



Visible Minority Women and their Access to Primary Healthcare in Canada: A Scoping Review

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Abstract

This scoping review was conducted to summarize findings regarding the experiences of visible minority women with the Canadian primary healthcare system to identify the challenges they face in accessing care. Articles searched from databases and grey literature were selected if they (i) were peer-reviewed, (ii) were published between 1990 and 2019, (iii) discussed the experiences of visible minority women with primary healthcare, and (iv) studied Canadian populations. The information extracted was tagged and sorted into themes based on Bronfenbrenner's ecological systems theory which separates society into layers for analysis. Barriers to healthcare for visible minority women were found to arise from interpersonal, community, and systemic levels. The findings demonstrate that a lack of social support and insufficient culturally sensitive care, among other factors, prevent visible minority women from accessing health resources. We provide recommendations for where improvements might be made to deliver truly equitable healthcare to this population.

Keywords: Visible Minority; Barriers; Primary Healthcare; Canada

Introduction

Contributing to its steady growth since the 1970s, Canada's burgeoning visible minority population is projected to comprise just over a quarter of the nation's total population by 2021 [1]. The health care system must continue to adapt to reflect the changing demographics in order to provide best possible care, and though advances have been made to add helpful services such as medical interpreters, there is a need for further and continual improvement [2,3]. It is known that immigrant and refugee populations overall experience higher rates of health problems than the Canadian-born population [5]. This is observed despite the "healthy immigrant effect", which describes a lower age-standardized mortality rate in recent immigrants as compared to

the host population [2,3]. This protective effect has been shown to lessen as the years since arrival increase, and the decline in health is more starkly evident in non-European immigrants [5]. Further, "due to a range of vulnerabilities such as higher incidence of poverty, overcrowded housing conditions, and high concentration in jobs where physical distancing is difficult" immigrants are more susceptible to COVID-19 infection than native-born citizens [6]. As visible minority populations are overrepresented in precarious jobs that have high exposure to COVID-19 (such as Personal Support Workers and nurse aids) they are more likely to suffer from the economic and health consequences of the pandemic than their white counterparts [6,7].

Visible minority immigrants experience increased incidence of chronic conditions with age, are twice as likely to have an

increased BMI, and ultimately exhibit a poor self-reported health status 10 years post-arrival as compared to their Canadian-born counterparts [4,8]. Additionally, immigrants of non-European descent are socioeconomically disadvantaged as compared to immigrants of European origin: they are poorer, less well-educated, and are more likely to be a single parent with a child under 25 [9]. These are known social determinants of health which negatively impact the well-being of individuals living in those conditions in both the long and short term [5]. Despite this, visible minority groups are less likely to access health care services in their new country of residence. Immigrants have a reported lower utilization of healthcare services, including primary care, mental health, and dental services [2]. While immigrants are proactive in taking precautionary measures related to the COVID-pandemic (e.g., wearing masks, physical distancing, and avoiding crowded places) evidence suggests that less likely to get vaccinated as compared to non-immigrants [6]. Research shows that this disconnect between the documented challenges faced by visible minorities and their willingness to engage with the health care system is a result of their facing organizational, structural, and clinical barriers, as described by Betancourt, *et al.* (2003). These features of the healthcare system hinder minority groups' access to care through (i) lack of representation of visible minorities in leadership and as part of the care provision team, (ii) lack of appropriate communication aids and help in navigating bureaucratic processes, including continuity of care, and (iii) inability to "accept, appreciate, explore, or understand" sociocultural disconnects within the doctor-patient relationship [11]. As a result, visible minorities experience a lack of trust and satisfaction in engaging with the health care system and are less likely to seek medical help [3].

These healthcare challenges are further complicated for minority women. They must navigate an increased likelihood of experiencing linguistic barriers, and lower class-status [8,11]. In contrast to the experiences of visible minority men, there is evidence that women in this group must additionally negotiate rigid gender roles and cultural norms that complicate their access to medical care [11,12]. As per scholars of postcolonial feminist theory, however, it must be taken into consideration that the attributes of visible minority women that result in their lack of access to healthcare do not inherently make them victims. In contextualizing their differing needs as a drawback or a lack of sophistication, they are further robbed of their power and status in society [12].

An in-depth understanding of the social determinants of health affecting visible minority women in Canada is lacking. There is compelling evidence that conclusions about immigrant and minority health cannot be drawn by treating the population as a homogenous group, as migratory experiences which impact well-being vary with not only age and ethnicity, but sex as well [9,11]. The evidence from the COVID-19 pandemic has reiterated the need to collect race-based data to fully understand "the differential rates of COVID among visible minorities in Canada" [7]. Previous studies have been able to identify barriers that affect the well-being and health of immigrants and refugees overall, but little has been done for visible minority women in particular. This scoping review seeks to identify the barriers to accessing health care experienced by minority women in Canada at the systemic, community, and interpersonal levels. To this end, we hope to shed light on the particular issues and cultural contexts surrounding visible minority women's health to inform health care providers and policy-makers in promoting this population's accessibility to health care services.

Methods

In this study, a scoping review was conducted to collate, summarize, and report on the findings of academic literature that describes experiences of visible minority women while seeking health care. Specifically, the purpose of this paper was to scope evidence related to the interactions between visible minority women patients in Canada and facets of the Canadian primary health care system. The methodology described by Arksey and O'Malley (2005) was used to conduct the review as it provides a rigorous and transparent framework for handling the literature. There are five stages to this methodology: (I) identifying the research question, (II) identifying relevant studies, (III) study selection, (IV) charting the data, (V) collating, summarizing, and reporting the results. This framework was applied as below.

Identifying the research question

The research question developed and examined in this review is: "what aspects of primary health care in Canada impede access to care for immigrant and refugee visible minority women?". Visible minority groups include individuals, other than Indigenous peoples, who are non-Caucasian in race or non-white in colour, as per the definition by Statistics Canada [14]. As of 2011, just over 65% of visible minorities in Canada were born outside of Canada, which means the majority are relative newcomers [14].

The ‘barriers’ cited in the research question, as explained earlier, may include organizational, structural, and clinical barriers, as outlined in the paper by Betancourt, *et al.* (2003). We aim for the results of the review to include barriers to accessing health care at several levels of society to gather a holistic understanding of these challenges.

Finally, ‘healthcare’ here will describe primary healthcare (PHC). Clinicians involved in primary healthcare include family physicians, nurse practitioners, and pharmacists [14]. Primary healthcare was targeted as it comprises the gateway to the health care system, and is focussed on health promotion, disease and injury prevention, and deals with managing determinants of health in order to promote the population’s well-being [14]. As such, most Canadians turn to primary healthcare when they require medical help, so examining barriers at this point would provide a comprehensive critique of the system [14].

Identifying relevant studies

The search strategy for this review was developed in consultation with a librarian at Western University. The period chosen for this review was January 1990 to August 2019 in order to accurately represent the modern landscape of immigration and minority health. Databases that were targeted included MedLine, Scopus, CINAHL, Web of Science, and PsycInfo. The aim was to cover not only medical journals but also works in the fields of allied health care, such as nursing. As well, papers were obtained through hand-searches in Google Scholar, Social Sciences and Medicine, and Journal of International Migration and Integration, and by recommendation from experts in the field. Qualitative, quantitative, and mixed-method studies were reviewed.

Next, search strings were constructed using the Boolean method, and refined through multiple phases of testing to obtain relevant and high-quality papers. The following summarizes the keywords used and the concepts targeted:

Concept 1 - health care barriers

- Barrier* to health care
- Health care accessibility (MeSH)
- Health services accessibility (MeSH)
- Attitude to health (MeSH)
- Social determinants of health (MeSH)
- Patient acceptance of health care (MeSH)

Concept 2 - primary care

- Primary care
- Primary health care (MeSH)
- Family physician (MeSH)
- Physicians, family
- Family doctor
- Nurse*

Concept 3 - minorities

- Visible minority
- Minority groups (MeSH)
- Refugee*
- Emigrants and Immigrants (MeSH)

Concept 4 - women

- Women
- Girl*
- Mother*
- Female*
- Women’s health

Concept 5 - Canada

- Canada

Study selection

Inclusion and exclusion criteria were set after the search was conducted to narrow down results. Studies were included if they were (i) peer-reviewed, (ii) published between 1990 and 2019, (iii) discussed the views and experiences of visible minority women with primary health care, and (iv) the study population was Canadian. As mentioned, the term “visible minority” denotes non-Aboriginal individuals that are not Caucasian or white, as per Statistics Canada [4]. In turn, studies were excluded if they did not mention elements of the primary healthcare system, that is, family physician and public health nurses, among other providers, as defined by the Health Council of Canada [5]. Studies in both English and French, Canada’s official languages, were included. The final selection of studies was based on ranking by Weshues, *et al.* using a 5-point scale. Studies were ranked from not relevant (“1”) to highly relevant (“5”) based on the number of criteria that were satisfied as well as the overall quality of the article. For example,

if the study met all the inclusion and exclusion criteria, and it provided insightful conclusions to healthcare barriers experienced by minority women, it was ranked as “5”. Only articles that were ranked three or higher were read in full and included in the review. The ranking process was conducted by each author individually and results were compiled to maintain rigour. The flow of study selection is summarized in figure 1, as per the preferred reporting items for systematic reviews and meta-analyses statement: scoping review extension.

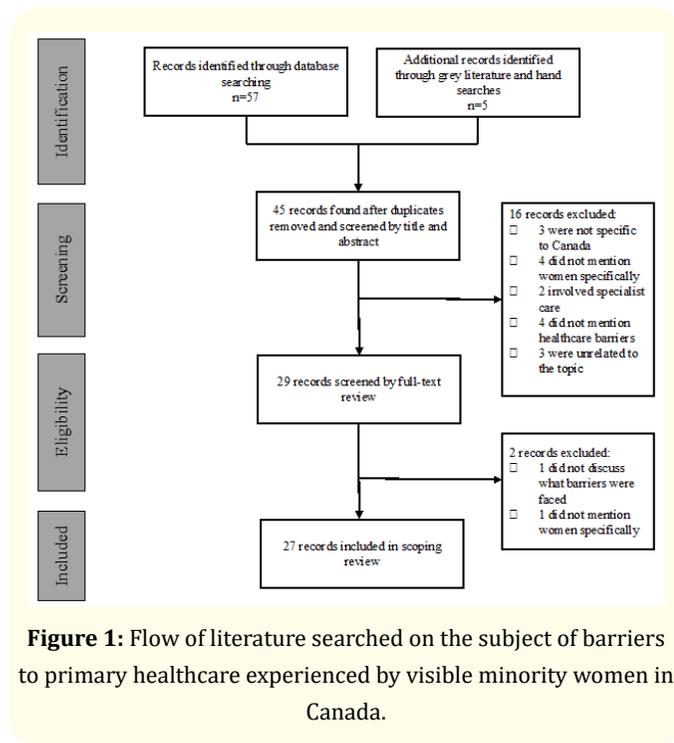


Figure 1: Flow of literature searched on the subject of barriers to primary healthcare experienced by visible minority women in Canada.

Charting the data

Studies were reviewed to collect the following information: author(s), year of publishing, study objective, sample population, study design, and barriers to healthcare discussed. The information was recorded in a table on Microsoft Excel. As the findings sought in this review involve the thoughts and experiences of other people, a reflexive approach was implemented during the charting process in order to ensure that the authors’ own views and perspectives do not influence results [15]. The authors’ identity factors and lived experiences were kept in mind throughout.

In mining study data regarding the barriers to healthcare, units of information concerning visible minority women and

their various experiences with the primary healthcare system were collected and documented using Taguette, an open source tool used to tag research material [16]. In studies that included both visible minority male and female subjects, only findings that explicitly involved or documented the experiences of visible minority women were included.

Collating, summarizing, and reporting the results

Tags generated during the review process were sorted based on Bronfenbrenner’s ecological systems theory, which describes the differing layers of social interactions that surround and affect an individual [17]. These “levels” of society are defined as: (1) the microsystem, (2) mesosystem, (3) exosystem, and (4) macrosystem [14]. The microsystem involves interactions between the individual and their immediate surroundings, including their family or friends, for example. The mesosystem encompasses connections between aspects of the microsystem, such as how this individual’s family’s behaviour might affect their relationship with their friends. The exosystem describes the community that the individual belongs to while the macrosystem encompasses broader culture, social norms, and laws [17]. Ecological systems theory puts importance on considering the social environment as inherent to human growth and wellbeing [17,18].

To apply this theoretical framework to the research question, Bronfenbrenner’s layers were further elaborated to fit the topic. The effects of the following levels of society on visible minority women’s access to health care were examined:

- **Microsystem + mesosystem:** The patient’s immediate family, colleagues, and friends, and connections between each
- **Exosystem:** The patient’s community, including the family physician’s clinic, and experiences with other care providers
- **Macrosystem:** Includes cultural norms, societal values, and bodies of knowledge that impact patients’ experience with primary health care.

Tags were classified under the above-mentioned categories to create themes. Subthemes were identified as well to ensure a richer analysis. Themes are summarized in table 1.

Microsystem + mesosystem interactions	Exosystem interactions	Macrosystem interactions
Lack of social support/network	Language or communication barrier	Lack of permanent housing
Stigma within own community	Lack of health literacy	Trouble with transportation
Lack of belonging	Cultural sensitivity issues	Economic costs
	Lack of cultural awareness in HCP	
	Differing cultural expectations of HCP role	
	Preference for HCP of same background	
	Preference for female HCP	
	Lack of sensitivity to alternative health care options	
	Differing understanding of privacy	
	Experiences of racism	
	Lack of trauma-informed care	
	Trouble with navigating health care system	

Table 1: Summary of themes obtained through the scoping review describing the factors which impede visible minority women’s access to primary healthcare in Canada.

Findings

Overview of literature search

Overall, barring duplicates, 40 articles were obtained from database searches. An additional 5 articles were obtained through hand searches or from grey literature, for a total of 45 papers considered for review. Among those articles, 30 were selected following title and abstract searches, and full text screening yielded a final total of 27 articles included in this scoping review.

A range of papers was obtained through this strategy. There were 14 interview-based studies, 7 comparative quantitative studies, 1 scoping review, 1 systematic review, 1 chart review, 2 survey-based studies, and 1 commentary. The majority of papers studied either immigrant populations or both immigrant and refugee populations grouped together (19/27; 70%). 3 papers considered the experiences of primary health care providers while 1 paper examined the perspectives of both immigrants and primary health care providers. Most papers sampled either visible minority

individuals from Southern Ontario, Alberta, or indiscriminately across Canada (23/27; 85%). Of the qualitative studies included (16/27; 59%), all of them specifically sought to examine the experiences of racialized bodies, for example by restricting the sample population to those originating from East Asia, South Asia, South America, or Africa. 3 of the papers examined pre- or post-natal care delivery while 5 papers in total addressed women’s health topics specifically, such as breast cancer care.

These findings are based on the 27 papers selected for the review.

Theme I - Barriers to accessing healthcare arising from microsystem and mesosystem interactions

Activity in an individual’s microsystem has direct impacts on their behaviour and wellbeing, as described by Bronfenbrenner [17]. The most common microsystems level issue that arose in this review was a lack of social support experienced by the women in their communities [19-21]. Their isolation from family, friends, or

other familiar community members notably inhibited them from accessing childcare, which in many cultures is a role exclusively fulfilled by those groups [19]. This meant that the women had little time to attend to their own health needs and visit their family physicians when required. A lack of affordable and culturally appropriate childcare further prevented some visible minority women from engaging in preventative health strategies, such as exercise, which increases the likelihood of poorer health outcomes long-term [20]. In particular, a lack of social support may increase stress levels and emotional distress [23]. Moreover, it might contribute to the general sense of non-belonging experienced by some of these women [23]. One study showed a positive correlation between a feeling of belongingness and access to a family physician, demonstrating how feeling alienated from one's community may constitute a barrier to accessing healthcare [24]. This may in fact be because a robust social network was important for many of these women to find primary health care resources, as one study found [20].

For some women, cultural stigma associated with disease and ill health perpetrated by family and friends comprised a barrier to accessing health care [23-25]. In some cultures, experiencing certain illnesses such as leprosy, having mental health issues, or receiving counselling, for example, is shameful for an individual and their family within social contexts [23,24,26]. This prevents the people suffering from accessing care as they are afraid of the backlash they will face if others find out [27]. It is known that stigma is used as a method of domination by groups in power [27]. When this culturally ascribed power differential is combined with the power differential created between visible minorities ("the other") and white bodies, the barrier to seeking care for visible minority women is significantly increased [12]. Stigmata may even further contribute to the childcare burden of women in these families, as exemplified by the following:

"The child's grandmother believed that no one outside the family should care for her developmentally delayed grandson: "Sometimes we also ask our relatives to take care of our son. If we cannot find any family member we would pay school teachers . . . my mother-in-law worries if an outsider takes care of the son" [25].

Therefore, the threat of stigma, especially in combination with the aforementioned point regarding a lack of social network, may

further decrease this group's access to health care. The complex intersection of gender with ethnicity positions women in a vulnerable position with respect to accessing a primary health care provider [25].

Theme II - barriers to accessing healthcare arising from exosystem interactions

Communication skills played a significant role in visible minority women's access to primary health care. Discrepancies in language ability, communication styles or techniques, and lack of regular access to translators was a major issue for both the women and healthcare providers alike [19,21,23,25,29,30]. This led to incomplete exchanges of information, inability of the women to advocate for their own needs (such as asking for a glass of water or a walking aid), mistrust of providers, and decreased the overall quality of interactions with the healthcare system [20,25,30]. The review yielded many examples of women feeling as though procedures were explained inadequately, or that they answered questions without knowing what was truly being asked [24,31,32]. Some felt that their inability to use English was also a barrier to expressing emotion in their illness narratives [25]. Health care providers' communication styles, in turn, were often found to be confrontational and too direct, or their appointments too brief [40,46]. Some patients felt that pamphlets and factsheets provided were insufficient as written material is not considered seriously in certain cultures [23]. The issue is further exacerbated as some women cannot attend language classes to improve their English due to lack of transportation or help with childcare [21]. This barrier led many visible minority women to seek out physicians that spoke their native tongue to facilitate ease of communication, which in itself is can be a challenge [20].

Health literacy was another oft-cited barrier to minority women accessing healthcare. In particular, their degree of understanding of preventative medicine and prenatal care often prevented them from consenting to or reaching out to acquire those health resources [19,21,33-36]. Some women felt that prenatal care was superfluous, or excessively delivered in Canada [33]. Others were not aware of risk factors of certain conditions, such as post-partum depression, and did not know to ask for help if they became ill [34,35]. Others yet were not current with knowledge about self-care or baby care, or rather their awareness did not overlap with

what is considered “common knowledge” in Canada [21]. As such, the finding that some minority women lack health literacy may be more meaningful when contrasted against the very medicalized healthcare culture in North America [33]. The duty of prenatal care, for example, may be the responsibility of family members in some cultures and not freely discussed with doctors or the concern of the mother herself [37]. This point will be further discussed under theme III.

Insufficient sensitivity to other cultural norms and values on the part of health care providers was a significant barrier to visible minority women’s access to health care [19,21,24,31,33,34,36]. The nature of the patient-provider encounter was often a source of distress for the women. Many visible minority women felt shy or uncomfortable about exposing their body during physical exams, or did not feel comfortable consenting to certain procedures, especially those involving screening, as they did not understand the utility of such tests [33,35,38]. Others were not comfortable speaking about medical conditions for fear of being stigmatized by the provider, while some misconstrued care provision, such as mandatory reporting of abuse, to be a violation of their privacy [21,24,34,39]. Many were also dissatisfied by the lack of, or insensitivity to, alternative healthcare options, such as herbal medicine, cultural pre- or post-natal rituals, or dietary supplementation [19,21]. These views on the patient-provider interaction stemmed from diverging cultural beliefs held by the individual as compared to the reigning majority and resulted in negative outcomes if providers were not sensitive to the differences. Women leaving these experiences felt that unsuitable, rushed, or impersonal care was delivered, or that their views and opinions were not respected, which has potential to damage the therapeutic relationship [35,39]. Moreover, some felt infantilized by their providers [39].

In order to negotiate this power imbalance, many visible minority women were compelled to seek female health care providers or those of the same ethnic background [31,34,35]. Female providers were especially important for gynecologic or women’s health issues [51,58]. Some women believed that only healthcare workers that fit those demographics could address their needs with understanding and respect [31,32]. This only increased this group’s barriers to healthcare however as waitlists have only been increasing.

The experiences of visible minority women in accessing healthcare were not restricted to microaggressions perpetrated by providers and other members of the system: several studies described cases of overt racism, which prevented many from seeking further help [30,31]. This ranged from direct comments to patients regarding their ability to care for their children, for example, to subtle behaviour informed by prejudiced thinking [54]:

Although certainly not all informants expressed directly racist or stereotyped views, many, even those who were themselves members of visible minority groups, offered a variety of candid statements regarding the “low pain threshold” of members of certain ethnocultural groups, the tendency for others to be involved with illegal drugs, the peculiar body odors emanating from some patients attributed to strongly spiced cuisine, and the lack of attachment to children among some groups who reputedly freely “give away” their children to relatives [38].

Having a female identity already increases the chances of an individual’s pain to be perceived as negligent; considering the intersecting identities of “woman” with “visible minority” only exacerbates such perceptions [42]. Such thinking, and resulting discriminatory behaviour, often translated to visible minority women feeling overlooked in favour of white bodies [37]. The term “feeling invisible” was used to describe how their needs and asks were ignored at times [38].

Theme III - Barriers to accessing healthcare arising from macrosystem interactions

On the level of the overarching norms and laws of society, socioeconomic factors comprised a significant barrier to visible minority women’s access to health care. The GBA+ framework supports this finding as it emphasizes the importance of considering an individual’s socioeconomic identity as well as their gender and ethnic identity factors, among others, when critiquing policy [28]. Some studies reported a lack of permanent housing, or trouble with transportation being a major hindrance [20,25,34]. This group at times lacked a permanent address or phone number, or did not have the means to attend frequent appointments, all of which are important factors when considering follow-ups [20]. Older women especially were forced to rely on their children for transportation, creating further challenges [25]. Economic demands overall were a problem for many of these women since

their time was often split between working and childcare; some suggested the provision of bus tickets as potentially helpful [34]. These socioeconomic barriers demonstrate that the disadvantages experienced by visible minority women begin firstly at the systems level.

Overall, studies consistently show that there is a lack of access on the part of visible minority women, even in cases where researchers are not able to account for where in the overarching system the challenges arise from [42,43]. It has been shown that the ideological process of racialization, perpetrated by the members of dominant society and reinforced by the media, negatively impacts the health of visible minorities [42,43]. Even though there was no clear evidence to support these claims, visible minorities were historically associated with ideas of uncleanness, disease, and infection [43]. Illness in these populations were attributed to problems with their countries of origin, instead of on the stresses of immigration or shortcomings of their adoptive countries]. As such, being viewed in such an othering and stereotypical context in everyday interactions in the healthcare system would further tip the power imbalance between patient and provider [42,43]. Certainly, the discomfort created by such an imbalance would prevent these women from accessing the system's resources.

Discussion

This scoping review demonstrated that visible minority women in Canada must overcome multiple barriers in order to access primary healthcare. These barriers originate from the interpersonal microsystems level to the level of the overarching norms of society. In particular, visible minority women must deal with communication difficulties, a lack of social support, health-related stigma in their community, a lack of cultural sensitivity within the healthcare system, socioeconomic status-linked limitations, and clashing values and priorities with the overall Canadian medical culture. These barriers are unlike those experienced by members of the majority group and put visible minority women in a vulnerable position; their different appearance, comportment, values, and priorities correlated with difficulties with accessing care that they perceived to be helpful and adequate. As a result of the barriers, many of these women were prevented from reaching out to or continuing to engage with their primary health care providers for fear of experiencing inappropriate care, discrimination, or shame [24,34]. These factors also seemed to increase the power

differential between provider and patient, as these women were viewed as "other" and often more "difficult" to deal with [38,39]. Their language barriers, and culturally informed reluctance to engage in certain topics with health care providers further widened that gulf.

The primary goal of the Canadian Health Act is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" [44]. These results however demonstrate that there is a distinct inequality in the number and size of barriers to primary healthcare experienced by visible minority women. The impacts of this observation are far-reaching. As some studies in the review indicated, some of these barriers resulted in several women being less inclined to follow-up with their family physicians or participate in preventative health care measures [34]. Facing such barriers and dealing with the racial microaggressions which are supported by the systemic discrimination evidenced in this review further weighs on individuals, as Wong-Padoongpatt., *et al.* (2017) found [45]. Recent evidence confirms that COVID increased the frequency of "harassment, attacks, and stigma" on immigrants and visible minorities due to their racial identity, ethnicity and/or skin colour, thus compounding their vulnerabilities to the negative "health and economic impacts of COVID-19". Visible minority women were more likely to be targets of unwanted behaviours compared to their male counterparts or non-visible minorities [6,7].

As such, groups that are perceived as perpetual foreigners by the majority population experienced psychological distress through consistent devaluation of their self-esteem [46]. When compounded with sex-based microaggressions, and the stress associated with a lack of social network as reported by many women in the review, the psychological toll on this group becomes significant [19,31,32]. Overall, these results underline that, since visible minority women comprised approximately 23% of the Canadian population in the 2016 census, a significant proportion of Canadians require much-needed supportive measures to access the healthcare to which they have a right [1].

The findings in this review mirror those present in the literature, though a review on the barriers to healthcare for visible minority women specifically was not found through this search strategy. The

paucity of studies on this subject in general indicates a research gap in the field. In studies where both the experiences of men and women were considered, the barriers cited most often or uniquely by women were those regarding childcare, lack of family/social connections, lack of alternative healthcare options, and preference for female physicians [20,22,25]. These observations are supported by the fact that many societies attribute childcare responsibility to women primarily, and a lack of family help increases the burden of this responsibility for the individual, thus becoming a barrier for visible minority women seeking healthcare resources [47]. Further, modesty is an important value for many ethnic groups, and is a construct that informs behaviour, manner of dress, and relationships between genders [47]. Modesty also informs visible minority women's level of comfort with disrobing for physical exams, engaging in sensitive procedures (such as screening for breast cancer), and consenting to invasive examination techniques, which explains their preference for female physicians [36,47].

Finally, the increased likelihood for visible minority women to consider a lack of alternative healthcare to be a barrier, as compared to their male counterparts, parallels trends observed in the general Canadian population: middle-aged women, especially those who are educated, show the highest propensity for seeking alternative healthcare options, such as chiropractic [48]. It can be concluded, therefore, that some barriers to healthcare cited in this review are unique to visible minority women due to their female identity.

Study limitations

This scoping review included studies that were conducted on individuals identified as visible minority women, immigrant women, and refugee women. In such a way, all visible minority women were considered a monolithic group; teasing out their views based on their ethnic backgrounds was not within the scope of the research question. This is a shortcoming to the study however since different cultures may have very contrasting views on expectations of their family physicians, for example [22,23,40]. Further, in extracting the findings, no distinctions were made among time since arrival to Canada, or the generation of visible minority, therefore the impacts of these variables on perceptions of barriers to healthcare cannot be commented upon. This is a limitation to the study as there is certainly a diversity of experience among

each of these subgroups, especially when considering the Healthy Immigrant Effect [9]. These limitations however demonstrate the richness of data that is yet to be collected from this population and indicates other future areas of research.

Conclusion

This scoping review was conducted to examine the barriers to accessing primary healthcare experienced by visible minority women in Canada. By analyzing papers from a collection of sources, barriers were identified and sorted according to which layers of society they originated from: the microsystem, mesosystem, exosystem, or macrosystem level, as described by Bronfenbrenner [17]. At the micro- and mesosystem levels, visible minority women cited a lack of social support, social isolation, and health-related stigma as major barriers. At the exosystem level, communication issues, a lack of health literacy, insufficient cultural sensitivity on the part of health care providers, and experiences with racism prevented this group from accessing healthcare. Finally, at the overarching macrosystem level, visible minority women's socioeconomic status, and a clash in cultural values with the Canadian medical system were the most important hindrances. Visible minority women embody several intersecting identities, including that of "female" and "ethnic minority", each of which are linked to unique challenges; these labels must be examined individually to create more equitable opportunities for marginalized groups [29]. While the COVID-19 pandemic has had negative health, financial, and social consequences in Canada and globally, the inflow of recent immigrants to Canada demands targeted healthcare efforts to understand the long-term health effects on immigrants based on the intersectionality of race and gender [6,7]. In the meanwhile, supports such as reliable interpreter services available, and creating outreach programs to help with navigation of the healthcare system, are strategies that some institutions have already implemented to good benefit [49,50].

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