um, [sighs] I don't know how much they would report to a care provider.

Moreover, domestic violence does not only mean physical abuse. It can manifest as emotional, mental, financial, and verbal harm. One participant recalled a case of an immigrant woman, a victim of female genital circumcision in her country of origin, who just gave birth.

> …she always had a lot of pain during intercourse and her husband would be like you know what is wrong with you, why aren't you, um, [sighs] and, and she actually called to ask me, about, um, you know, was there some support that she could get or someone to be able to get another wife for her husband so that he could be with somebody who enjoyed having sex to meet that need for him.

The participant added that though the woman was not getting any emotional support from the husband, she still put his needs first. She asserted, "there was no empathy around what was happening for her and what had happened to her. She had a baby girl so that was what kind of brought it forward for her".

Cultural Influences

Cultural and social stigma. All participants acknowledged the stigma attached to mental health illness and help seeking, especially with their immigrant clients. The healthcare providers believed that in many cultures, the concept of mental health is not as embraced as in Western culture. Participants articulated that mental health issues such as anxiety and depression were not talked about as much. Likewise, a common observation made by the participants was the feeling of embarrassment around mental health struggles. Participant 3 stated, "Many [immigrants] feel embarrassed that someone else is going to know that there's something wrong with them… the stigma and the shame".

Participants also voiced that dealing with a diagnosis of a mental illness for some immigrant clients meant denying and not accepting their condition. Participant 7 shared her

experience, “And a lot of it too, I find it's very difficult for them to recognize or accept that there may be something going on… that there may be some mental health concerns going on”.

The stigma attached to mental illness influences the adherence to the medication regimen (O’Mahony & Donnelly, 2007). Similarly, a participant shared that the fear of having mental illness affected compliance to treatment. She stated:

> If [immigrant women] are being advised to do something so whether that’s a medication for depression and anxiety but they don’t want to admit or they can’t share with a partner about their mental health struggle… they, they don’t follow through.

Help seeking behaviour was also said to be influenced by negative feelings towards mental illness. This is supported by Amri and Bemak (2013) who note that the fear of criticism from the community and family were evident in immigrant women. One participant stated, “they just don’t feel safe admitting that or it feels so uncomfortable to be under that label…”. Similarly, Participant 7 shared the cultural aspect tied to mental health. She furthered:

> The stigma around that and again culturally, you know, might not be acceptable where they’re coming from to talk about it openly… Like do they feel safe to, you know, seek services to explore those feelings or do they feel like they just have to cope themselves and, you know, bury it down and just keep on, on going because they, you know, don’t want to be judged or they, you know, don’t want to share.

Additionally, for many cultures, seeking help for mental health reasons is seen as a sign of weakness and brings shame to the family (Amri & Bemak, 2013). This was also opined by Participant 6 who shared, “whether or not they’re allowed culturally to seek out other supports or

opinions or advice can be a barrier. There can be a family structure that prevents them from doing that".

Due to the stigma attached to cultural taboos on mental health, many immigrants believe that having a mental illness will jeopardize their immigration status. As a result, they become hesitant to open up about the mental struggles they may be experiencing. This is consistent with the findings in the literature (Guruge et al., 2015; Mengesha et al., 2017; O'Mahony & Donnelly, 2007; Straiton et al., 2018; Sword et al., 2008). Participant 4 shared:

> …there's a lot, a lot of trust issues. And depending on the country where you come from are you going to share my secrets with the government [laughter] and are you going to be able to sponsor my family [laughter] that's a big, you know, concern, you know, if I disclose that I have a mental health situation and I see a psychiatrist or a counselor maybe the government doesn't want [to sponsor me]…

Another participant stated that many of her immigrant clients who are in Canada on work permits are experiencing stress around their immigration status and if they are allowed to deliver their baby in Canada. She expounded:

> One huge fundamental is like their resident status in Canada and the huge layers of stress if they don't have landed immigrant status… There's some women who might have a work permit but then maybe not able to continue working due to health. So, I mean just massive stress around their immigration status and if they're goanna be able to have their baby here.

Participant 7 also added:

> Fear of especially if their immigration is not secure. I think that there would be probably a concern about accessing services if its not, you know, what I mean, if, if it could endanger their immigration claim which would tie back into stigma.

Interestingly, when immigrant women do seek help for their mental health struggles, many of them fear how their family would react. As a result, many of these women conceal it from their family, especially their partners.This was also similarly reported in the study of Sampson et al. (2021) and Sword et al. (2008) who found when immigrant women are experiencing perinatal mental health issues, they may be hesitant to share these mental health concerns due to fear of being rejected. Participant 1 shared an experience she had with an immigrant woman:

> This woman that just came… that really surprised me because I thought, wow, like the courage for her knowing that this, we're already not in a good situation but her feeling safe enough to, to talk about that knowing probably like her partner did not know.

In providing mental health care to a woman from a different cultural background, Participant 3 shared that she keeps in mind the possible cultural differences between what she's accustomed to in Canada and that of the country of origin of the client. She expounded:

> I do find that culturally some of the mental health piece isn't as talked about as , you know, say in our culture like in Canada, you know, mental health is kind of at the forefront of everything and you hear about it all the time but I, I think and this is my own opinion but in other countries I, I don't think its as openly talked about, I think it's a little taboo still.

She also admitted that she is not certain if her immigrant clients are knowledgeable about mental health and illness during her prenatal check-up encounters. She stated, "I'm not even sure if they

really know the details about mental health like, you know, anxiety and depression and, and those kinds of things like postpartum depression like if they're even aware that". As such, she takes time in exploring the client's mental health awareness.

Gender preferences. Many immigrant women express stronger preferences for same-gender professionals when choosing members of their care team (Aubrey et al., 2017; Suphanchaimat et al., 2015); a preference that contributes to difficulties in provision of mental health services. This is especially problematic in some areas where most doctors are male. Participant 4 voiced the challenge when some immigrant women request for a female-only doctor. She recalled, "It's been very challenging especially with the various refugees and women who are, you know, more conservative Muslim because they only want to see a female doctor and there's a very big limitation of accessing doctors in our community".

In using interpreters, some immigrant mothers also request a female translator. Lyberg et al. (2012) posited that male interpreters often did not understand the needs of immigrant women receiving maternity care. Participant 1 expressed the same concern that some male interpreters may not translate in full what she is asking especially when the topic is delicate. She shared:

> …[Some immigrant women] are asking for a female interpreter because in some cultures its, its awkward having a conversation with a male interpreter, yeah, because like I, I've experienced that it seems a bit filtered and I know they're not saying [laughing] all the questions I was asking.

Similarly, Participant 6 stated, "interpretive services can be helpful, but it can be limiting… gender and power struggles can be impacting the communication".

The increasing use of virtual check-ups by HCPs, especially male providers, is seen as a potential concern by Participant 4. She shared:

> If we have a rash, we just see the doctor and show them the rash. These women are moreshy and the doctor tells you, the virtual doctor when you don't have a family doctor he tells you send me a photo of that so I can see it, many women they stop...

Language Limitations

Language proficiency. Immigrant women often face many communication barriers such as language differences when seeking medical and social help (Delara, 2016; Priebe et al., 2016). Lack of English language proficiency is also a major barrier to expressing mental and social needs and understanding how the healthcare system works (Mirza et al., 2020). This obstacle was reflected by Participant 1 who commented:

> When they go for their doctor's appointments if they're not speaking English, you know, …like the communication there's just a barrier and not really understanding their care or like, you know, what its going to look like having their baby in Canada and what the follow up might be.

Similar with the findings in several studies (Guruge et al., 2015; O'Mahony & Clark, 2021;Sampson et al., 2021; Straiton et al., 2018; Sword et al., 2008), providing important health information and services was also seen to be strongly impacted by language barriers. Participant 2 shared her encounter with an immigrant mother, "…with the education piece, because we share information about like prenatal classes and groups, you know, they can't really access those things unless, you know, they have a translator come". She furthered that even when they are able to provide their own translator, immigrant women still get left behind in group classes due to the fast-paced setting. She explained, "…when they do get someone, which makes it difficult

when people are talking… Like at a fast pace to have somebody translating and it's a little, you know, distracting for other members of the group".

Participant 8 shared her struggles due to the language barrier between her and the client. She admitted, "the language barrier, I think, you know, like I can do the absolute best that I can do, and they can do the absolute best that they can do, but sometimes it just still doesn't land". Furthermore, Participant 4 voiced the difficulty in finding a provider who can communicate in the same language as the client. She shared, "…if we can't find anyone to provide mental health in their language which is really hard to, you know".

Although some immigrants to Canada can speak limited English or French, their ability to express their concerns, describe physical symptoms and social quandaries, and negotiate treatment may be limited (Kirmayer et al., 2011). Participant 4 shared her observation that even when some of her immigrant clients can communicate in English, they seem to have difficulty articulating what they feel when they are under stress. She stated:

> …[Some] they communicate in English but when you are stressed and [at a] time in your life is hard. Hard to understand, you know, when it's not your first language. Because even if the language skills are good [but] the client is under stress its really hard to communicate in exactly what they're feeling and the details of their situation in English.

However, it is also important to note that one participant stated that she has not perceived language as a barrier as she has not encountered an immigrant client who had difficulty conversing in English.

Translated resources. It has been found that many migrant women do not utilise formal health care and other community services due to several reasons. This includes language barriers,

lack of meaningful multilingual information about health issues, and difficulties in understanding healthcare information (Higginbottom et al., 2015). These barriers not only have a huge impact on immigrants' health literacy but also contribute to the deterioration in their health status in Canada over time (Simich, 2009). Moreover, a significant number of studies have informed that pre- and postnatal education and classes should be offered in the language of the immigrants (Higginbottom et al., 2015; Jarvis et al., 2011). Some participants say that translated materials have become more accessible over the years particularly in Kamloops. Participant 1 stated, "I think the community has gotten way better about resources being available in several different languages or access being the translator from Kamloops Immigrant Services". Another participant mentioned a government-funded telehealth program that provides health information in different languages. She stated, "HealthLink BC, you may be able to have those conversations translated on the phone which provides translations…". However, most participants shared that many of the perinatal printed materials and resources are not translated. Participant 6 voiced, "The language barrier is huge with the printed information and resources that is so limited". Participant 2 shared a similar sentiment, saying:

> In Kelowna, we've got like mental health services through Interior Health, the same with Kamloops, many of the areas have got specific perinatal programming, they don't offer it with interpretation though and its not specific to immigrant women like it would be your standard service.

Although most immigrant women clients of the participants can speak English, there are still some mothers who speak very little to no English. The HCPs voiced that due to the lack of translated materials and resources, they rely on resources from other provinces. She shared:

> …the one thing that's difficult is providing them with resources because we don't have a lot of translated resources to pull from… [it's] difficult if they don't read English so that's one thing that I kind of wish we had… and a lot of stuff that we access to send these women is actually based out of Ontario, it's called Best Start.

Many of the online and printed information on mental health and perinatal care are only available in certain languages. Participant 6 mentioned B.C.'s best practice guide called Baby's Best Chance that is only available in 5 languages, namely, English, French, Chinese, Punjabi, and Spanish. She shared her common experience with immigrant mothers:

> If they're not English or French or maybe two other languages, they're left with only English. Only send it to me in English because then they can have it translated from family or friends… Is it actually literally translated the right way or is there influence there? And just really recognize that Baby's Best Chance is only really in English, you know? And that's not a reflection of our communities, right?

Similarly, the participant noted they utilise Ontario's resources, particularly Best Start, when they need translated material for certain immigrant clients. She stated, "Lots of our stuff we rely on Ontario Public Health because they have translated stuff, but they don't have Baby's Best Chance translated".

An issue raised by a participant about using translated materials from a different province is that some services may not be available in B.C. which may add more confusion to the immigrant. Additionally, the participant purported that some languages don't have any available resources at all. She stated, "for some languages, like Russian, for instance there, there's really nothing… there is the odd different language where we really have nothing to pull from".

Participant 2 spoke about the potential problems that may arise with the lack of approved translated resources for immigrant women. One of which is resorting to online sources with unverified credentials. She stated, “but as far as accessing like resources say online that could be a rabbit hole because what they do get in translated might not be, you know, a research or evidence-based”. Misinformation would not only affect their health literacy but also their health and the baby’s well-being.

Access to Mental Health Services

Transportation. Immigrant women have reported difficulties in getting to appointments including check-ups and prenatal classes due to lack of transport (Higginbottom et al., 2015; Turin et al., 2020). This challenge was also expressed by the participants, noting that many of their immigrant mother clients miss their health and wellness appointments for this reason. Participant 3 shared, “whether they, these women have transportation, um, you know, can affect [access to services] too like if they can go to a drop-in mental health wellness if they can’t get there”. It was also pointed out by a participant that many immigrant families she works with only have one vehicle, and it usually is the male partner who uses the automobile often. She furthered:

> Other things might be just the limitations of their own situation, you know, their partner may be off at work with the only vehicle, they don't have any a bit way to get out. They wouldn't know how to find their way.

It was also interesting to note the noticeable difficulty in getting around the city during the winter according to Participant 1. She expounded:

> Transportation, I’ve found, we were having lots of families who, you know, from October until March when it got colder it was like, okay, yeah, we don’t go out

anymore in the winter so it's a completely different culture in Canada…

[Immigrant women tell me] the cold really gets to me like I don't want to go out.

Consequently, the participants informed that their respective organisations offer services that would help immigrant clients with transportation. However, one participant noted that this assistance is not promoted as the funds are limited. She furthered:

> If a family that we have on our caseload and they're really struggling to access services, we do have like funds that we can get them a taxi, but we don't advertise it. It is limited but so another specific example would be if their child needs medical services.

Similarly, if getting around the city to get to appointments is a concern, one participant stated that she works with other agencies to provide aide. She explained:

> …if they need transportation to the, to get to their doctor's appointments at the hospital so I'll go get taxi vouchers or, um, you know, a bus pass or connect them with the city bus pass and, and so really working together to reduce as many barriers as possible.

Unfamiliar with available mental health services. The participants often mentioned the immigrant women's unfamiliarity with mental health services available to them, which affected how these women sought help. This lack of awareness has also been pointed out in numerous studies (Ahmed et al., 2017; Thomson et al., 2015). Participant 1 shared, "That's a huge one that I've found. Not a lot of women or families that we speak to are aware that there's such things [mental health services]… in the bigger centers". Participant 8 echoed the same observation. She stated, "across the immigrant clients that I have had, [discussing] how to get them to understand

and be able to navigate the systems and the way they're laid out in Canada, that's being usually the biggest, like the biggest".

As the lack of awareness of the available health services were revealed by the participants, it was also stated that some HCPs are unaware of available resources in the community. Participant 8 stated, "other care providers, like health care providers in town don't know what services are available. So, it's really a lot of like, you don't know that something can help [patients] because you don't know what exists". Similarly, Participant 6 shared that many of their immigrant clients perceive their doctor as the health authority, including mental health. This poses a problem as physicians do not always know the services offered. She furthered:

> A lot of times, the docs don't know what's available in their communities or on mine and so most of the time, it's — these people are going to call you to talk about this [laughter] because they just don't keep some things— they have lots of things they want to talk about.

Another participant voiced that even with Canada's universal access to health services, people, particularly immigrants, often don't utilize available mental health services unless the situation is grave. She shared, "…it is universal access, but it is also [a lack of] awareness… Uh, they just, uhm— unless things are really difficult, most times they don't access it."

One participant also highlighted the challenge of promoting the available mental health services in the community. She mentioned that a lot of immigrant women are unaware of what services they were entitled to. She shared:

> It's more about having ways to promote our services with all the different organisations in, in the community… Have you been to immigrant services because, you know, even if you're coming from another province there's

> something that you will be benefitting from, it doesn't matter how long you've been in Canada, you know, we always have something that, that you can learn from.

Participant 8 shared a similar concern, stating that a lot of her immigrant clients did not know what services are available to them in the community and whether they are eligible to avail of those services. She stated:

> Primarily, [it is] understanding what services are available. And then secondarily, "how do I get to that?" Am I eligible for that? So, it like how to how to get their way into those services that can help. That's usually what we come up against.

Access to care providers. There is a shortage of physicians in Canada, with more than 4.6 million Canadians without a primary care doctor (Statistics Canada, 2020). Likewise, Canada has one of the least physician-to-population ratios at 228 doctors per 100,000 people. This critical shortage of doctors was highlighted by many participants as one of the major concerns for immigrant mothers to access mental health services. Participant 5 shared, "We've got such a shortage of doctors. So, [do they] have direct family care provider that they might see repetitively, that might actually notice any kind of a pattern in that client that doesn't exist very often?". Participant 6 also voiced that walk-in clinics are a challenge to immigrant clients as they see different doctors at each visit, thereby decreasing continuity of care. She explained, "lots of times, it's just a walk in and you get random doctors, and you might get this information and then you might get that information. So that can be confusing for clients".

Encouraging clients to access available health services is a challenge. So much so that when Participant 7 successfully convinces her immigrant clients to seek help, she considers this a

goal met. However, she expressed that the lack of physicians and long wait list was a barrier. She shared:

> You finally get a family on board and wanting and seeking help, and, and it's more than what our agency provides. So, we need to refer out but then there's wait lists, right? And, or lack of physicians or lack of, you know, pediatricians, it's just like, okay, we finally got the family here. But we can't provide that extra support for them.

Summary

This chapter examined health literacy determinants of immigrant women. The lack of social support networks during the perinatal period was associated with isolation. Meanwhile, the shifting roles of immigrant mothers and the patriarchal dominance in many immigrant families were also revealed to be a determinant. In addition, the cultural influences on immigrant women, identified as cultural and social stigma, and gender preferences on healthcare providers were also found to be determinants. Likewise, language constraints faced by immigrant women, such as their proficiency in the English language, and availability of translated resources were identified as factors that impacted HL. Lastly, access to mental health services were affected by transportation, their knowledge on available mental health services in their communities, and access to healthcare providers. The next chapter will discuss the impacts of the COVID-19 pandemic on immigrant women's mental health and the delivery of mental health services.

Chapter VI: Findings and Discussion:

Impacts of the COVID-19 Pandemic

This chapter presents the impacts of the COVID-19 pandemic on the mental health of immigrant women in the perinatal period and on the delivery of care and health information to immigrant women. Participant narratives reveal how the shut down of many clinics and health programs affected not only the access to health services but also had mental health implications on immigrant women. Consequently, many health services and programs shifted to virtual care. While the transition to virtual care was welcomed by the participants, limitations were still noted which compromise both the quality and access to care. Moreover, health information and protocols are changing rapidly due to the novel nature of the COVID-19 virus, forcing compromises in the timeliness of important communications.

Negative Mental Health Outcomes

Anxiety, depression, and uncertainty. As the primary focus of the government during any public health emergencies shifts to the physical safety of its citizens, scholars have noted that the COVID-19 pandemic has brought upon a mental health crisis with anxiety, depression, and other mental health problems (Benjamen et al., 2021; Ashcroft et al., 2021). Moreover, Statistics Canada (2020b) reported that recent immigrant women reported moderate to severe symptoms of generalized anxiety disorder more often than men at 32% and 26 %, respectively.

Participant 3, a telehealth nurse focusing on assisting pregnant women, shared that when lockdown at the height of the pandemic was imposed, she noticed that her calls with immigrant mothers were longer than pre pandemic times. She shared:

> But with Covid, we've just found there's a lot more, you know, anxiety and emotional health needs and just that connection with somebody. We've just found

> that our calls are a little more intense and a little longer… because of course, people aren't having that interaction… So, the conversations can get, you know, pretty complicated and complex.

Additionally, due to the noticeable increase in anxiety and depression among her clients, she admitted that this has caused an accumulation of patients needing mental health assistance thus resulting in longer waiting times to access services. She shared:

> I have noticed [that] because of the increase in anxiety and depression with Covid, it has caused a bit of a backlog with mental health because of the amount of referrals they're receiving. That is a concern for all women because now, you know, they need the service now but there's a two- or three-month waitlist, right?

The same observation was made by Participant 6 who shared, "accessing mental health, you know, it's a— I would say the wait list has become huge".

Perinatal women have experienced feelings of uncertainty during the pandemic (Iyengar et al., 2021). This has increased immigrant women's anxiety levels as they are battling a myriad of other factors such as job stability and care of children. Participant 6 shared:

> We have noticed a big wave and changes in anxiety for different topics as the year has gone by. So, initially it was when COVID started, it was lockdown. Everybody was losing their jobs and I'm gonna lose my job, my income, everything. It's like… world disaster. Sort of, a real panic around. How am I going to get groceries? How am I going to meet even that basic need like, how am I gonna feed my family and where am I going to live? How do I get back to work and my kids are still home?

She continued that over the course of the pandemic, immigrant mothers have adopted to lifestyle changes. Consequently, the level of stressors and perceived stress have changed over time. She shared:

> The kids can go to school and the kids can go to day care and [they have] kind of figured out how to do work or not work and so those levels of mental health, uhm, stressors have changed over the year.

Similarly, Participant 5 commented that many of her clients verbalized concerns about the shift to online learning when face-to-face classes were suspended. She shared:

> The worries and the anxiety changed to being that constant caregiver with daycare and all of that closed and schools closed. And one of the incomes may be lost but that added an extra level of what do I do with them all day long? So, you know, there are those cautions around stress and violence and everything for the family because everybody deals with a stressful situation differently. So, it's a safety piece as well.

Isolation. At the time of the interviews with participants, the Canadian government had policies in place including, but not limited to, workplace closures, restrictions on public events and gatherings, public transport restrictions, stay-at home orders, and international travel restrictions. Further, COVID-19 regulations meant that crucial sources of informal and formal support that many immigrant families rely on have been restricted or removed entirely (Brown et al., 2020; Guruge et al., 2021). The participants commented that many of their immigrant women clients reported feelings of isolation. Participant 5 stated:

> …especially for these new mums or pregnant mums, they've got through their pregnancies and deliveries and having a new baby through Covid and, and it's been

> so isolating. I think absolutely, it's made things more difficult in terms of isolation. We're seeing definitely an increase in, in mental health so existing clients that we had are facing more challenges.

Participant 6 shared her experience with immigrant families who arrived in Canada during the pandemic. She recalled:

> Mental health has increased simply because of the isolation factor for them and uh, you know, some of our families and communities they've only been there since COVID and they have no family, friends, anybody. Anybody. So, it's very isolating for a lot of them… So, COVID's really kind of amped, really increased, uhm, mental health, well, I would say emotional health for families.

Participant 6 added, "from speaking to women, you know, I've spoken to a couple of new immigrants recently and they said they're so lonely like very isolated feeling at home all the time". Similarly, Participant 7 commented that due to the restrictions placed by the B.C. government especially during the first wave of the pandemic, in-person communication with peers and family was difficult for everyone. She further observed:

> Yeah, um, I think that isolation is very real for all of us with the pandemic. And I do worry about, um, people that are stuck at home that have no other outing and no way to communicate with other people. That, that's, you know, kind of concerning for me.

It has been purported that spousal relationships have been negatively affected by the pandemic (Brown et al., 2020). Participant 4 has observed increasing family violence and feelings of isolation among her immigrant clients. She commented, "because it is increasing in family

violence and isolation and rejection has gone way up and we do not know just to making sure [they are okay]. Sometimes, women are very reluctant [to share]".

Information Available on COVID-19

Health information on the novel coronavirus has changed frequently overtime. Participants revealed that they were also confused with the different information and messaging communicated regarding COVID-19 especially during the start of the pandemic. Participant 5 commented:

> Even we were confused. Like, oh, what now? Now we have to wear a mask. Like [they] said, it doesn't work. But now you are saying we have to like, Oh! You know, even as a healthcare provider, you get frustrated. I can only imagine as like, just a general population but then with limitations of language. Oh, my.

Participant 8 added that due to the evolving information released by government health agencies, she found it difficult to assist her clients, especially immigrants in navigating the health system. She stated:

> It was very difficult for me to help them navigate that healthcare system for the birth of their child, because so many things within the healthcare system had changed so quickly, that even I was really scrambling to, to know enough in order to help them navigate it.

Similarly, one participant shared her struggles in providing the best available information to her clients due to the changing health narratives during the pandemic. She revealed, "because the information changes so quickly, for me to know enough on that to give them the best information has been a real struggle this whole year. It's been, yeah, it's been very difficult".

Participant 6 commented that at the start of the pandemic and when the vaccines were rolled out, her pregnant clients had many questions and concerns. She revealed that there are times when she did not have the answers for them.

> You know, so it's COVID, and then first trimester, and then there are families that we talk to… Do we get [the] vaccine? And what does the antibodies circulating in mom's system being, having active COVID due to their developing baby. And sometimes we can be put in very, sort of, situations where, I have no idea, you know. And just being honest that we just don't know… We just don't know. It doesn't lessen their anxiety but sometimes even just verbalizing it is helpful.

Further, the lack of evidence-based information breeds anxiety and increased stress levels to many people, especially pregnant women (Iyengar et al., 2021). One participant said, "It seems whatever the hot topic is, that's the anxiety or stress level on. Right now, it's all about, I'm pregnant, I'm gonna be breastfeeding, is it safe for vaccine?".

When asked if there was enough communication shared in the immigrant women's first language to promote understanding of important ongoing health information, the participants had mixed responses. Participant 6 felt that there were not enough updated translated resources that immigrant women can pull from. She shared:

> No, there is not enough translated resources or online information for them at any venture, you know. It's really… it takes them a lot of support to navigate that. And that's why if we have a multicultural society or a cultural group that's kind of come together to navigate that, and then it becomes what the friend said [laughter]. And you hope that the friend got it right.

On the other hand, Participant 2 said that while she knows that Health Link B.C. has translated resources in over a hundred languages, she does not know if there are translated resources for COVID-19 related information. She stated, "I'm not sure to be honest I haven't been into the Health Files to see what kind of Covid information is available". Still, many of the participants revealed that many of their immigrant women clients could understand the English language. Participant 1 shared, "Most of the immigrant women that I've worked with, uh, actually had very good English speaking as well". She added that Kamloops has improved a lot in terms of providing translators and translated resources to immigrants. She stated, "I think the community has gotten way better about resources being available in several different languages or access being the translator from Kamloops Immigrant Services".

Limited Access to Health Services

Public health restrictions implemented to mitigate the risk of COVID-19, such as quarantine, physical distancing, and telehealth appointments, have affected the provision of practical and emotional support provided to perinatal women (Iyengar et al., 2021), a support established to be critical in reducing depression and anxiety to new immigrant mothers (O'Mahony & Clark, 2021). Similarly, Participant 2 shared her observation:

> There's less in-person opportunities or peer support… I have spoken to newcomers who really want to get out and meet other women and families from their new communities and although there's mum's, um, new baby groups like they're all on hold right now so I think its quite isolating.

To complicate matters, many of the in-person perinatal services were not accessible to immigrant women during the pandemic. Participant 3 shared that services which were usually offered in-person such as prenatal breastfeeding classes were done virtually. She commented:

> Now that's on hold for everybody like they're not offering that now so that's a gap. A lot of the pregnancy outreach programs, you know, same thing it's all virtual, its not in person. So, there is some health services that just, it's changed the way that they offer services… And then there is some services that are completely suspended and still are so I mean in that way it can affect people.

While having virtual classes in lieu of in-person meetings was noted to be a good alternative, Participant 3 voiced that virtual programs are not as intimate and interactive. This may cause some immigrant women to discontinue their classes (Iyengar et al., 2021). Similarly, Participant 8 commented, "Now that we're in the pandemic, I, it really takes away… a lot of that rapport is lost, now that I'm doing them either through the phone or through video chat".

In the study conducted by Benjamen et al. (2021), 68% of clinicians in Canada noted that immigrant and refugee access to care was lower during the pandemic. Participant 3 also reported that during the start of the pandemic, many services were put on hold and HCPs were not seeing patients face to face. She noted, "early on when the pandemic was starting because everyone was kind of panicking, didn't really know what was coming, what was happening so a lot of like healthcare providers, for instance, were not seeing patients face to face". Subsequently, due to the limited access to mental health services, Participant 4 commented, "there's definitely a delay and, uh, and a level of frustration". She continued that when many health services were put on hold, it was difficult to book appointments in walk-in clinics and reach someone over the phone. She stated:

> They don't receive the care and accessing the walk-in clinic is at times impossible, call, call, call. The people who answer are extremely rude, it, it's happened to me when I'm calling for, for a client a number of times, the rapid urgent care clinic…

Participant 8 shared that due to the restricted in-person visits, one of her immigrant clients had difficulties finding a provider for the usual prenatal checks. She stated:

> I'd only managed to do one in-person meeting with them before everything shut down really hard… It was a real struggle for me, and for them to get them the appropriate, uhm, like birth support. There were no midwives who were doing anything, the few midwives that were, like still working through the pandemic were booked all the way up. And they didn't get the full amount of care that the midwife normally would have given them like several meetings beforehand… It was very stressful for them. They needed to find someone to watch over their older daughter, while the wife was giving birth. It was just there was so many awful, messy things that they had to deal with.

Virtual Care

Information and communication technologies. Health care organisations across Canada have implemented the cancelation of elective and nonurgent clinics as part of their response to the pandemic (Government of Canada, 2020). This measure was done to reduce the risk of exposing patients to COVID-19. As a result, most HCPs have shifted to virtual care to continue to provide safe, timely, and accessible care to patients (Wong et al., 2021). Virtual care is the interaction between members of the care team and the patient that occurs remotely using information and communication technologies (ICT) (Wong et al., 2021).

The use of ICTs tools such as social media, messaging apps, and telehealth have been widely adopted amidst the COVID-19 pandemic (Benjamen et al., 2021; Wong et al., 2021). All participants stated that most of their work and patient encounters have shifted to virtual meetings

since the start of the lockdown. Participant 2 shared that in her workplace, they have changed how they offer services to adjust to the protocols set by health agencies. She commented:

> For physician, midwife appointments, they continue to offer, I think it's about fifty/fifty in person and fifty, you know, the other fifty percent remote. And then prenatal classes are offered by Zoom, um, some of the prenatal outreach programs are continuing to work in person so women could go in person. They're just smaller class sizes and numbers.

While the participants have expressed that switching to virtual care is better than completely shutting down all services, they still emphasized the importance of providing the care their clients want to receive. One participant shared that it was important for her to determine which medium her clients want to use when doing her virtual visits. She stated:

> Determining which communication style is more comfortable for a different client. might have one client who exclusively likes to text because she can now process what she wants to say, and she can edit it, and then she can send exactly what she wants to say. Some people exclusively want to do video chat, because they, they enjoy seeing me and reacting to things their baby is doing.

She added, however, that if she assesses that a secure video conferencing is needed, she lets her clients know and would offer to do a video call. She commented:

> And if things are going very badly, like if I can sort of read that there is a crisis brewing, I will want to— I will specify, "let's do a video chat, I want to see you". Because even though you're not there in front of them, and you can only read from like the collar bones up, that's more than they're able to communicate just over the phone or by text.

Similarly, Participant 8 stated that although most of her clients are comfortable using video and messaging platforms such as Facebook Messenger, if their clients did not have access to such platforms, her organisation had protocols in place to conduct home visits. She shared:

> I've been lucky in that all of my clients have been able to, they've had available technology to them, and they've been technologically literate enough to use like, even Facebook, video messenger. This was very— I use that with a lot of, especially my immigrant clients, actually. But if, if I did have a client who didn't have access to those things, then we have sort of a, like a, like a health and safety checklist in order for me to be able to go physically still be in the home, because it's all about delivering the service to the client.

Participant 6 stated that offering different ways to communicate helps in giving necessary health updates and information. She explained:

> Lots of times it's knowing where our parameters stop on a phone conversation and then how can we get them the supports to where they are. So, the e-mail that we send them helps in communicating the resources, and where they're located for them to access.

Moreover, Participant 2 found engaging over the phone gives immigrants more freedom to express themselves. She stated, "I think actually for many women when it is over the phone, it kind of makes them feel safer and we do have a lot more disclosure of information".

One participant, who is connected with Kamloops Immigration Services, shared that the agency has launched different initiatives to assist marginalized immigrant families during the pandemic. She stated:

> We have been giving computers away to clients who, you know, are low income and we feel that they are isolated. Even if they have one computer at home, if the kids are on Zoom now with COVID, we want to make sure that the adults have access to communicate with us and all the service providers on Zoom. We have an IT person training our clients who need that, you know, accessing Zoom and Microsoft teams".

Limitations of virtual care. Many participants spoke about the challenges they faced with the transition to virtual care. Participant 6 shared one of the disadvantages of providing perinatal care virtually compared to an in-person visit. She commented:

> When docs or midwives provide consultations over-the phone instead of an in-office visit, uhm, you know, docs have a short fifteen-minutes, right? And so, they can feel really rushed, they can, you know, forget to have questions, you know, uhm, it's not as efficient and not maybe as practical of appointments for some of our immigrant families. They, [clear throat] prefer the face-to-face, is my stance.

She stated further that limited access to technology interferes with virtual encounters. She reasoned, "Uhm, lots of them don't—you know, if they don't have, uhm, computer for zoom—And the doc doesn't do Zoom, they only do phone calls. Uhm, that conversation can look very differently".

As a result of the challenges mentioned, participants felt that the caring aspect of encounters are lost in the process. Participant 3 opined, "[Virtual visits] are not as interactive and intimate".

One participant voiced her frustration while assisting an immigrant client with setting an appointment in one of the clinics. She shared:

> The people they have answering the phones I can understand that they might be burnt out, that there's a lot of people calling but there has to be something done where they rotate because an immigrant with insecurities is not gonna call back.

Participant 7 shared that while most of their services have shifted online, they still do in-person visits on a case-to-case basis with strict protocols to be observed. She commented:

> Sometimes I'll have women stopping right at our office and we are able to take them, and we can find a room, practicing social distancing, of course… We do have some plexiglass partitions. too. So that we could set it up on a table with the Plexiglas between us so that does help.

However, she revealed that she finds in-person visits with the COVID-19 protocols in place a challenge. She shared, "...with that mask [on], and you can't— yeah, especially if the language barrier is already there. And then you got this muffling mask, I do find it very difficult".

Interestingly, Participant 6 saw some positive outcome from the limitations brought by virtual care in terms of communication among health professionals. She shared:

> I'm pleased that with COVID, it's sort of— 'cause everything kind of stopped and it was all being done virtually. And then they just had to come together as an obstetrical community to figure out how safe is it for the moms to just have virtual appointments. It's not safe. You need to hear baby's heartbeat, the fetal position of baby. So, they've really come around to how to do the in-person appointments safely and I think that's important for them.

Summary

This chapter presented the impacts of the COVID-19 pandemic on immigrant women's mental health and the challenges faced by HCPs in delivering health information to immigrant

women clients. The pandemic effected negative mental health outcomes on immigrant women in the perinatal period. Anxiety, depression, and feelings of uncertainty were highlighted as mental health concerns for immigrant mothers. Isolation due to the protocols enforced to avoid the spread of the coronavirus was also observed to be common among immigrant women.

Information available on COVID-19 continues to rapidly change. The healthcare providers expressed their confusion of the changing health information and guidelines released by health authorities. While some HCPs felt that the health community in the Okanagan region had access to interpreters for their clients who needed translation services, some believed there is not enough translated resources for non-English speaking individuals to access.

Limited access to healthcare services due to the restriction of in-person services impacted the provision of care, especially prenatally. Clinics were inaccessible to many; prenatal care and other maternal and reproductive health services were compromised. This led to a spike in mental health concerns among pregnant immigrant women who needed access to these services. The pandemic prompted an increase in the utilization of virtual care through ICT tools such as video conferencing and text messaging. While the reception of remote encounters was mostly positive, HCPs still made certain that if an in-person visit is needed, they would conduct a face-to-face encounter following strict protocol.

The final chapter will discuss the recommendations to promote health literacy among HCPs and immigrant women alike.

Chapter VII: Summary of Overall Findings, Recommendations, and Conclusions

This chapter is a summary of findings from preceding chapters. A synthesis of the previous chapters is presented and a discussion of the findings is offered alongside existing literature. Implications and recommendations for healthcare practice, research, and public policy are presented to enhance understanding of the health literacy of healthcare providers and the mental health of immigrant women during the perinatal period.

Healthcare Providers' Role and Health Literacy

At the center of the adapted socio-ecological framework (SEF) is the immigrant woman who possesses knowledge, skills, and attitude on mental health (See Appendix F). The intrapersonal level of the SEF is influenced by other internal factors such as gender, beliefs, values, and experiences of immigrant women. These factors may affect their mental health as well as their perception of mental health needs and utilizing mental health services. Moreover, addressing intrapersonal factors to improve HL involves interactions with HCPs (Hawkins et al., 2021), which, in this current study, belong to the interpersonal level of the SEF. Consideration of cultural diversity in HL is crucial especially among HCPs (Simich, 2009). The need to foster trust, comfort, and communication with immigrants are at the forefront of improving HL levels (Simich, 2009). Taking these into consideration, the participants have emphasized building trust through relationships with their immigrant women clients as the first step in embarking on the client-provider relationship. Additionally, as previously mentioned, HCP encounters with immigrant women are initially medical in nature. Thus, employing a client-centered approach and establishing rapport and attending to immigrant women's immediate needs were reported to improve trust.

Assessing immigrant women's mental health needs is one of the mentioned roles of HCPs. While the participants have acknowledged that mental health concerns often come secondary to physical conditions for many immigrant women, they are still able to assess for immigrant mother's mental health through different methods. The participants were all in agreement that it is through meaningful conversations and employing creative means in mental health assessment that they are able to get a better insight of immigrant women's mental health.

Effective delivery of health information is a major tenet of improving health literacy. It has been said that HL is not just a one-way process or just a personal ability that depends upon the individual's capacity to comprehend written health information such as discharge notes and doctor's prescriptions (Simich, 2009). HCPs play a vital role in transmitting important health information especially to immigrants who are faced with language, cultural, and structural barriers.

The perinatal period is a very stressful time for women, especially considering the cultural stigma attached to mental health. Knowing this, normalizing mental health was considered a necessary conversation during pre- and postnatal visits with immigrant mothers Avoiding medical jargon is a common HL practice stated in the literature (Hawkins et al., 2021; Simich et al., 2009). As such, participants used simple terms especially in conducting health teachings. Being an immigrant and pregnant poses several challenges unique to immigrant women. Thus, providing support and positive reinforcement in any way HCPs can is important in client-provider interactions. Further, HCPs are mindful of and make a conscious effort to know and understand their client's cultural background and beliefs. Participants noted that they allow traditional practices as long as it does not harm the mother and the baby.

Partnering with other health professionals and health organisations is an essential role for HCPs as the goal is to provide the best care to immigrant women. In the organisational level of the SEF, these partnerships play a crucial role as this may promote or endanger patient engagement and service utilisation (McLeroy et al., 1988). Participants have agreed that HCPs and agencies should not work in silos and working together would be beneficial for immigrant women but maintains that client safety and comfort will always come first. Moreover, it is reported that immigrant women find solace in religion and belonging to a group of the same ethnic background (Urindwanayo, 2018). As such, HCPs partner with faith-based organisations and encourage engagement of immigrant women with ethnic groups. Interactions with groups that share the same cultural values, beliefs, and gender-related norms is embedded at the community level of the SEF and can highly influence immigrant women's mental health. Finally, HCPs work closely with translation services when their clients do not speak English. It is essential for interpreters to be screened and possess linguistic and cultural knowledge. Again, it is the role of the HCP to ensure that the client feels comfortable and safe with using interpreters, especially when using male interpreters. While partnering with translation services is an organisational issue, provision and allocation of funds for interpreters falls under the policy level.

Health Literacy Determinants of Immigrant Women's Mental Health

Examination of narratives showed various contextual factors that affect the health literacy determinants of immigrant women's mental health. Some of the HL determinants stated included social support networks, gender roles, cultural influences, language limitations, and access to mental health services. Being away from their usual familial support was seen as a concern, particularly for women whose cultural background relied heavily on support from their extended

families. Lack of social support was also thought to magnify feelings of isolation especially when women are home alone attending to their children. Additionally, cultural differences in child-rearing between the women's country of origin and Canada added to the women's anxiety levels. The many roles and responsibilities of immigrant mothers at home can hinder them from accessing mental health services (O'Mahony & Clark, 2018). Immigrant women also tend to prioritise the needs of their families and communities over their own. This often leads to a deterioration in their health, particularly their mental health. On the interpersonal level of the SEF, health literacy is influenced by social supports and social networks, such as family, friends, and community. Strong social support networks are said to improve HL levels, improve access to mental health services, reduce isolation, and protect against poor mental health outcomes (Hawkins et al., 2021). However, participants have commented that for many migrant women, decision-making, including health decisions, relies heavily on their spouse. This is consistent with the findings in the study of Mengesha et al. (2017) whereby immigrant and refugee women were not allowed to make reproductive health decisions for themselves. This reliance can negatively impact these women's HL levels as their health-seeking behaviours and activities will depend on others than their own. Thus, the interpersonal level of the SEF may positively or negatively affect the HL of immigrant women (Guruge et al., 2015; Mengesha et al., 2017).

The stigma attached to mental health was thought to be highly influenced by immigrant women's cultural background. Many of the participants noted that immigrants are often hesitant to embrace the concept of mental health. This is in contrast to the widespread acceptance of mental health in Western culture. Additionally, help-seeking behaviours are said to be impacted by immigrant women's view of mental health. The fear of being criticized due to having mental health issues was also highlighted as a common factor that affected help-seeking behaviours. In

an SEF context, the community level puts its lens on how shared identities, cultural values and norms influence HL. At this level, the most prevalent factor shaping attitudes and behaviours is the stigmatization of mental illness (Posselt et al., 2017; Salami et al., 2018, Wohler & Dantas, 2017). These cultural and societal beliefs around mental heath informs willingness to access available mental health resources and services (Roder, 2018). As such, the community may adversely affect immigrant women's health literacy.

Immigrant women's language limitations were identified as barriers in accessing health services, thus impacting their HL levels. It hindered them from expressing not only their mental health needs but also social needs. Their ability to receive pertinent health information was also affected by language differences. Likewise, participants also voiced their own difficulties in delivering health information to immigrant women with limited English skills. Though it was noted that translators were available through several agencies, the HCPs have stressed the importance of verifying if what is translated coincides with the client's facial expression and other non-verbal cues. Additionally, it was acknowledged that while most of their clients can understand and communicate in basic English, they have difficulties articulating their feelings in English and emotions when they are under stress. A major concern raised was the lack of translated perinatal printed materials in B.C. Oftentimes, they are forced to rely on printed resources from other provinces as they can offer more translated materials. This was seen as problematic especially when services offered from province to province are different. Another potential problem identified was the lack of approved translated materials, which may lead to clients resorting to online sources with unverified content. On the interpersonal level of SEF, language barrier is cited to negatively impact HL. However, language is not the only communication barrier. HCPs relationships with immigrant women is complicated by a lack of

cultural understanding around symptoms, diagnosis, and family and societal norms (Roder, 2018). This could potentially be detrimental to the immigrants' mental health as lack of cultural awareness often leads to misunderstandings, misdiagnosis, and ineffective treatment.

Access to mental health services were affected by availability of transportation, unfamiliarity with mental health services, and access to care providers. These factors are magnified for immigrant women as they intersect with other reproductive health concerns that may greatly impact access to mental health care services (Hawkins et al., 2021). Agencies and organisations are cognizant of the difficulties encountered by immigrant women in commuting to their health appointments. To address this, they are either providing taxi vouchers or working with other agencies. At the organisational level of the SEF, logistic difficulties have been cited as barriers to access to mental health services. Additionally, it was cited that many immigrant women are hands-on mothers and do most of the childcare, and more often than not, lacking their own transport.

Physician shortage was highlighted as one of the major problems not only in Kamloops but across Canada. Adding to the lack of primary care providers, many immigrant women live in rural areas making access to HCPs more difficult. This shortage results in fragmented and decreased continuity of care that is detrimental to immigrant women as this may cause confusion. It was also highlighted that encounters felt rushed, and time spent with providers were diminished.

Participant narratives also revealed that many immigrant women were unfamiliar with available mental health services in the community. They were also observed to have difficulties in navigating the Canadian healthcare system, citing reasons such as possible health service differences from their country of origin. O'Mahony et al. (2012) had similar findings in their

study, where immigrant and refugee women discovered that healthcare services were different in their country of origin. Immigrant women's familiarity of available mental health services and access to care providers intertwines with both interpersonal and organisational levels of the SEF. Part of interpersonal communications between HCPs and immigrant women should underline making these women aware of available services. However, due to physician shortage and limited access to providers where many immigrant women reside is said to be a challenge within the organisational level (Ganann et al., 2020; Hawkins et al., 2021)

Impacts of the COVID-19 Pandemic

Participants identified several impacts of the COVID-19 pandemic. The pandemic negatively affected immigrant women's mental health outcomes, increasing anxiety, depression, feelings of uncertainty, and isolation. These mental health outcomes have resulted in longer than usual encounters with HCPs. It was observed that more immigrant women needed mental health assistance which led to longer wait lists to avail of mental health services. Furthermore, feelings of uncertainty brought about by the novel nature of the virus early in the pandemic caused more anxiety to immigrant women as they also contend with job stability and childcare. Immigrant women who have school-aged children were said to have verbalized additional stress as schooling shifted virtually.

Many immigrant women felt isolated due to the policies in place during the pandemic, including public transport and travel restrictions, workplace closures, and public events and gathering limitations. The COVID-19 restrictions also meant that immigrant women's usual sources of formal and informal support were inaccessible to them. Participants highlighted that the restrictions added a layer of mental health concern especially to pregnant immigrant women during a pandemic. It was also observed that family relations have been negatively affected and

family violence has increased since the start of the pandemic. As such, HCPs employ more assessment techniques such as observation for non-verbal cues, thorough interviews, and allowing women to verbalize their feelings to determine their mental health state.

Health information on COVID-19 has evolved numerous times since the start of the pandemic. Participants admitted that the changing information posed as a challenge in terms of delivering health teachings to and assisting their immigrant clients in navigating the healthcare system. Furthermore, lack of available information bred more anxiety and increased stress levels among pregnant immigrant women. While some participants stated that there was enough translated information and communication in the women's first language, some argued that communication in the women's first language was not enough.

Due to the restrictions enforced to prevent the spread of COVID-19, there were decreased opportunities for in-person formal and informal support, especially for pregnant immigrant women. Participants noted that most health programs and services were put on hold which resulted to delays in service provision and difficulty in finding care providers. The COVID-19 pandemic also saw a shift in virtual care provision. HCPs offered virtual care to their clients and made use of ICT tools such as social media, messaging platforms, and telehealth depending on their clients' preference. Allowing clients to choose the platform for communications was deemed important in conducting encounters with immigrant clients, as HCPs noticed many women could freely express themselves.

Conversely, while it was acknowledged that virtual care has its advantages, the shift to virtual care has brought its own set of challenges to immigrant women and their families. Increasing incidences of family violence has been widely reported among immigrant and refugee families (Vigod et al., 2021; Iyengar et al., 2021). Thus, ensuring client safety was still reported

to be of utmost importance. Participants shared that they conduct video conference calls or even request for in-person visits whereby they assess that their clients' safety is compromised. Some HCPs implied that virtual encounters felt impersonal and did not build rapport as well as in-person encounters. However, all participants recognized that virtual care was better than having no access to healthcare providers at all. The interpersonal level within the SEF includes provider-client relationship and communication. As discussed in previous sections, at this level, HCPs play a vital role in limiting or promoting immigrant women's HL. Participant narratives have shown that they employ communication techniques that best suit their clients' needs given the limitations of virtual care and the circumstances brought about by the pandemic.

The COVID-19 pandemic is unprecedented, leaving governments around the world scrambling for ways to mitigate the spread and protect its citizens. Along with the changing information on the nature of the COVID-19 virus came the ever-changing response plans of governments. The regulatory policies and procedures enforced by both the federal and provincial government in response to the pandemic is within the policy level of the SEF. Such procedures and policies, while regarded as necessities, may promote or prohibit immigrant women's access to both mental health and prenatal services. These factors ultimately affect immigrant women's health literacy, as available health information and access to services are regarded as HL determinants (Delara, 2016; Simich, 2009).

Recommendations for Practice

Health Literacy Practices. The relationship between the HCP and immigrant women is viewed as one of the key components that influences HL at the interpersonal level (Hawkins et al., 2021; Lambert et al., 2014). HCPs, through their regular encounters with immigrant women, have the means to inform and educate them on important health information and mental health

services available to these women. This situates HCPs in an optimal position, as their HL levels as well as their ability to perceive the HL level of immigrant women may indirectly affect care provision (Coleman et al., 2017; Hawkins et al., 2017; Mackert et al., 2011). Participants have put emphasis on building rapport and developing healthy working relationships with their immigrant women clients. They have underlined providing a client-centered approach, with each plan of care tailored for the client. Accordingly, HCPs need to continue to make conscious efforts and devote time in building trusting relationships with immigrant women. Providing a client-centered approach in care encounters can foster trust-building and facilitate in assessing immigrant women's mental health status and health care needs. Further, through employing different assessment techniques during encounters, HCP may unravel mental health issues that immigrant women may have or not be aware of. Standardized mental health screening for pre- and postpartum mothers are available in almost all health agencies. Incorporating standardized mental health screening tools with creativity in conducting mental health assessments are encouraged to be utilized by HCPs. Being creative could involve rewording or rephrasing questions, becoming active listeners during clinical encounters, and paying attention to non-verbal cues. As Simich (2009) and Yu (2017) have informed, without trust, health interventions may not be successful in immigrants, and their HL behaviours may not improve.

Three domains of good HL practices have been highlighted in the literature: verbal communication, written communication, and visual tools (Hersh et al., 2015; Shohet & Renaud, 2006; Yu, 2017). The most auspicious methods are those that combine all domains and direct interpersonal communication (Simich, 2009) as it has demonstrated to increase patient satisfaction and promote information retention (Hersh et al., 2015). This was also echoed by the participants, who use a multi-domain approach in doing health teachings. In addition, during

clinical education, HCPs are encouraged to use plain, nonmedical language, and ensure that the client is understanding the intervention. Moreover, written information should be clear and legible if written, limited to key points, and avoiding unnecessary detail (Hersh et al., 2015). The use of visual tools is also found to be useful, especially for immigrants who speak limited to no English (Simich, 2009). As is the case for verbal and written information, visuals need to be clear, simple, and easy to understand. It is also important to note that he availability of culturally appropriate translated printed information is vital.

Working with support networks. Given the collectivist culture in many non-Western countries, involvement of support groups such as extended families, religious groups, and ethnic communities may be beneficial for immigrant women. Within the interpersonal and community levels, social support groups such as extended families, support from women of similar backgrounds, and faith-based groups, can highly influence one's health-seeking behaviours (Na et al., 2016). The presence of support network can also be vital in pregnancy outcomes (Kingsbury et al., 2019). HCPs are encouraged to assess immigrant women's support groups, and, if it is permitted, include them in the plan of care.

Education and training. Participants have called for more education and training on trauma-informed practice and cultural safety and competency training so they could be more effective in caring for their immigrant women clients. At the organisational and policy levels, these trainings enable HCPs to critically analyze how cultural, social, structural, and historical factors impact the health and health-seeking behaviours of immigrant women (O'Mahony & Clark, 2021). While participants stated that they have had cultural sensitivity and trauma-informed practice training in their workplace, they admitted that they did not receive training at the undergraduate level. As such, participants saw it beneficial for future HCPs to start cultural

competency training at the undergraduate level and reinforced throughout the semesters. Among the health professionals, nurses spend the most time with their clients. Cultural competency training allows the nurse to develop the skill to tailor and explain the plan of care according to the client's needs that may not always be in line with the conventional parameters of providing care. The core components of cultural competency include awareness, attitude, knowledge, and skills. Through cultural competency training, these core components can be instilled in future nurses. Awareness of how they react to clients whose cultural backgrounds and experiences are different from their own, and analysing how their belief systems can produce cultural bias to their immigrant clients are steps to promote cultural safety. Additionally, examining one's beliefs and values correspond to one's action and behaviour, and having culturally competent behaviours integrated into practice can improve how they negotiate the mental health needs of their immigrant women clients. Schachter et al. (2008), through the Public Health Agency of Canada, wrote a handbook on sensitive practice for healthcare practitioners which "aims to foster a sense of safety for patients" (p.107). Sensitive Practice include nine principles, namely, respect, taking time, rapport, sharing information, sharing control, respecting boundaries, fostering mutual learning, understanding nonlinear healing, and demonstrating awareness and knowledge. The set of guidelines include four categories; context of encounters, encounter with patients, challenges in encounters, and disclosure. Moreover, the Association of Faculties of Medicine of Canada provides a training program for teachers to promote cultural awareness among future medical doctors (Thille & Frank, 2006). Key areas provided in this cultural diversity training program are teaching and learning strategies and faculty development strategies. Cultural awareness, sensitivity, humility, and competence cannot be learned and absorbed in one training session; it is a life-long process. Guidelines and training programs, such as the Sensitive Practice

and cultural diversity training program, if sustained and continued all throughout the HCPs career, is key in caring for women from different cultures. Regular and mandatory cultural competency training would be advantageous for organisations if the goal is to promote health equity and culturally competent care to all.

As HL is an outcome of health education and its practices, investment in sustainable health education is recommended to produce competent HCPs who can contribute to the improvement of the quality of healthcare and patient engagement. With consistent and sustainable training and education, HCPs can develop healthy HL practices and effective communication skills that would benefit immigrant women.

Engagement in critical reflexivity. Engagement in critical reflexivity is equally important for HCPs to better recognise their own cultural and linguistic assumptions and biases (Hawkins et al., 2021; O'Mahony et al., 2012). Health professionals need to develop a deeper understanding and recognition of how structural factors such as racism, discrimination, and provider-client power imbalance impact immigrant women's experiences within their social circle, community, and healthcare system. Thus, HCPs can engage in critical reflexivity on how their practices are shaped by the same structural factors (Hawkins et al., 2021). Further, providing culturally safe care by critically analyzing how contextual and structural factors may influence the health of immigrant clients is crucial in order to deliver care that does not demean, degrade, retraumatize, or further marginalize immigrant women (Hawkins et al., 2021). A critical self-reflective health professional is better equipped to provide culturally competent care to immigrant perinatal women, which in turn can assist immigrant mothers' help seeking and utilization of available mental health services.

Recommendations for Policy

While HCPs can advocate and lobby for policy changes and creation, it is ultimately the policy and lawmakers who can impact social systems. Healthy public policy is warranted to promote health literacy and mental health outcomes for immigrant women on a larger scale. The following are recommendations for legislators and policy makers to improve the HL of immigrant women and to support these women's mental health.

Government agencies might want to consider funding and collaborating with immigrant-serving organisations and ethnocultural partners to design health promotion strategies that focus on strengthening social ties and integration of immigrant women. These strategies can enable them to build social capital and foster supportive environments which can benefit their mental health. Just as the participants have recommended, strategies should be multi-sectoral and collaborative to address HL determinants of immigrant women's mental health. In addition, the SEF suggests that interventions must, at a minimum, target two or more levels to foster change (McCormack et al., 2017). Thus, it is recommended that public health policies and programs should acknowledge and address the factors that affect the interpersonal, organisational, community, and policy levels in terms of promoting HL and immigrant women's mental health. Further, lawmakers should invest in public awareness campaigns on mental health through the use of different media such as television, social media platform, printed materials, and radio. Constant messaging on mental health promotion may lessen the stigma attached to mental health illnesses and will encourage immigrant women to seek mental health help when needed.

In gender sensitive and culturally safe policies, interpreters play a major role in communicating with immigrant women who do not speak English. Participants have raised concerns about the quality of interpreters available to immigrant women. One instance was

raised when an immigrant woman requested a female interpreter, but only male interpreters were available. Gender sensitive policy would require interpreters from different languages need to reflect gender sensitivity and be available in community, primary, and specialised care settings (O'Mahony & Clark, 2018). In a socioecological framework lens, working effectively with interpreters goes beyond the lists of technical tips surrounding the HCP-interpreter relationship (Leanza et al., 2014). To usher meaningful change, changes at the organisational and policy levels are required (Leanza et al., 2014). Healthcare systems and policy-making bodies are called to recognise that policies, ethical guidelines, and legislation need to support patients' right to have access to health care in a mastered and meaningful language (Leanza et al., 2014). Having trained interpreters who can effectively convey information about context and meanings to both providers and clients while reflecting gender sensitivity and cultural competence is a step to recognising the right to having access to healthcare. Therefore, ensuring that government-provided interpreters undergo necessary cultural competency and gender sensitive trainings is recommended.

Lack of translated printed information, especially for the less common languages, was reported by the HCPs in this study. This made it difficult for them to provide provincial-approved materials to some immigrant women. Funding from the provincial government for printed health information to be available in more languages is recommended.

Recommendations for Research

Within the socioecological framework, multiple levels impact individuals as they interact with their physical and social environments. This framework expands the lens of HL beyond the immigrant woman to examine the delivery of health information, the materials presented to clients, the communication skills of HCPs, and the policies that shape the healthcare system

(McCormack et al., 2017). The primary aim of this study was to explore the HCPs health literacy skills and practices in their encounters with their immigrant women clients in the perinatal period. Future research might consider viewing the effectivity of the framework in the lens of immigrant women to substantiate the findings of the study. A study in the perspective of immigrant women would not only enhance understanding of the contextual factors that affect their health literacy and mental health but also promote cultural safety. Moreover, immigrant women's perspectives on HL determinants of their mental health will provide relevant information for future development on both mental health services for immigrant women and the improvement of their health literacy.

The COVID-19 pandemic saw the rise of electronic health (eHealth) as many services shifted virtually. However, little is known if eHealth systems match the health literacy of clients, especially immigrants who may not be as tech savvy. Future research may want to explore immigrant women's eHealth literacy as it seems eHealth and the use of ICT tools is here to stay.

Limitations

This study has certain limitations. First, study participants are healthcare providers who are directly involved in the care of immigrant women in the perinatal period. While one of the aims of the study was to explore the HCPs health literacy, part of the study discussed the HL determinants of immigrant women's mental health. The voice of immigrant women is lacking in this study and relies solely on the perspective of HCP participants. I acknowledge the critical significance of examining both perspectives, however, due to time and financial constraints, it was not possible for this thesis. Second, a small sample size was chosen to discover meaning and richness of information. Thus, findings of this study cannot be generalized to all immigrant women.

Conclusion

Perinatal immigrant women are burdened with many factors such as being in a new country, lacking vital social support networks, and the hormonal and biological changes that occur during the perinatal period. These challenges make immigrant women vulnerable to mental health problems. Yet, it has been revealed that many of these women do not actively seek mental health services. Examination of contextual factors that shape how immigrant women perceive and handle their mental health concerns and access services is important to gain a better understanding on how to provide optimum care for this population group.

Healthcare providers interact with immigrants on a regular basis and serve as the pivotal point of health literacy (Baumeister et al., 2021). They play a critical role in ensuring the effective flow of health information and in supporting their clients in finding, understanding, appraising, and applying this health information. However, a healthy working relationship built on trust is essential before effective delivery of health information can occur. A client-centered approach in the assessment of mental health needs and in the delivery of health information can empower immigrant women and facilitate increased health literacy. Collaborating with other agencies and working with other organisations such as faith-based groups and ethnic groups were found to be important in providing mental health support to immigrant women.

The COVID-19 pandemic has exacerbated pre-existing inequalities among immigrants, especially immigrant women. Changes to healthcare service delivery has heightened anxiety, depression, and feelings of uncertainty among immigrant women. Imposed restrictions have also impacted the level of social support received by women during the perinatal period. However, these challenges were not limited to the restrictions placed on social support networks. Information that would dispel concerns of how COVID-19 could impact both the woman and the

infant was insufficient. Virtual approaches to care have been adapted throughout the course of the pandemic to provide an alternative for in-person consults.

The socioecological framework emphasizes the importance of considering multiple levels of influence on individuals as a result of their physical and social environments (McCormack et al., 2017). It is widely acknowledged that for health programs and interventions to support sustainable change, action should be taken at multiple levels of the SEF (Hawkins et al., 2021; McCormack et al., 2017). As such, interventions that target intrapersonal, interpersonal, community, organisational, and policy factors are recommended to address gaps in mental healthcare services and promote engagement of immigrant perinatal women.

Knowledge generated in this proposed research will add to the existing knowledge as to how HCPs assess and communicate the mental health needs of immigrant women in their perinatal period. Improving the health literacy practices of HCPs can improve their communication skills and techniques during client encounters. This in turn will improve immigrant women's health literacy, health behaviours, and health outcomes. Additionally, this study will shed light on the various contextual factors that affect the HL and engagement of immigrant women. The findings of this research may inform HCPs, health policy makers, and healthcare leaders to provide health literacy training for HCPs, develop accessible information tailored for immigrant women, and improving access to health services.

Multiple knowledge translation activities will be used to disseminate findings of this research. Findings will be communicated to public health policy makers and professional health organisations as they have far-reaching influence. Publication, as well presentation conferences, will offer opportunities for dialogue among experts in this field and will assist with sharing the

findings to broader audiences. The completed publication will be sent to the Minister of Health for the province of B.C.

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Appendix A: Sample Interview Questions

Preliminary questions

1. Can you tell me about what your typical day at work looks like in terms of assessing patients, planning encounters, etc.

Questions about mental health and mental health services

1. Please tell me your experience with immigrant women in the perinatal period.
    a. How do you assess for their mental health and well-being? Do you use any assessment tools to determine if they need referral?
    b. Do you have special considerations when dealing with immigrant women?
    c. How do you make them understand their situation? How do you make sure that you understand their mental health needs?
2. How do you organize, present information, and communicate with immigrant women regarding their mental health status and needs?
3. What do you think are the most substantial issues or factors for immigrant women in seeking mental health care information and services during the perinatal period?
    a. Do immigrant women reach out to you to get information with regard to their mental health or accessing available mental health services?
4. What specific policies and resources do you know that are designed to improve the mental health of immigrant women during the perinatal period?
5. What kind of training for healthcare providers do you believe would help to improve the mental health as well as access to mental health care services for this group of immigrant women?

Appendix B: Sample Socio-demographic Questionnaire

Please provide a name (feel free to use a pseudonym. This will be used when quotes are used in the study. No identifying information will be disclosed and will be kept confidential. The following information will only be collected to help guide the interview.

Name: _____

Age:
___ 18 – 29
___ 30 – 39
___ 40 – 49
___ 50 – 59
___ 60 and above

Gender:
___ Male
___ Female
___ Other (please specify) _____
___ Prefer not to say

Ethnicity:
___ Caucasian
___ Indigenous Canadian
___ Asian
___ Hispanic
___ African (please specify) _____
___ Other (please specify) _____

Years of work/professional experience:
___ <1 year
___ 1 – 5 years
___ 6 – 10 years
___ 11 – 20 years
___ >20 years

Discipline:
___ Physician
___ Nurse
___ Social Worker
___ Community Outreach Worker
___ Psychologist
___ Counsellor
___ Other (please specify) _____

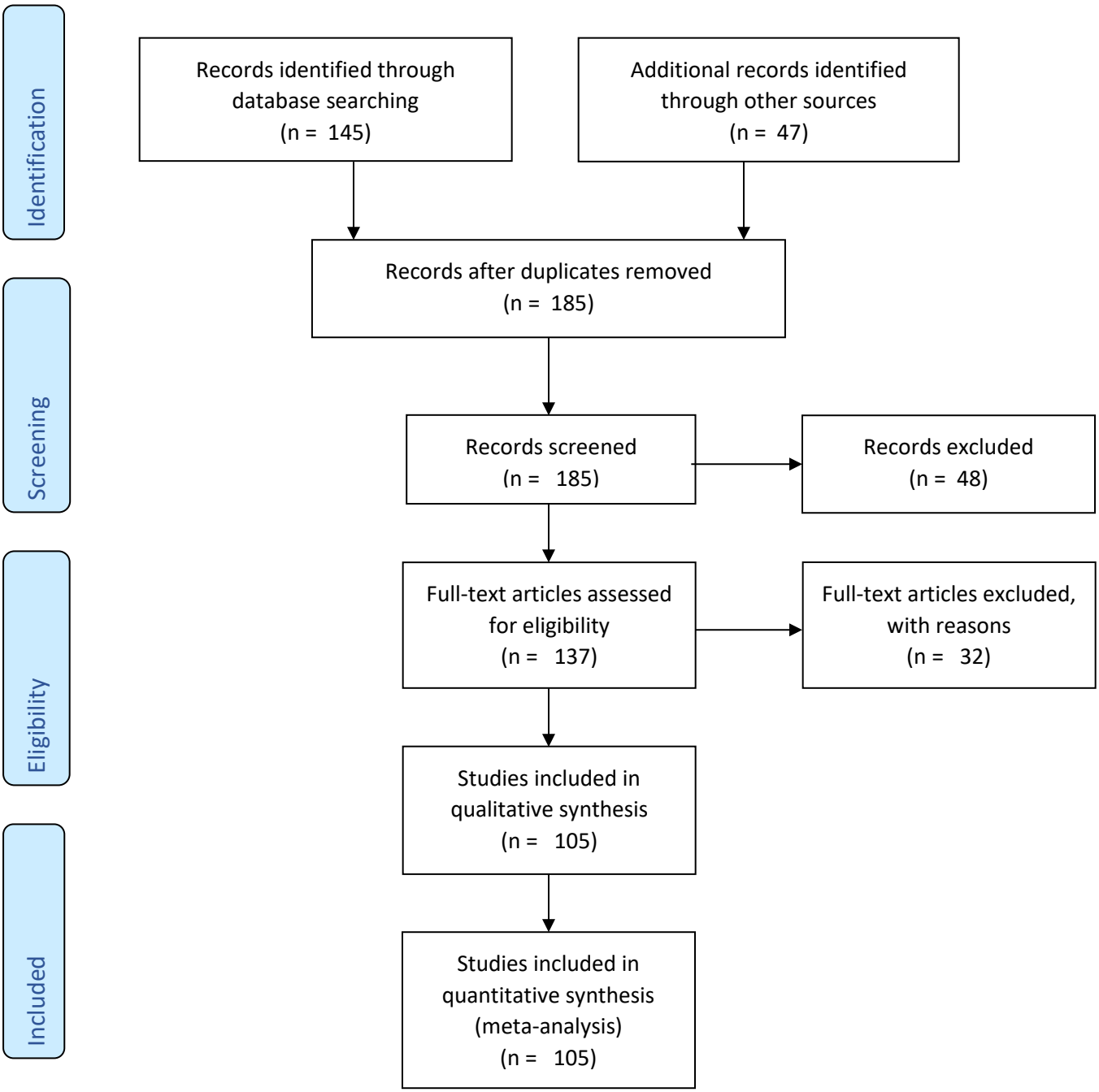
Work Status:
___ Full-time
___ Part-time

Highest education level:
___ Hospital Certificate
___ Diploma
___ Bachelor Degree
___ Graduate Diploma/Certificate
___ Masters
___ Doctorate

What best describes your role (the majority of your work hours)?
___ Direct Clinical
___ Managerial/Administrative
___ Education
___ Research/Clinical trials
___ Other (please specify) _____

Primary work setting:
___ Community-based
___ Hospital
___ Other (please specify) _____

Appendix C: PRISMA Flow Chart



Appendix D: Information Letter

Information Letter

Title: Healthcare Providers' Health Literacy and the Mental Health Needs of Immigrant Women in the Perinatal Period

Dear Prospective Participant:

This letter is to provide you with some information on the forthcoming research study. My name is Conchitina Lluch, currently a Master of Nursing international student at Thompson Rivers University and this research is being performed as part of my Master of Nursing degree. My varied nursing background consists of 7 years of experience in nursing education and renal nursing. My supervisor is Joyce O'Mahony, RN, Ph.D, an Associate Professor in the School of Nursing.

The purpose of this research project is to explore health literacy of health care providers working with immigrant women and mental health needs in the perinatal period. Through this research, broader understanding may bring attention to the accessibility of health materials and tools, health provider communication skills, and the institutional structures that support active engagement of immigrant women.

The purposive sample will consist of eight to ten health care providers that meet the inclusion criteria of: a) English speaking; b) Healthcare provider (psychiatrist, psychologist, registered nurse, social worker, counsellor) working in direct contact with immigrant women in the perinatal period, and mental health issues in the community; c) Two years working experience or more.

The participant will have one semi-structured interview. Each interview will be about 30-40 minutes. I will provide a summary of findings to all participants at the end of the study.

A questionnaire consisting of open-ended questions will be utilized for data collection. Data collection will occur from January to February 2021. Due to the pandemic, the participant may opt to have a virtual meeting in lieu of an in-person interview. The participant will have full discretion as to where and how the meeting will take place.

Thank you for your interest and potential participation in this relevant research study about immigrant women and health literacy. Using this knowledge can improve mental health care services and supports for immigrant women in the perinatal period. Should you need further information, you may contact me by phone at (236) 457-2585 or by email at lluchc19@mytru.ca.

Respectfully yours,

Conchitina Lluch

Appendix E: Ethics Approval

Thompson Rivers University Research Ethics Board

Certificate of Ethical Approval for Harmonized Minimal Risk Behavioural Study

Thompson Rivers University
805 TRU Way
Kamloops, BC V2C 0C8

Also reviewed and approved by:

- **Interior Health**

Principal Investigator:	**Primary Appointment:**	**Board of Record REB Number:** **Board of Record:**	**UBC REB Number:**
Joyce M. O'Mahony		Thompson Rivers University Research Ethics Board	H20-03470

Study Title:
Healthcare Providers' Health Literacy and the Mental Health Needs of Immigrant Women in the Perinatal Period

Study Approved: January 21, 2021 **Expiry Date: January 21, 2022**

Research Team Members: Conchitina Lluch

Sponsoring Agencies: N/A

Documents included in this approval:

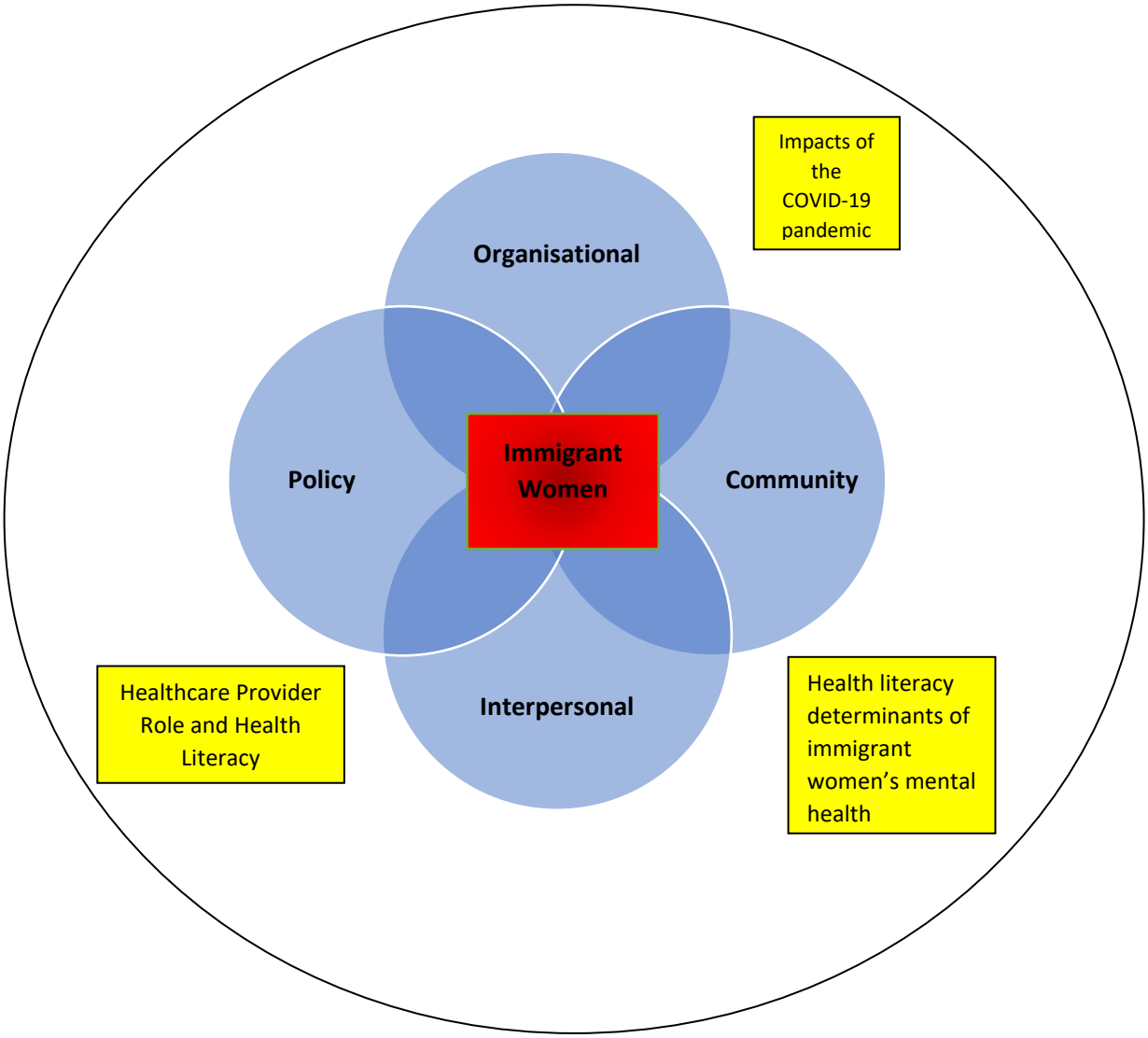
Document Name	Version	Date
Protocol:		
Research Proposal	N/A	November 15, 2020
Consent Forms:		
Informed consent	2	January 18, 2021
Questionnaire, Questionnaire Cover Letter, Tests:		
Sample interview questions	N/A	November 15, 2020
Demographic questionnaire	2	January 18, 2021
Letter of Initial Contact:		
Information letter	2	January 18, 2021
Other Documents:		
Transcriptionist confidentiality form	N/A	December 1, 2020

This ethics approval applies to research ethics issues only and does not include provision for any administrative approvals required from individual institutions before research activities can commence.

The Board of Record (as noted above) has reviewed and approved this study in accordance with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2, 2014).

The "Board of Record" is the Research Ethics Board delegated by the participating REBs involved in a harmonized study to facilitate the ethics review and approval process.

Appendix F: Socioecological Framework



Adapted and modified from McLeroy et al., 1988