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Review Article

A Critical Review of Social Exclusion and Inclusion among Immigrant and Refugee Women

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International and global migration has risen over the last 50 years, and this trend is not expected to change. Immigrants and refugees make sociocultural and economic contributions to settlement states; however, this does not always mean that they feel included or welcomed. Social exclusion as a determinant of health reflects the social inequalities of some groups in a population over others. Immigrants and refugees are excluded from participating in social, economic, civic, and political domains within Western settlement countries; women experience greater social exclusion because of intersecting social identities and the interplay between sociostructural systems that create inequalities within host societies. To explore this phenomenon more fully, we conducted a critical review of how social exclusion and inclusion are experienced by women settling in Western contexts and the factors that impact daily life and health. Intersectionality was the lens with which we situated, examined, and analyzed the findings of the critical review to inform the development of a conceptual model. A five-stage process was used to comprehensively review the literature using six databases. Sixty papers were included in the review. The conceptual model highlighted two overarching themes that were further distinguished by micro-, meso-, and macro-level factors of exclusion and inclusion. The first theme considers the causes and outcomes of social exclusion represented as social determinants in the context of settlement and includes social environment, social supports, language ability, discrimination and racism, settlement and identity, income and employment, education and professional credentials, institutions, and government services. The second theme of social inclusionary processes consisted of social capital, social and civic participation, empowerment, and policies and settlement programs. The conceptual model advances knowledge of potential improvements required in formal settlement programs and the importance of informal programs that collectively may enhance inclusion for immigrant/refugee women and their families in Western contexts.

1. Introduction

The migration of populations has seen an increase in the last 50 years. As of 2019, there were approximately 272 million international migrants living in another country than their origin birthplace globally [1]. The percentage of international migrants varies across countries. Sixty-one percent of international migrants settled in Europe and Asia, 22% in North America, 10% in Africa, 4% Caribbean, and 3% in Oceania [1]. The United States of America (USA) continued to be the top place of settlement, followed by Germany and Russia, Saudi Arabia, the United Kingdom, the United Arab Emirates, France, and Canada. Most people migrate internationally for work, family, or study, while others leave their home country due to conflict, persecution, or disaster. As well, there are international migrants who are refugees that have been displaced and require additional support [1].

Immigrants/refugees bring sociocultural and economic contributions to settlement countries. While there are anticipated benefits to international migration, including employment, settlement, and asylum in a peaceful state, there are also challenges, in particular, feeling a sense of inclusion for settled immigrants/refugees as they adapt to the host country. Inclusion is dependent on societal and policy issues of the settlement country. Any one policy is prone to affect others in terms of the settlement experience, for example, policy areas of family reunification, labor market inclusion, political participation, naturalization,

education, and language [1]. Social inclusion has been conceptualized as a "multidimensional, relational process" that provides opportunities for social, economic, and cultural participation and interactions with the host society that engenders respect and recognition of difference, integration, and access to all aspects of social life [2, 3]. International migrants may face social exclusion due to intersecting individual social identities and the interplay between systems of privilege and oppression that uphold social inequalities at the sociostructural level [4]. Limited access to education, health services, or political engagement separately may not signify social exclusion; however, barriers to all of these (and others) are mutually reinforcing [5]. For example, low levels of health and education are inextricably linked to low income, unemployment, and lower participation in civic or political activities. Thus, it is the additive features of disadvantage among some groups that represent manifestations of exclusion.

Social exclusion is a determinant of social well-being and health and reflects the unequal distribution of power across groups within a specific society that, in turn, leads to economic, political, social, and cultural inequalities [6]. Therefore, some population groups do not have a chance to contribute to or be engaged in the communities in which they live, work, and play [7]. Specifically, immigrant and refugee women experience greater exclusion due to many factors, including competing role responsibilities, that limit their ability to enter the labor market, and in turn, this impacts income and social status [7–10] Organization for Economic Cooperation and Development (OECD), 2017. When immigrant/refugee women decide to enter the labor market, they are forced to accept low-wage and low-skilled positions and are prone to exploitation, racism, or sexism [11]. Because of the interplay between economic exclusion and other domains of social life, immigrant/refugee women are further excluded from opportunities to make social connections, be part of social networks, learn the language, and engage in other aspects of social participation [6, 12]. While settlement and integration services are available in most Western contexts, there continues to be gaps in awareness or access of services or programs to support immigrant/refugee women in the cultural transition [6, 13]. As social exclusion is subjective and experienced by immigrant/refugee women in their social context, it is important to consider factors that collectively uphold exclusion as well as those processes that promote inclusion. Therefore, we conducted an in-depth critical review to answer the following research questions: (1) How do immigrant and refugee women experience social exclusion and inclusion in Western contexts? and (2) What processes improve social inclusion and, in turn, impact the daily life and health of women? Our purpose was to gain knowledge that would be of use in furthering our understanding of social inclusion in local community contexts that will inform changes in community practice, policy, and education.

2. Materials and Methods

2.1. Theoretical Framework. An intersectionality lens was used to guide this study as it represents a knowledge project to examine a social problem, social exclusion of immigrant/refugee women, that impacts health and well-being [14]. Intersectionality can be traced back to the Black feminist movement. Intersecting power relations of race, class, gender, and sexuality and its impact on African-American women in the USA provided a mechanism to assess and analyze social, political, and cultural realities of diverse populations [15]. According to the intersectionality framework, the social identities of "race, class, gender, sexuality, ethnicity, nation, ability and age (and other) operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities" ([14], p. 2). Understood in relational terms, "intersecting systems of power" bring to light inequalities related to material resources, and social experiences of immigrant/refugee women that are bound by time and space, such as during settlement, and integration in a new country. Immigrant/refugee women have been historically marginalized and oppressed, and the intersectionality lens allows us to examine social identities at the micro level of individual experience (i.e., race and gender) and macro sociostructural level (i.e., racism and sexism) [14, 15]. By using an intersectionality lens, we were able to examine the experiences of immigrant/refugee women within their social location of settlement and factors that contributed or hindered inclusion via the preexisting literature.

2.2. Critical Literature Review. A comprehensive review of the literature was undertaken using a systematic process to search for articles and gray literature to identify how social exclusion and inclusion were experienced by immigrant/refugee women. This formed the basis of the critical review that moved past description of literature by synthesizing the relevance of diverse sources to develop a conceptual model [16, 17] that may be used to guide future research and practice. We used a systematic process while maintaining the emphasis on the conceptual relevance to select included literature. The process entailed (1) a preliminary scoping of literature for preexisting papers, (2) literature searches utilizing identified search terms, (3) the synthesis of data for conceptual development, (4) reporting of findings, and (5) a discussion and conclusion [18].

The preliminary scoping of literature enabled us to gain familiarity with papers and to refine search terms. This was followed by a search of six databases for the period beginning 1990–2020: Ovid Medline, CINAHL, Gender Studies, PsychINFO, Social Sciences Citation Index, Sociology Database, and the International "Grey Matters" Tool. Google was searched for relevant publications reporting on social exclusion and inclusion. Major subject headings and free keyword terms included: Immigrant*, Immigration/emigration, emigrant*, transients/migrants, transient*, migrant*, refugees, refugee*, minority groups, ethnic diversity, ethnic groups, social exclusion, social isolation, social inclusion, social integration, social closure, loneliness, social participation, participa*, acculturation, social determinants of health, theory, social theory, framework, conceptual framework, and concept. We included papers published from 2000 to 2020 that consisted of original research,

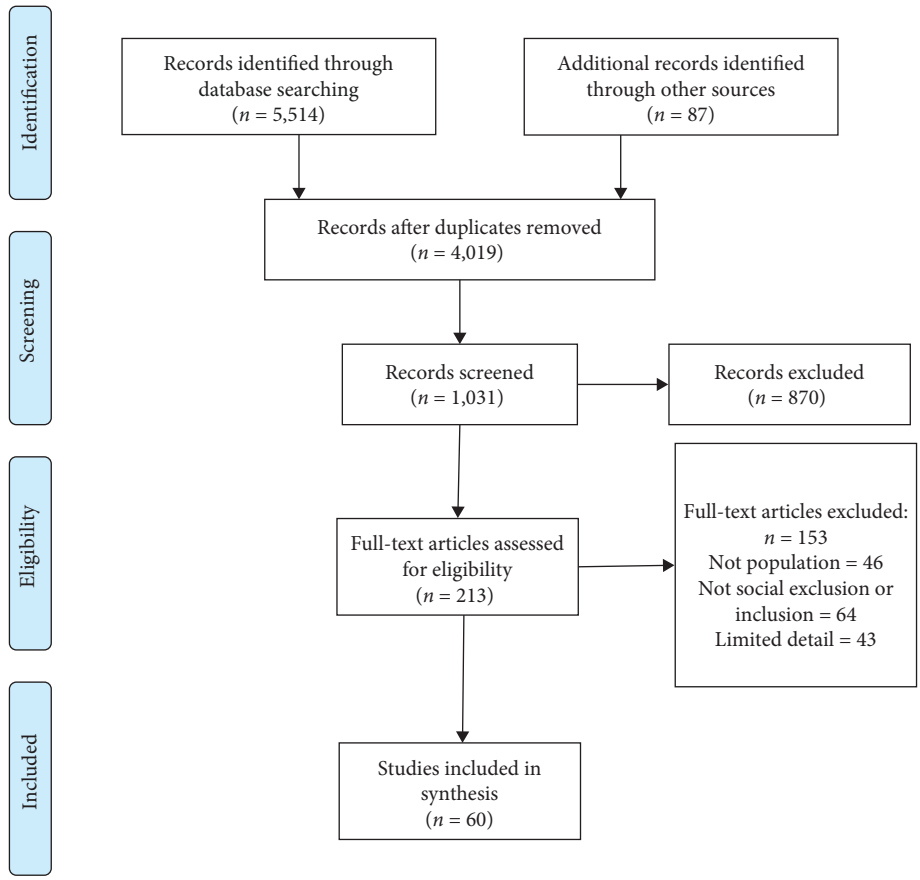

Figure 1: PRISMA extension for scoping reviews. From: Tricco, AC, Lillie, E, Zarin, W, O'Brien, KK, Colquhoun, H, Levac, D, Moher, D, Peters, MD, Horsley, T, Weeks, L, Hempel, S et al. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. Ann Intern Med., 169(7):467-473. doi:10.7326/M18-0850. For more information: http://www.prisma-statement.org/Extensions/ScopingReviews.

grey literature reports, and availability in English and full text. Theses, commentaries, or editorials were excluded. Two authors conceptualized the topic for review, two were engaged in citation screening, and four authors undertook full-text reviews and data extraction. Consensus was used to resolve any disagreements. All authors contributed to the manuscript. Endnote was used to manage citation screening and full-text article review.

3. Findings

Our combined searches yielded a total of 5,514 citation returns, including 87 additional papers from scanning reference lists (Figure 1). Once duplicates were removed and relevance established, 1,031 citations remained for the initial screen. A total of 213 full-text papers were reviewed, and 60 papers and reports published from 2001 to 2020 were included in the review. Most papers were qualitative studies ($n = 44$), with almost half originating from Canada ($n = 27$). We report on the conceptual model (see Figure 2) developed from the synthesized data of research findings (see Tables 1 and 2). The following is a narrative synthesis of social exclusion and inclusion. Social exclusion and inclusion concepts are briefly defined, which is followed by the two overarching themes that were generated with interconnecting subthemes: (1) the causes and outcomes of social exclusion represented as social determinants in the context of settlement and (2) social inclusionary processes.

3.1. Conceptual Model

3.1.1. Social Exclusion. Over time and across global contexts, social exclusion has been conceptualized in different ways, dependent on geographical, historical, political, and institutional contexts. In defining social exclusion, one must ensure that it reflects the social, economic, and political context of the state in question. Social exclusion is dynamic, multidimensional, and relational, occurring in a specific time and place; it considers a structural foundation and encompasses social processes, and subsequent impacts are cumulative, intertwined, and compounded [79, 80]. Many definitions exist globally, and because there are no universally agreed upon definitions, we focused on a definition based on an extensive review of what best delineated the social, cultural, economic, and political aspects of social exclusion. Thus, Labonte et al.'s [81] review provided a comprehensive overview of the processes of social exclusion and was chosen to underpin the conceptual model. Social exclusion incorporates limitations in (1) material resources and social needs;

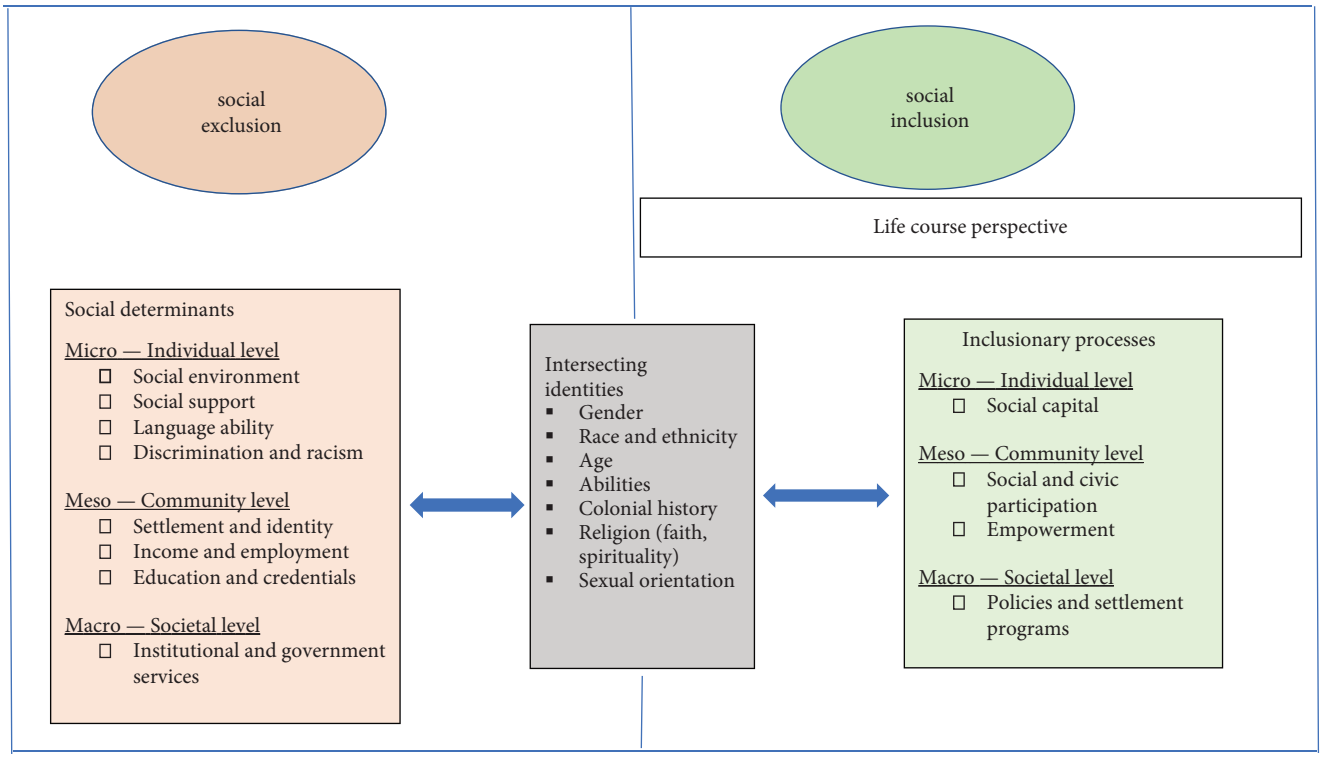

Figure 2: Conceptual model of social exclusion and inclusionary processes for immigrant women.

(2) income from secure employment or government support; (3) access to the labor market to secure stable income and develop social relations; (4) access to affordable housing; (5) access to education and skills to engage in the labor force and social participation; (6) personal safety due to systemic racism and discrimination that impedes access to employment, education, health care or other aspects of social participation; (7) opportunities for social participation, limited social support, and established social networks; and (8) power to speak out on behalf of government policies, which impacts civic participation and influences aforementioned domains [81].

3.1.2. Social Inclusion. Social inclusion, the opposing concept of social exclusion, has had limited theoretical and conceptual attention [81]. Simplistically, it is a relational process that has multiple dimensions relating to increased chances for individuals to engage and participate in social, economic, cultural, civic, and political realms. Social inclusion facilitates increased access to opportunities for social participation, including enacting social roles, expanding social ties of respect and appreciation, and greater social bonds and integration at the societal level [3]. Most of the literature highlights participation, a sense of connection and belonging, and citizenship and rights as key dimensions of social inclusion. Inclusionary processes serve to facilitate intercultural communication between different groups or systems that increase access to social participation in all spheres of life.

3.1.3. Theme 1: Causes and Outcomes of Social Exclusion. Micro-, meso-, and macro-level factors are interrelated and may lead to social exclusion or inclusion. Micro- or individual-level factors refer to individual and family capital, education, income, and skills [80, 82]. Immigrant women have multiple social identities that intersect to influence the acquisition of capital based on premigration and postmigration histories and experiences [4]. Meso- or community-level factors consist of programs, services, and policies that enable access to available community resources [80]; for immigrant women and their families, this includes ethnocultural or social services. Macro- or sociostructural-level factors include national and government policies, such as the economic status of the country, immigration policies, and resources such as child benefits, housing, and healthcare, and acceptance based on gender/cultural societal norms [80, 82]. Inequalities in opportunities and lack of acceptance because of cultural and gender norms influence exclusion.

(1) Micro-Level Factors. The following social determinants of health revealed causes and outcomes of social exclusion among immigrant/refugee women and communities in Westernized contexts. These determinants and the social identities of immigrant/refugee women intersect in multiple ways to sustain social inequalities (Figure 2).

Social Environment. The way in which immigrant/refugee women negotiate their spaces in a new context is important as it reflects challenges at the individual and structural level of how neighborhoods, communities, or services are organized or made accessible. Exclusionary processes at the individual or structural level are risk factors for social isolation and ill health [28]. For immigrant/refugee women, social identities of age, gender, class, race, ethnicity, abilities, religion or sexual orientation, family roles and responsibilities, neighborhoods, and racism and discrimination intersect to

Table 1: Studies and reports related to immigrant and refugee women.

Author, year, country	Purpose and methods	Population	Social determinants of exclusion								Social inclusionary processes		
			SE*	SS*	LA*	D&R*	S&I*	I&E*	E&C*	P&S*	Micro$^{\alpha}$	Meso$^{\alpha}$	Macro$^{\alpha}$
Acharya and Northcott, 2007 [19], Canada	Mental distress and coping strategies. Qualitative interviews	$N=21$. Indian immigrant women. Age: 60–74		√	√			√			√		
Alvi and Zaidi, 2017 [20], Canada	Relationship between well-being and quality of life. Qualitative interviews	$N=10$. South Asian immigrant women. Age: 55–81	√	√	√		√	√					
Baird, 2012 [21], the United States	Situation-specific theory of well-being during cultural transition 1: Qualitative ethnography. 2: Community-based action research	$N=20$, Southern Sudanese refugee women. Age: 21–63			√		√		√		√		
Banulescu-Bogdan, 2019, [22], the United States	Strategies for socially isolated to participate meaningfully. Literature review	Immigrant/refugee women. $N=$ organizations for OECD countries	√	√	√	√	√	√	√	√			
Bhuyan and Schmidt, 2019 [23], Canada	Isolation and vulnerability to social exclusion qualitative interviews and focus groups	$N=35$, immigrant women. $N=15$, front-line service settlement workers. $N=5$, key informants, leaders in organizations	√		√	√		√	√		√		√
Chai et al., 2018 [24], Canada	Economic security in central Alberta qualitative interviews	$N=22$, immigrant women in Canada for <10 years		√	√		√	√	√		√	√	
Choi et al., 2014 [25], Canada	Examined acculturation experiences and cultural identity. Qualitative ethnography interviews	$N=15$, Korean immigrant women. Age: 51–83		√	√	√	√	√	√		√		
Choudhry, 2001 [26], Canada	Impact of immigration and resettlement. Qualitative interviews	$N=10$, South Asian immigrant women. Age: 59–78			√	√		√					
Creese and Kambere, 2003 [27], Canada	Examines how an accent creates barriers to employment and civil participation. Qualitative focus groups	$N=12$, African women/Vancouver			√	√		√	√				
Fernbrant et al., 2017 [28], Sweden	Theoretical understanding on what characterizes processes, challenges, and relational conditions. Qualitative Interviews	$N=14$, Thai immigrant women. Age: 29–63	√	√	√	√		√					
Felsman et al., 2019 [29], the United States	The levels of distress to develop interventions to enhance the resettlement. Mixed methods: quantitative questionnaire and qualitative interviews	$N=23$, refugee women. Age: 19–60		√	√	√	√	√		√			
Gagnon et al., 2013 [30], Canada	Examine processes to respond to maternal-child health and psychosocial concerns in relation to social inclusion. Qualitative interviews and participant observation	$N=16$. International migrant women. Age: 27–38			√					√	√		√
Greenwood et al., 2017 [31], Ireland	Aspects of social context that shape experiences. Quantitative survey	$N=172$. Immigrant women. Age: 18–57				√							
Hansen et al., 2017 [32], Canada	Experiences of visually impaired immigrant women. Qualitative interviews	$N=8$. Visually impaired immigrant women. Age: 20–60			√			√	√				

Table 1: Continued.

Author, year, country	Purpose and methods	Population	Social determinants of exclusion								Social inclusionary processes		
			SE*	SS*	LA*	D&R*	S&I*	I&E*	E&C*	P&S*	Micro$^{\alpha}$	Meso$^{\alpha}$	Macro$^{\alpha}$
Ho et al., 2012 [33], Hong Kong	Exogenous variables such as marital contentment and social support, and demographics that predict integration. Quantitative survey; literature review	$N = 506$. Chinese immigrant mothers. Age range: 20–56									√		√
Kielsgaard et al., 2018 [34], Denmark	Perspectives of single mothers on living conditions and significance on exclusion. Qualitative interviews	$N = 3$. Immigrant single women. Age: 37–39	√	√	√		√	√					
Madhavi et al., 2014 [35], Canada	Experiences of loneliness. Qualitative narrative interviews (repeat, drawings, and objects of meaning)	$N = 2$. Sinhalese women. Age: 65 and older	√		√		√						
Martin-Matthews et al., 2013 [36], Canada	Explores the diversity and heterogeneity of widowhood in later life. Qualitative interviews	$N = 20$. Chinese immigrant widows. Age: 69–83		√				√			√		
McMichael and Manderson, 2004 [37], Australia	Explores meaning, order, and sense of well-being. Qualitative ethnography interviews	$N = 42$. Somali refugee women. Age: 19–65 years		√	√	√					√		
Northcote et al., 2006, [38], Australia	Explores settlement experiences, facilitators, and barriers to successful adjustment. Qualitative interviews	$N = 38$. Muslim Sudanese and Afghan refugee women. Age: 20–45	√		√		√	√		√			√
Premji and Shakya, 2017 [39], Canada	Examine pathways between under or unemployment and health plus ways that social identities intersect to structure relationships in Toronto. Qualitative interviews	$N = 30$. Racialized immigrant women. Age: 30–59	√			√	√	√			√		√
Rahder and McLean, 2013 [40], Canada	Immigrant women's perceptions of knowing their place in Toronto. Qualitative interviews	$N = 6$. Immigrant women. Age not provided		√					√	√		√	
Renzaho and Oldroyd, 2014 [41], Australia	Explores views and perceptions about sociocultural barriers and health needs during pregnancy and postnatal periods. Qualitative focus groups	$N = 35$. Migrant mothers, Afghani, African, Chinese, and Middle Eastern. Age: 24–38	√	√	√		√						
Rodriguez, 2007 [42], the United Kingdom	Examines migration as change in gendered division between private/public spaces and ability to renegotiate participation in public. Qualitative interviews	$N = 10$. South Asian women. Age: 3 time-points: before migration (1970s–1980s), after 5 years and 20 years (2003–2004) of settlement	√	√							√		
Salma et al., 2017 [43], Canada	Experiences of health-promoting practices with focus on social connectedness, social roles, and social support. Qualitative interviews	$N = 16$. Arab immigrant women, Syria, Lebanon, and Palestinian. Age: 45–75	√										
Sanchon-Macias et al., 2016 [44], Spain	Examine factors that determine subjective social status. Qualitative interviews	$N = 10$. Latin American immigrant women. Age: 24–55	√			√		√	√				

Table 1: Continued.

Author, year, country	Purpose and methods	Population	Social determinants of exclusion								Social inclusionary processes		
			SE*	SS*	LA*	D&R*	S&I*	I&E*	E&C*	P&S*	Micro$^{\alpha}$	Meso$^{\alpha}$	Macro$^{\alpha}$
Shan, 2009, [45], Canada	Explore how Chinese immigrant women refashion lives to participate in labor market. Qualitative interviews	$N=10$. Chinese immigrant women. Age: 28–45 years			√				√		√	√	
Suto, 2013 [46], Canada	Explore participation in leisure occupations in resettlement. Qualitative interviews	$N=14$. Migrant women. Age: 20–55		√	√	√			√				
Tastsoglou, and Miedema, 2003 [47], Canada	Examines meaning of community from participation in organizations and contributions to community development. Qualitative interviews	$N=40$. Immigrant women. Age: mean age of 30									√		
Walker et al., 2015 [48], Australia	Examines social support and mobile phone-enhanced communication. Mixed method: qualitative interviews only reported	$N=111$. Refugee women. Afghan (31), Burmese (36; 25 Buddhist, and 11 Muslim), Sudanese (44)			√								
Waters, 2011, [49], Canada	Experiences of immigration and transnationalism change over time and in place in relation to citizenship and belonging. Qualitative interviews	$N=5$. Immigrant women of 28 families ($N=28$) in 1999, and 2007	√		√								
Zaheer et al., 2018 [50], Canada	Experiences of immigration and relationship with distress and suicide-related behavior. Qualitative interviews	$N=10$. Chinese immigrant women. Age: 19–51	√	√		√	√			√			√

*Social environment (SE); Social support (SS); Language ability (LA); Discrimination and racism (D&R); Settlement and identity (S&I); Education and credentials (E&C); Program and services (P&S). $^{\alpha}$ micro; social capital; meso; social and civic participation (S&C); macro; policies and settlement programs.

Table 2: Studies and reports related to immigrant and refugee women and men.

Author, year, country	Purpose and methods	Population	Social determinants of exclusion								Social inclusionary processes		
			SE*	SS*	LA*	D&R*	S&I*	I&E*	E&C*	P&S*	Micro$^{\alpha}$	Meso$^{\alpha}$	Macro$^{\alpha}$
Ajrouch, 2008 [51], the United States	Associations and measures of social isolation, loneliness, acculturation, and support. Secondary data analysis	$N = 101$. Arab American immigrants. Age range: 56 and older. 56% female	√	√									
Anucha et al., 2006, [52], Canada	Examine the structure and types of social capital, how gender and other variables mediate access, and outcomes of access and use of social capital in Windsor, Ontario. Mixed methods: Quantitative survey; Qualitative interviews with key stakeholder organizations and women	$N = 300$, East Asian, African/Caribbean, South Asian, and West Asian/Middle Eastern women and men. $N = 22$, settlement organizations. $N = 20$, immigrant women (age: 23–50)	√	√	√	√		√	√	√	√	√	√
Chen et al., 2017 [53], Australia	Relationship between social integration and physical and mental health. Secondary data analysis	$N = 2{,}399$. Humanitarian migrant adults, refugees, and individuals seeking asylum. Age: 35.5 mean age. 46% female	√		√		√				√		
Curtin et al., 2017 [54], the United States	Meaning of home among immigrants aging out of place. Qualitative interviews	$N = 17$. Hispanic immigrants. Age: 65–83. 11 females	√				√						
Danso, 2002, [55], Canada	Initial settlement needs and experiences. Mixed methods: (1) qualitative interviews; quantitative survey	$N = 115$. Ethiopian and Somali refugees. Mean age: 33.3 years. 44% female			√	√		√	√	√			
Gronseth, 2006 [56], Northern Norway	Health and sickness as embedded in social life and cultural values. Qualitative interviews	$N = 100$ for fieldwork. $N = 2$ case samples. Tamil refugees. Case study 1 : 1 female. Case study 2 : 1 male. Age: Not reported	√			√	√	√					
Hellgren, 2019 [57], Stockholm and Barcelona	Relationships to place on mitigating negative effects of rejection felt by racialized immigrants and minorities. Qualitative interviews	$N = 60$ immigrants: $N = 30$ in Stockholm; $N = 30$ in Barcelona. $N = 21$ stakeholder interviews. Equal men/women. Age: Not reported				√		√			√		
Higginbottom et al., 2014 [58], England	Health and social care needs. Qualitative focus groups and interviews	Phase 1: $N = 51$. Horn of African Blind Society, service providers, Somali community groups. Phase 2 and 3: $N = 37$. Visually impaired Somali refugees and informal carers. Age: 30+. No gender distribution	√		√			√					
Hout et al., 2013 [59], Canada	Challenges of integration faced by French-speaking immigrants. Qualitative(ethnography) interviews	$N = 8$. French-speaking immigrants (4 males and 4 females). Age: 18–65									√		
Ip et al., 2007 [60], Australia	Explore problems encountered by older women in daily and social lives. Mixed methods: qualitative focus groups; quantitative survey	$N = 74$ (44 were women). Chinese immigrants. Age: 60+	√		√								
Khvorostianov and Remennick, 2017 [61], Israel	Perceptions and practices of volunteering. Qualitative interviews	$N = 21$. Russian immigrants. Age: 49–90. 17 females			√	√	√				√	√	

Table 2: Continued.

Author, year, country	Purpose and methods	Population	Social determinants of exclusion								Social inclusionary processes		
			SE*	SS*	LA*	D&R*	S&I*	I&E*	E&C*	P&S*	Micro$^{\alpha}$	Meso$^{\alpha}$	Macro$^{\alpha}$
Kim and Hocking, 2016, [62], New Zealand	Adjustments to a new environment. Qualitative interviews	$N=25$. Korean immigrants. Age: 32–58. 15 females	√		√	√			√		√		
Kim and Kim, 2013 [63], the United States	Characteristics of stress-related growth as a result of acculturative stress. Qualitative interviews	$N=13$. Korean immigrants. Age : 65–82. 6 females			√		√	√	√		√	√	
Kislev, 2017 [64], Israel	Effect of individual and country characteristics, social and policy environment on economic outcomes. Literature review	$N=7$. Western European immigrants						√					√
Lee et al., 2014 [65], the United States	Factors that contribute to poverty among immigrant older adults. Literature review	$N=3{,}820$. Korean immigrants. Age: 65+			√			√					
Lightman and Gingrich, 2012 [66], Canada	Social characteristics and personal attributes that intersect to direct divergent economic realities. Secondary data analysis	$N=38{,}000$ total, 4,300 immigrants. Visible minority immigrants, Canadian-born individuals. Age: 18–64. Gender Distribution: N/A						√					
Lightman and Gingrich, 2018 [67], Canada	Patterns of economic exclusion in Canada's labor market. Secondary data analysis	$N=32{,}870$. Visible minority, white and nonwhite immigrants, and Canadian-born individuals. Age: 18–64. 47.74% female				√	√	√					
Montesanti et al., 2017 [68], Canada	Engagement of marginalized populations and plan health services and programs. Qualitative case studies and key informant interviews	$N=28$. Low-German-speaking immigrants, refugee women, and francophone seniors. Community Health Centre staff. Age: Not reported. Gender Distribution: N/A			√			√		√			
Neville et al., 2018 [69], New Zealand	Socially inclusive communities for older immigrants. Integrative review	10 papers reviewed. Immigrants. Age: 62–93. Gender distribution: N/A	√		√		√					√	
Park, 2015, [70], the United States	Importance of ethnic identity in understanding racial and ethnic experiences. Qualitative interviews	$N=16$. Korean immigrants. Age: 41–55. 62% female			√	√	√						
Park and Kim, 2013 [71], New Zealand	Experiences and intergenerational family relationships. Qualitative interviews	$N=10$. Korean immigrants. Age range: 71–88. 5 females	√		√								
Sakamoto, 2007, [72], Canada	Experiences with the settlement process and social services. Qualitative interviews	$N=52$. Skilled immigrants/spouses (32 women; 20 men). Age: 29–54			√		√			√			
Simich et al.,2010 [73], Canada	Examines family and social factors that affect mental health and analyzes the concept of home. Qualitative interviews	Study 1: $N=220$. Study 2: $N=30$. Sudanese refugees. Age range: 20–60. Gender distribution: N/A	√	√			√	√					
Stewart et al., 2008 [74], Canada	Explore the experiences of Chinese and Somali immigrants in new settlement country. Qualitative interviews	$N=120$. Chinese (N = 60) and Somali immigrants (N = 60) from Edmonton, Vancouver, and Toronto	√		√		√		√			√	

Table 2: Continued.

Author, year, country	Purpose and methods	Population	Social determinants of exclusion								Social inclusionary processes		
			SE*	SS*	LA*	D&R*	S&I*	I&E*	E&C*	P&S*	Micro$^{\alpha}$	Meso$^{\alpha}$	Macro$^{\alpha}$
Stodolska et al.,2007 [75], the United States	Examines leisure enclosure acts as a drawback or resource to economic achievement. Qualitative focus groups	$N=204$. Korean immigrants. Age: 18–81. 43% females		√				√	√				
Wali, and Renzaho, 2018 [76], Australia	Explores the impact of social and cultural changes, how migrants cope, and the role of social capital in the settlement. Mixed Methods: Phase (1) Quantitative survey. Phase (2) Qualitative interviews	$N=164$. Refugee and migrant families; Afghanistan, Sub-Saharan African countries, Bangladesh, Burma, Nepal, India. Age: 18–80. ~50% females	√		√		√					√	
Wilson-Forsberg and Sethi, 2015 [77], Canada	Examine common volunteering to obtain relevant skills for employment. Combined findings from two studies. Qualitative focus groups	$N=16$ (69% female) Latin American immigrants, Brantford and Cambridge; $N=20$ visible minority immigrant women, Grand Erie			√				√			√	
Wright-St Clair and Nayar, 2017 [78], New Zealand	Examines how participation contributes to civic society. Qualitative (grounded theory) interviews	$N=74$. Chinese, Indian, and Korean immigrants. Age: 55+				√					√	√	

*Social environment (SE); Social support (SS); Language ability (LA); Discrimination & racism (D&R); Settlement and identity (S&I); Education and credentials (E&C); Program and services (P&S). $^{\alpha}$ micro; social capital; meso; social and civic participation (S&C); macro; policies and settlement programs.

cause isolation [28]. Northcote et al. [38] reported on the isolation cycle, which recognizes that social identities and social, political, and institutional processes of the receiving country create intersecting, complex, and equally reinforcing mechanisms that create isolation and exclusion among immigrant women. The experience of isolation tends to occur soon after migration or years after settlement for both younger and older women.

Younger immigrant/refugee women experienced isolation due to limited time for integration and role responsibilities [28, 34, 41, 42], patriarchal values, language, digital technology barriers, or being a single parent [23]. Women who accompanied a spouse had reduced access to services, delayed language learning and employment, difficulty navigating social spaces, which collectively created isolation [23]. Unemployment increased social isolation [39], and for single immigrant women, attending to children's needs and financial security without support accentuated isolation [23]. The stressors of acculturation led to feelings of isolation and alienation from participating in programs due to racial discrimination [23, 50], which led to a loss of confidence in intercultural relationships [28].

Similar to younger women, older immigrant women indicated that loss of prior social supports, chronic illness, limited social relationships, and opportunities led to isolation [20, 28, 35, 41, 43, 44]. Likewise, loss of status and privilege and the inability to communicate led to loneliness and, in turn, psychological disturbances and other health issues [35].

Isolation has also been experienced by immigrant populations who (1) were less acculturated [51], (2) lacked social acceptance and belonging [53, 54, 56, 58, 62], and (3) did not feel welcomed [53, 78]. A sense of loss, feelings of displacement, and family separation also contributed to feelings of isolation [54, 69, 73, 83]. Lack of familiarity with the new culture [71], particularly for older women who relied on others [60], being excluded from national celebrations [56], language and cultural barriers [3, 60, 69, 74], and lack of social supports and family dynamics [60, 74] were linked to isolation. Poor health [51], psychological stress, reduced quality of life [58], and depression [60, 71] also contributed to isolation.

Social Supports. If there are limited social supports, an individual's social environment is compromised, and in turn, this may lead to spatial clustering of disadvantage for immigrant/refugee women. Loss of or limited social support, meaningful relationships, or opportunities to socialize were common themes described by women [20, 22, 26, 29, 41, 42]. Lack of social support made it difficult to navigate new social spaces, gain knowledge, and access community resources [22]. For some immigrant women, social exclusion resulted from (1) spatial separation from one's coethnic community, being a single mother, and transportation issues [52, 37]; (2) loss of cultural "ethic," where neighborliness and reciprocity were missing [37]; and (3) difficulties establishing new social networks [50]. Even when coethnic supports were available, shame and stigma from the host society created a sense of mistrust to engage with others [28]. Older women's lack of social support was related to losses, family working and tending to grandchildren [36], or family living away [34]. Friends were sought out for informal support [36], and this was linked to differing norms within families that created conflicts [26].

Social support was lacking among immigrant communities due to limited language ability and transportation [83], interactions with cultural and social communities [72], relationships outside family networks [51], and separation from extended families [73]. Coethnic social supports were important; however, this created some exclusion from other sociocultural contexts [75]. Spatial and resource constraints made it challenging for some to support one another [74].

Language Ability. Proficiency in the host country's language excluded immigrant/refugee women from accessing the social environment and intercultural conversations, social supports, resources for living, and employment opportunities [19–30, 32, 34, 35, 37, 38, 41, 45, 46, 48]. Despite time since initial settlement, women had deteriorated levels of English language proficiency, and this impacted their sense of belonging [49]. Foreign accents contributed to the racialization of skill and perceived language ability. An African accent excluded women from gainful employment even though they had advanced English language education [27], and good language skills with a "strong accent" were perceived to be inadequate [24]. Some immigrant women, including those with visual impairment, were particularly challenged because they relied on family for language support or were not comfortable navigating public spaces and transit [25, 32, 36, 37, 40].

Likewise, for immigrant communities, language skills impeded access to social, economic, and civic aspects of life [52, 53, 55, 58, 60–63, 65, 68–72, 74, 76, 77, 83]. This impacted self-esteem and self-confidence, and over time, English language proficiency remained low because of limited opportunities to engage in education, meaningful employment, or practice through intercultural contact [24]. A greater majority of immigrant women than immigrant men reported moderate to poor language ability [52]. Lack of participation in language training due to caregiver and role responsibilities resulted in a loss of independence, self-esteem, and identity because of having to forgo career aspirations [77].

Discrimination and Racism. The intersection of visible minority status, skin color, accent, and religion enhanced social exclusion due to stigma, devaluing of education and professional experience, and unwelcoming attitudes. Visible minority women reported greater acculturative stress that led to psychological symptoms because they had to deal with more overt discrimination and exclusion of ordinary privileges than white populations [31]. Discrimination was related to (1) appearance, language, and accent [25, 27]; (2) stigma and prejudice related to beliefs about their culture [28, 38]; (3) religion [22]; (4) undervaluing prior education, professional credentials, and poor remuneration [44]; and (5) exploitation and racism [23]. Prejudice and discrimination put women at risk for social isolation and mental health issues [28]. Racialized women were psychologically impacted due to family responsibilities, excessive expectations from

employers, disrespectful attitudes, and racism and sexism [39]. Immigrant women faced systemic racism from employers, schools, and public spaces, along with additional challenges with employment, housing, and other settlement needs [23]. Interpersonal and institutional racism not only heightened acculturative stress among women but also limited integration into coethnic communities [50] because they felt more comfortable [28, 46, 50] in sociocultural spaces, such as churches and community organizations [46] or had lost confidence in building intercultural relationships [50].

Over half of immigrants reported that discriminatory attitudes centered on race, ethnicity, gender, and religion, which they felt were responsible for the loss of social status and plunging socioeconomic mobility [55]. The highest discrimination scores were among visible minorities [67]. Immigrants experienced negative attitudes and racist or discriminatory comments [52, 78] in employment and institutional settings [83] and in public spaces [52, 57]. Stereotypes [61, 62] and stigmatization related to one's skin color and social class preserved institutional stereotypes among some immigrants [56]. Negative stereotyping, racialization, and microaggressions impacted the sense of belonging [57] as immigrants did not feel welcomed [57, 78] or were viewed as foreigners [70]. Intercultural contacts are positively associated with a strong sense of relationship to place. Perceived racism and intolerance of immigrants limited intercultural contact and created "invisible walls" to inclusion into social life, and for some, ethnic, geographical, and socioeconomic segregation served to further exclude [57].

(2) Meso-Level Factors: Settlement and Identity. Immigrant/refugee women experienced exclusion due to loss of social status upon settlement [20, 25, 26, 35], loss of identity and some traditional values [26], and loss of individual autonomy [28]. Some refugee women experienced acculturative stress [29], other immigrant women embraced the ethic of emotional independence to cope with settlement stressors [36], while some immigrant women believed it was their destiny and reconciled to the cultural changes imposed by the settlement country [26]. When immigrant women lacked opportunities to integrate due to language barriers, working inside the home, or limited social support networks, they resorted to picking and choosing cultural practices to retain [41]. After settlement, maintaining one's cultural identity and religious practices for self and family were essential for some women, and they did not go against their own beliefs and values [38].

Transitions that occur during settlement represent loss of social identities and difficulties with adjustment to the cultural context, for example, societal values, host society language, and development of social relationships [21, 22, 29, 38, 50]. The loss of identity impacted self-esteem as women did not feel valued [35] or had low confidence due to language ability [24]. Low self-esteem and self-worth were integral to experiencing difficulties finding purpose in the settlement life [22] or a sense of hopelessness, particularly for single or divorced women and those with limited education and language proficiency [21]. Refugee women experienced shifting identities during settlement, including cultural transitions of separation, liminality, and integration [21]. Unlike voluntary settlement, refugee women were separated from home, family, and culture due to political persecution; felt they did not belong in one's own culture nor to the American culture ("in-between," liminality) and identity transformation through both internal and external forces facilitated integration [21]. Navigating the new culture fostered more independence and confidence that led to changes and collectively a sense of renewed identity, and this led to changes in women's roles within family and social networks.

Acculturative stress was experienced by immigrants/refugees during settlement [63, 76]. Internal conflict with traditional social and community structures exacerbated stress, and immigrants struggled in the new cultural environment [76]. Other factors that contributed to acculturative stress included the sense of loss of home [73], limited sense of comfort in the community [54], pressure to adopt language or dress [76], language or cultural barriers [69], low confidence in language ability [60] and inability to be part of civil society due to lack of agency and social connections [61].

Immigrants felt excluded because of loss of independence, career, and professional identity [77], social status or suspicion from the settlement society [56, 67, 69], negative attitudes in abilities or visual impairment, and lowered social status [58]. For immigrant elders, the dependency on others sustained one's lowered social status [83]. Social identities of race, gender, and class intersect with lower social status; for example, females, visible minority status, and age created greater disparities [67]. Loss of professional identity, language challenges, and loss of sense of selfled to sorrow and depression for some [72]. Despite learning the language of the host society, one's physical appearance impacts their social identity due to cultural barriers [70]. Self-identity in the settlement country was expanded when immigrants felt they were welcomed [53]. For some, an examination of ethnic identity uncovered different identity formations during early life and settlement, with a wish to reexamine ethnic identity in later life [70].

Income. With lowered class status on migration, immigrant women reported limited or fixed income [19, 20, 46], financial stressors [50], or dependency on others [26, 28]. Gender roles and dual responsibilities to children and household duties [25, 39], prioritizing spouse and children [28, 34], and managing work and caregiving responsibilities [50] lowered immigrant women's social standing in settlement countries. As well, low-income status was related to limited or no access to childcare or social supports, unsupportive partners, and inability to commute for work [39]. Poverty prevented women from pursuing education or training [25, 59] or accessing nontraditional health resources [36].

Overall, immigrants had greater financial hardships [52, 58, 63, 64, 65, 68, 73, 75, 83]. Racialized recent immigrants and women experienced greater economic exclusion over time than other population groups [67]. When immigrant women were the main income earners, they experienced more disparities and exclusion, and this impacted their ability to support family [66, 75]. Being female, older, living alone, unemployed, and experiencing language barriers increased the odds of living in poverty [65]. Economic exclusion extends

beyond material resources as it negatively impacts an individual's feelings of connection or sense of belonging, and in turn, this affects health and wellness.

Employment. Employment is interconnected with income and other social identities and determinants. Immigrant/refugee women experienced: (1) limited employment opportunities [20, 24]; (2) challenges finding work [24, 25, 29, 32, 38]; (3) unfamiliar working conditions and low-skill paying jobs [22, 24, 25]; (4) precarious work conditions, at risk for unemployment, feeling undervalued, and having fewer rights [44]; (5) exploitation, lowered social status, and exclusion [23]; and (6) imposed restrictions such as requiring a drivers license [32]. Family roles and responsibilities made it challenging for immigrant women to seek employment [24, 34, 50], which also delayed language learning [23], and they were forced to take low-quality jobs despite qualifications [22, 24, 50]. Social exclusion from the labor market unfolded as continual rejections, which affected immigrant women's morale and made them feel an "ambiguous sense of place" [27].

The employment challenges for immigrants were similar, including limited opportunities [52, 83], unemployment [52, 55, 63, 67], lack of training or skills [55], institutional racism or discrimination [55, 57], and difficulties with transportation [83]. When looking at time since migration, immigrants settled for 11–20 years had greater odds of unemployment working for only 25 or more weeks a year [66]. Immigrant women tended to have lower-status jobs than immigrant men [56] or were told they were overqualified or did not have experience in the settlement country [52], and in some cases, this led to stress and depression [52]. Often, immigrants were forced to work two jobs to meet needs, and in turn, they were unable to actively participate in community or social activities [68].

Education and Professional Credentials. Education and recognition of professional credentials intersect with income and employment opportunities, and this impacts one's social identity to facilitate exclusion. Lack of education and low literacy have been attributed to a fear of poverty due to the inability to obtain certifications for potential jobs, a driver's permit, or perform well in employment interviews [29]. Factors that impacted immigrant women's ability for career opportunities included lack of educational requirements [21, 32, 34, 44]; underemployment and deskilling [23, 50]; inability to participate in education and training or having to withdraw from schooling due to family roles [25, 34]; and lack of spousal support [34]. Accessibility to education was due to a lack of awareness, cultural pressure to avoid mixed-gender training, ineligibility, distance, or child-care issues [22]. The loss of employment also affected immigrant women's sense of self, which required them to seek out learning and retraining [32] as they had limited career options [46]. Even when women obtained training in the host country, this did not guarantee a position in their field. Decreased self-confidence regarding previous education and lack of employment and income security impacted the health of women and their families in terms of access to resources for living [39].

Different avenues were used to navigate ways to obtain experience for immigrant women, such as volunteering [24, 52]. However, some experienced frustration with gaining experience through unpaid volunteer hours [52] and, in turn, the depletion of savings [40]. Traditional, formal, and unpaid internships or co-ops were other avenues to obtain work experience for immigrants [77]. Immigrants obtained hours despite unequal power relationships and barriers to acquiring credit through volunteer or unpaid internships. Employers expected immigrants to secure unpaid work to obtain experience in the settlement country. While volunteering, immigrants had to take two to three "survival jobs" to support their families, limiting their time to be with family or participate in the community. Public service internships had strict criteria, and this was also limiting for some immigrants [77].

The devaluing or unfair assessment of professional and education credentials from origin countries was a common theme experienced by immigrant women [24, 27, 39, 40, 44, 45]. Lack of recognition for credentials, education, training, and skills made it difficult for immigrants to secure employment [55, 72]. Some immigrants had higher levels of educational achievement than host society members applying for the same positions [52, 63], yet this was not perceived to be valued in pursuing a professional career upon settlement [62, 74].

(3) Macro-Level Factors: Institutional and Government Services. Settlement services for immigrant women were limited due to a lack of trained interpreters [29] or culturally appropriate services [38]. Lack of awareness and the complexity of the system made it difficult to access services [38, 50], and limited subsidies from the government impacted women's ability to maintain financial security [50]. If women were a spouse of an international marriage or living with relatives, they were excluded from social programs and employment [28]. Inadequate information led to mistrust and a reluctance to participate in government programing or enter buildings [22]. Additionally, a lack of familiarity with the school system made it challenging for immigrant women to advocate on behalf of children [29]. Community-based programs that previously were free for immigrant women became prohibitive due to funding cuts; this was particularly relevant for low-income immigrant women [40], who were denied participation that enabled them to socialize and build social networks.

Limited awareness of services and resources, culturally inappropriate services, language, cultural and socioeconomic barriers, lack of intersectoral collaboration, lack of trust in social and economic systems, ineffective coordination between federal immigration and labor market policies, and limited funding for social service were all factors that led to social exclusion for immigrants [68, 72, 83]. Employment and language programs were not geared to immigrant women's needs of entering the labor market; rather, they were tailored at a homemaker level [72] or focused on resume writing [52]. The system barriers that persist in programs for immigrants' center on encouraging them to adopt the norms of the country or workplace. Even immigrant women with adequate language skills encountered the same difficulties in building social connections because they could not participate in community service organizations [52]. In some cases, immigrants preferred to access educational

institutions [52], ethnic associations, and people of their culture because social workers in governmental organizations were unprofessional or uncooperative in supporting them [55].

3.1.4. Theme 2: Social Inclusionary Processes. For immigrant/refugee women to experience meaningful inclusion, individual and structural level processes are important to consider. Social inclusionary processes that emerged from the literature will be presented, incorporating the interconnected dimensions at the micro, meso, and macro level.

(1) Micro-Level Processes: Social Capital. Social capital facilitated inclusion and was positively associated with the acculturation experience of immigrant women [33]. Economic, human, and cultural capital were identified as social inclusionary processes by immigrant women [30]. Being able to access education, employment, and housing, overcome language barriers, pursue personal interests, and perceive a sense of safety and financial security were individual resources that fostered inclusion. Immigrant/refugee women reported receiving bonding social capital from a partner [25], family members [19, 24], extrafamilial support with those of the same ethnic background [24, 46], connections made at community centers [42], and engagement in religion and cultural activities at faith-based places of worship [19, 21, 25, 36, 52]. Emotional, social, and financial support were provided in these contexts. Families provided support via free housing, references and transportation for employment opportunities, and information about the school system [24]. Among immigrant women, greater marital contentment, more children, financial security, and support were correlated with greater hope and higher perceived integration within the host society [33]. Financial support exerted the most significant effect on hope, and this, in turn, increased a sense of belonging. Transnational connections were also important to social capital, whereby immigrant women maintained familial relationships by telephone, mail, or Internet [37].

Participation in leisure activities with other women from one's culture provided support to deal with stress associated with unemployment and feelings of loneliness, which strengthened bonding capital, fostered a sense of community, and enhanced social well-being [37, 46]. Shared spaces for some women were important to support the continuance of the culture, and it improved social capital by engaging with other women in public spaces to learn about the receiving country, employment opportunities, or where to access services [37].

Cultural and linguistic capital facilitated intercultural dialog using the English language with children's teachers, parents, healthcare workers, or customer service [46]. A woman's proficiency in English or accent situated her within a certain social position, either strengthening or weakening it. Sometimes, employers provided bridging social capital by subsidizing apprenticeships or courses to bridge unskilled to skilled positions and offered temporary free housing or support to find housing [24]. This represented secondary social capital as human capital was lacking. If women had class-based resources and access to social networks in the receiving country, this facilitated greater upward social mobility because they were able to secure positions that matched credentials.

Social capital fostered inclusivity for immigrant women if they had access to educational opportunities [25], financial government support [19], employment opportunities, and the ability to manage one's own money and to drive as a form of independence [21]. Immigrant women created opportunities to increase social capital by volunteering [24] or organizing into groups for political, cultural, or civic activities with other women, which assisted them to make friends, fulfill spiritual, religious and ethnic needs, and expand connections to paid employment [47].

Coethnic communities provided support in unfamiliar surroundings [78]. Participation in one's coethnic community alleviated stress, provided essential support and advice, and increased a sense of community [52]. Those who reported feeling welcomed and having more friends tended to have better mental health and wellness [53]. A familiar environment where language, culture, and norms were understood offered a sense of control and comfort and enabled immigrants to transition to new ways of being in the settlement society [62]. Drawing on resources provided by ethnic enclaves were important, but also valuable to seek out resources for living from outside the enclave.

Immigrants strive to regain social capital by engaging in training, language classes, learning the cultural norms of the host society, and negotiating ways of being in workplaces or other contexts by following social norms of behavior [59]. Enhanced social capital and better integration outcomes were achieved by immigrants if they had better language proficiency and ability to communicate, participated in places of worship, developed relationships with friends from diverse groups, and reported higher self-sufficiency [53, 63]. Immigrants who felt the settlement experience provided ample opportunities for intercultural contact to share experiences enabled them to gain acceptance through integration [57]. Most felt the openness to communicate in civil society was encouraged through local networks and cultural activities. Taking action to be part of the community by volunteering and social learning of the new state, politics, and citizenship enabled immigrant/refugee women to regain social capital and build comfort and solidarity, regenerating what was lost upon immigration, such as a sense of identity [61].

(2) Meso-Level Processes: Social and Civic Participation. Volunteering created opportunities to increase social networks, socialize and build social capital [24, 52, 69], locate employment opportunities [23, 40, 74, 77], and interact with other sectors, governments, and nongovernmental organizations [52, 61]. Immigrants who volunteered to support their coethnic community felt rewarded, and this created a sense of belonging, reduced negative challenges [63], and promoted a reciprocal environment of emotional and social support. Helping others also assisted with bonding and allowed immigrants to regain social status, making them feel useful and respected [69]. The availability of familiar activities from an immigrant's home country held in informal or formal settings were methods to increase access, promote integration, and develop connections with others [69].

Social and linguistic barriers led women to volunteer within their coethnic community [61], and this led to gainful employment opportunities and the development of social networks. Difficulties entering their profession in the new host country also pushed women to use prior skills to identify gaps in services in the host country that would meet the needs of coethnic communities. For some women, even if they found a job that aligned with prior professional skills, they continued to volunteer because it was more meaningful as it provided gratification on an intellectual and spiritual level where they felt fulfilled based on their talents and skills [61]. Feeling a connection to one's professional identity increased immigrants' sense of worth and self-esteem and gave them gratification in the settlement community [77].

Volunteering in coethnic communities was perceived as a duty where immigrants gave of themselves and enhanced cultural connections [78]. This was a way of reciprocating the supports provided to them when they were newcomers; and represented a feeling of moral responsibility to demonstrate this respect and be useful to the community and society through civic contributions. Activities included volunteering in a choir for a long-term care home, knitting for children, and community garbage clean up [78].

Empowerment. Personal empowerment was acquired through volunteer activities because immigrant women were altruistic [61]. Engaging with formal organizations as volunteers empowered women to improve language proficiency in the settlement country, learn more about the legal system, and meet native-born residents [61]. Participation as part of the integration process also provided a respite due to the loss of one's professional identity from occupational and social downgrading. Another form of empowerment was through social learning of the new state, politics, and citizenship. Immigrant women who use strategic tolerance and prior knowledge became agents of change in their communities [45]. This was achieved by immigrant women using experiences of mistreatment from employers as learning moments, integrating prior professional knowledge in the workplace to prove oneself, and being an agent of change by tailoring language, providing mental health and access to housing in one's own immigrant group; these acts were integral to changing views on race and class in the host society [45]. Immigrant women felt working outside the home was positive and improved self-esteem [52]; they felt less restricted and more independent, which made women feel more empowered due to personal and financial gains [76].

(3) Macro-Social-Structural Level Factors: Policies and Settlement Programs. Improved coordination between immigration and labor policies may facilitate greater inclusion in labor markets for immigrant/refugee women. Policies on immigration status and citizenship laws that are equitable for immigrants were factors that facilitated inclusion [30]. While broader policies exist for human rights that include antidiscrimination and institutional policies that raise awareness and promote positive social attitudes towards immigrants to facilitate meso-level inclusion, these macro-level policies need to be reinforced and targeted to employers in workplaces to promote social inclusion [64].

Settlement programs in some contexts included the provision of cultural programing in safe spaces for newcomers, such as arts and crafts, yoga, and conversation circles [23]. As well, they provided opportunities for language classes, skill development, employment training, and volunteer opportunities. Information about employment or volunteer opportunities, along with mental health and gender-based violence programs, also exist within these programs. For newcomers who actively use these services, this creates opportunities to make social connections and feel a sense of belonging [52].

To truly support immigrant women in their adaptation to a new settlement country, it is important that programs and services consider that societal adaptation is a lifelong strategy [38], not something that happens within the first three to 5 years of settlement. Additionally, social support services that were free of charge and culturally appropriate were proposed; for example, community support workers who were of the same background linguistically and culturally were most effective to understand traditions and values [33]. If immigrant women had greater immigration-related supports available, then they had increased hope, self-efficacy, and a sense of connection with the community, which also contributed to a sense of resilience [50].

4. Discussion

Our critical review highlighted social determinants of social exclusion and social inclusionary processes specific to immigrant/refugee women. The findings provide insights that add to the body of literature on the gendered nature of exclusion for immigrant/refugee women. In most cases, women migrate with a spouse or as a dependent of a principal applicant, while less often, refugee women migrate alone for humanitarian reasons, with or without children. Irrespective of the pathway to migration, it is evident that some women will experience social inequalities related to inclusion in their new settlement country. Depending on immigration status, women may not be able to access settlement programs despite efforts from most OECD countries at improving services for those with the greatest need [22]. The inability to access programs or services due to family and caregiving responsibilities or cultural norms may also influence participation. The interplay of factors at the micro-, meso-, and macro-level are responsible for greater risk of exclusion. This study extends current research from an exploratory review that addresses the feminization of migration that is impacted by key determinants of health, including social exclusion [84]. In recognizing the determinants of social exclusion, the intersecting social identities, and the focus on social inclusionary processes at all levels, this study may serve to provide an initial guiding conceptual model that aims to promote greater inclusion for immigrant/refugee women in various contexts.

Social capital has been critiqued and defined by many scholars and provides a lens to understand the importance of settlement experiences, especially for immigrant/refugee women. Social, economic, human, and cultural capital all relate to having resources, knowledge and skills, and

education to meet the needs of everyday life [85]. Of course, these forms of capital are dependent on wider societal influences within a settlement country. Bonding and bridging social capital enable women to achieve personal and professional goals through social connections within and outside of their coethnic community. Immigrant/refugee women need to rebuild social capital during and long after settlement as they experience losses and strive to regain social identities in the new context. If women are successful, this may prevent them from experiencing the outcomes of exclusion, such as loneliness and depression, which were similar findings identified in other work [84]. Although programs may have formal supports for settlement, ineffective coordination between federal immigration and labor market policies, limited funding for social services, or other social needs may not be sufficient for immigrant/refugee women, such as access to culturally appropriate services, informational support, or connections to informal supports within communities [72].

Women may seek out informal supports as their first point of contact because of the welcoming nature of community settings, for example, places of worship. Bonding social capital is important in this respect because there are opportunities to meet others from similar coethnic communities so that women may receive emotional and social support. These findings align with other research where "church" was seen as a safe space for immigrant women to share experiences within coethnic communities in informal spaces, such as culture, transitions, and faith [86]. Reciprocity was mentioned as a means to support one another during times of need. However, bridging social capital should not be overlooked. While our conceptual model recognizes that social capital promotes inclusion, the assessment of social capital (e.g., bonding, bridging, and other forms) of immigrant/refugee women within all formal and informal programing in the community context is important to provide a greater understanding of unique needs and access points of diverse populations.

Participation in community activities was foundational to being able to socialize, combat loneliness, and feel connected. As noted, this occurred mainly with activities that involved engaging with coethnic communities as these provided welcoming and safe spaces or bonding social capital, which has been associated with positive mental health in a study examining acculturation and sense of belonging [87]. Some immigrant women were empowered and engaged in the community through various cultural (i.e., ethnic/multicultural organizations), civic (i.e., YMCA), and political (i.e., electoral process or peace activism) activities [47]. These activities incorporated access to both bonding and bridging social capital. However, some immigrant women stayed within coethnic communities for many years because of personal comfort and self-realization [61] or because they felt disconnected from the broader community, particularly if the host society was unwelcoming or discriminatory [78].

While engagement with one's coethnic community is valuable to reduce isolation and build bonding social capital upon settlement, it creates a cycle of exclusion that segregates differences and expands the divide between immigrants and host society members, limiting intercultural contact, integration, and a sense of inclusion [28]. As noted by Berry and Hou [87], integration is the preferred acculturation strategy for immigrants and leads to a greater sense of belonging and well-being, while those who experienced discrimination or had lower socioeconomic resources faced exclusion.

Economic empowerment programs, volunteer programs, and nonwork initiatives were promising practices combatting social exclusion among immigrant/refugee women [22]. Empowerment is a key concept that was conceptualized in a study where personal autonomy, input into family decision-making, and political empowerment were identified as factors that led to improved inclusion among Muslim women in India [88]. As well, it was an outcome of an informal support group tailored to Muslim women in the United Kingdom [89]. Additionally, employment services could offer targeted programs that capitalize on individual skills outside of formal education or certification to enable women to not only build social networks but also gain financial independence and resilience [22]. However, obstacles remain in terms of the lack of workplace policies that support diversity and integration but rather continue to restrict immigrants' participation in some areas of the labor market [84].

Volunteer programs are a form of civic engagement and a good starting point for gaining access to formal labor markets; immigrant/refugee women may gain vocation-specific experience or newly developed skills. Although nonwork strategies, including sports, arts, or community gardening utilizing peer-to-peer programs, have been shown to be effective to target more isolated groups of immigrant women [22]. The value of these activities centers around facilitating participation, connections, and greater intercultural contact and bridging social capital with the host society, even if they do not lead to gainful employment. As well, Li [90] noted that civic engagement, including volunteering, translated into better self-perceived well-being and mental health. Economic empowerment and nonwork strategies represent small-scale strategies and often are not central to government settlement and integration programs; while volunteer programs require investment in training and support, they are of excellent value in reducing isolation and exclusion [22]. A community-based informal project tailored to Muslim women settling in the United Kingdom aimed to improve well-being, skills, and integration to facilitate empowerment, which reduced isolation and promoted inclusion [89]. The program reached women who did not participate in other settlement programs; and thus, the sustainability of informal programs to promote integration may be difficult because of limited funds and reliance on volunteers.

Immigrants fulfill a variety of occupations, yet a marker of successful integration tends to focus on preparation for labor market integration [59] in most settlement programs. Childcare providers, parents, homemakers, professionals, and employees are occupations held by immigrant/refugee women. Social systems and structures are integral to occupations, either facilitating or impeding engagement. During the adaptation to a new settlement country, women are continuously navigating many occupations and social identities. This process reflects the complexity of occupation, place,

and identity across various domains [59]. Prioritizing occupations is one of the challenges, particularly for immigrant/refugee women, if there are limited childcare options, which delays their ability to learn the language, train for employment, or participate in social activities [59]. Community-based informal programs that foster integration acknowledge these occupations and aim to overcome access by gaining trust within these communities and providing childcare [89].

Programs and services center on the "average" newcomer immigrant/refugee that does little to consider the diversity of migration experiences [22]. As a result, programs overlook those who do not fit the "average" and miss opportunities to identify other ways that immigrants/refugees may contribute to the host society. For example, within the transnational family, women are responsible for most of the "emotional work" of caring and socialization of the family [49]. Thus, immigrant women may delay employment and training and take longer to integrate into the workforce and society (10–15 years) and thus may not have access to settlement services [22]. Long-term integration support is needed to not only benefit immigrant/refugee women but also their children so the risk of family poverty and social, mental, and physical health problems are not transmitted to offspring. Delayed integration may also result in a lower sense of well-being [87]. As proposed in our conceptual model, applying an intersectionality lens and considering the life-course perspective of immigrant women may serve to promote inclusion for the whole family.

Long-term support for immigrant/refugee women who are less educated is also crucial to build initial language and basic literacy skills, followed by advanced education (formal or vocational) or support in establishing a business or volunteering at a later time [91]. Forming a network of intersectoral partners within local communities, including public health, to coordinate a collective response that meets individual needs over the life course will be essential [22]. While small-scale local and informal programs aim to promote inclusion, they are limited in assessing objective outcomes and thus not valued. This is compounded by the fact that social inclusion is not well-defined or easily measured, and collectively, it makes it difficult to justify funding for informal strategies that promote inclusion outside the labor market.

The conceptual model presents an initial guide for practice by narrowing the focus of social inclusion/exclusion domains [80] to concepts that are relevant to immigrant/refugee women in the local context within the spaces of a specific community. Future research may be of use to advance and build on these concepts, as well as identify interventions; informal and formal programing that are promising to use in specific circumstances to promote social inclusion among immigrant and refugee women.

A strength of this review is the systematic process we used to search, identify, and select papers and the conceptualization of the concepts in relation to immigrant and refugee women. However, we may have missed some papers because of the complex and multidimensional ways that social exclusion and inclusion are defined or studied. Including papers with immigrant women and men may be seen as a limitation; nevertheless, these papers were important to capture the gendered experiences and unique nuances identified, and thus, these were presented separately to make explicit in the findings. Some may also find that critical reviews have inherent weaknesses because no formal quality assessment of published and unpublished (grey literature) is required. However, this was not the purpose of our critical review; rather, it was more important to identify relevant evidence to conceptualize experiences of social exclusion and inclusion. The subjective nature of the synthesis and model is what is typically questioned in a critical review; however, our group and collaborative process during the review was a strength as we checked any biases through team meetings, email discussions, and consensus decision-making. Of course, we may have missed some concepts in the model because of the literature we reviewed. In considering the conceptual model for use in diverse contexts, it will require cultural adaptation so that it aligns with the unique and diverse sociocultural and public health contexts of Western countries.

5. Conclusion

Immigrant/refugee women encounter social, economic, cultural, and civic exclusion. Social identities intersect at the micro level, while systems of domination underscore multiple social inequalities that intersect at the meso- and macro-level to sustain social and health inequalities [4]. Assessing all aspects of social capital upon settlement and establishing opportunities for social and civic engagement will support social inclusion for those working with immigrant/refugee women. Government policies and settlement programs are a critical resource for immigrant/refugee women; however, these services require greater scrutiny as they cater to the "average" [22] and are limited in considering the diversity of women and, in turn, may inadvertently create exclusionary structures. Adopting a life course perspective and targeting programs to the unique needs of immigrant/refugee women would support those who delay entering the labor market and, in turn, engage socially in the community to promote health and wellness. Capitalizing on intersectoral collaboration to support informal programing may be promising if outcomes are evaluated, and this will expand the breadth of services to include the unique experiences and diversity of immigrant/refugee women settling in the Western context.

Data Availability

Data are held on Brock University OneDrive under the corresponding author's account.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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