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Résumé

Les réseaux sociaux des immigrantes et des réfugiées : les déterminants et les conséquences du soutien social chez les femmes nouvellement arrivées au Canada

Michaela Hynie, Valorie A. Crooks, Jackeline Barragan

Les immigrants et les réfugiés (nouveaux arrivants) diffèrent sur plusieurs points mais partagent des défis similaires. Les nouveaux arrivants doivent reconstruire des réseaux sociaux pour obtenir le soutien social dont ils ont grandement besoin mais ils doivent souvent affronter l'exclusion sociale en raison de leur race, leur langue, leur religion ou leur statut en tant qu'immigrants. Dans le cadre de cette étude, les auteures ont exploré les effets de variables circonstancielles et personnelles sur les avantages et les limites associées au réseaux sociaux de femmes nouvellement arrivées. Ayant recours à des entrevues et à des groupes de discussion auxquels ont participé 87 femmes de sept communautés, elles ont procédé à une analyse thématique et identifié cinq sources de soutien informel dans les sept communautés, qui étaient presque exclusivement limitées à des relations co-ethniques. Elles ont aussi relevé les types de soutien, les limites et l'élément de réciprocité pour chacune d'entre elles. Selon les perceptions, le plus important soutien reçu était celui de la famille et d'amis proches, et lorsque le soutien d'un proche n'était pas disponible, celui des fournisseurs de soins primaires. Les résultats suggèrent que les réseaux co-ethniques de soutien par des pairs présents dans les communautés de nouveaux arrivants peuvent s'avérer débordés en raison de leur ampleur limitée et du manque de ressources.

Mots clés : soutien social, exclusion sociale, immigrants, réfugiés, femmes

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Immigrant and Refugee Social Networks: Determinants and Consequences of Social Support Among Women Newcomers to Canada

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Recent immigrants and refugees (newcomers) vary on many dimensions but do share similar challenges. Newcomers must rebuild social networks to obtain needed social support but often face social exclusion because of their race, language, religion, or immigrant status. In addition, most have limited access to personal, social, and community resources. Effects of situational and personal variables on the benefits and limitations associated with the social networks of female newcomers were explored through interviews and focus groups with 87 women from 7 communities. Using thematic analysis, the authors identify 5 sources of informal support across all 7 communities, which were almost exclusively limited to co-ethnic relationships, and the types of support, limitations, and reciprocity within each. Perceived support was strongest from family and close friends and, when support from close relationships was unavailable, from primary care providers. The results suggest that co-ethnic peer support networks may be overwhelmed in newcomer communities because of their limited size and resources.

Keywords: social support, social capital, social exclusion, immigrants, refugees, women, mental health

The term "newcomers" can be used to describe both immigrants and refugees who are within the first few years of their arrival in a new country. Newcomers vary widely in terms of their cultural background, the reasons for and manner of their migration, the resources they bring with them, and the environments they settle into. However, they typically share a number of characteristics. First, all have experienced a rupture in their social networks and must now build and establish new networks in their country of residence (McMichael & Manderson, 2004; Schellenberg & Maheux, 2007). Second, many face social exclusion from the community by virtue of their immigrant status and may even face discrimination because of their race, language, and/or religion (Galabuzi & Teelucksingh, 2010; Schellenberg & Maheux, 2007). Third, for many recent newcomers, access to social and material resources may be limited and inadequate

(Beiser, 2005; Galabuzi & Teelucksingh, 2010; Walters, Phythian, & Anisef, 2006).

The purpose of this article is to capture the structural and social forces common to recent women newcomers to Toronto, Canada, that limit and shape their social networks and the support available from these networks as well as the implications for their physical and mental health and for the provision of services in their communities.

Newcomers, Social Support, and Social Capital

Social networks have been investigated as a critical determinant of physical and mental health through a number of different lenses (Cohen, 2004; Galabuzi & Teelucksingh, 2010; Gottlieb & Bergen, 2010; Lakey & Orehek, 2011). Two dominant perspectives from which to frame the impact of social networks are social support and social capital. Social support refers to the extent to which one's needs are or could be met by others (Cohen, 2004). Social support is supportive behaviours that are enacted or the perception that adequate support is available when needed (Lakey & Orehek, 2011). Social support includes instrumental support, which is the provision of tangible assistance like child care, food, or money (Finfgeld-Connett, 2005); informational support, which refers to the provision of the advice and information necessary for resolving problems or difficulties (Cohen, 2004); and emotional support, which refers to listening behaviour, encouragement, distraction, and other means of easing distress (Finfgeld-Connett, 2005). Having a social support network and perceiving that one is able to elicit and receive effective social support have consistently been found to predict improved physical and mental health and decreased mortality (Beck, 2008; Lakey & Orehek, 2011; Uchino, 2006; Xu & McDonald, 2010).

The other relevant concept is social capital (Glanville & Bienenstock, 2009; Portes, 2000). To have social capital is to be able to invest resources in relationships that are marked by reciprocity and trust and to possess the cultural knowledge necessary to build these relationships. Investments of social capital are fungible; individuals obtain personal benefits in exchange for the investments they make in social relationships. The result is an ability to acquire needed resources and to take control of one's social circumstances (Sen, 2000).

Research suggests that newcomers experience reduced social networks relative to non-immigrants and can experience prolonged periods of social exclusion in their new community (Galabuzi & Teelucksingh, 2010; Schellenberg & Maheux, 2007). Because of the links between social networks, social support, and social capital, poor access to social networks means that recent newcomers may have fewer resources and be

more vulnerable to physical and mental health problems in the face of multiple stressors, despite having implemented a range of strategies to rebuild their networks (Beiser, 2005; Yoon, Lee, & Goh, 2008).

Gender and Newcomer Status

While all newcomers can face the challenges of social exclusion and isolation, women may be even more socially isolated than their male counterparts. Women are less likely than men to speak the language of the new country and to be employed outside the home (Canadian Research Institute for the Advancement of Women, 2003). Because they possess fewer resources to invest and exchange, they are less likely to have opportunities to form new social relationships and the ability to build social capital through their relationships (Hao & Johnson, 2000). Furthermore, compared to male newcomers, women have been found to suffer more negative mental health consequences in the face of inadequate social networks (Haines, Beggs, & Hurlburt, 2008). The increased isolation of women newcomers, combined with a greater sensitivity to social isolation, may be a contributor to their elevated risk for developing mental health problems (Yakushko & Chronister, 2006). Women's participation in social networks is also complicated by gendered expectations regarding support: Women are expected to (and do) provide more social support than men (Armstrong, Armstrong, & Scott-Dixon, 2008). Thus, while female newcomers stand to benefit more than their male counterparts from mutually supportive relationships, gendered expectations may render these relationships more costly.

In summary, newcomers must actively build new social networks and relationships while simultaneously facing structural and social barriers to inclusion that result in social isolation and restricted social networks. Moreover, participation in reciprocal relationships has costs as well as benefits — costs that may be too high for those with limited personal resources, such as female newcomers. The aim of this study is to describe the support-seeking strategies of women across a range of cultural groups and to identify commonalities in the challenges that newcomers face in rebuilding their social networks and the structural as well as social forces that determine the success of these strategies in meeting their needs.

Methods

The analyses reported here entailed both one-on-one interviews with female newcomers (n = 35) from seven different cultural-linguistic communities and focus groups with female newcomers (n = 7 groups, 52 participants) from six of those communities (we were unable to arrange a focus group with the Afghan community). Method triangulation

through the use of both interviews and focus groups was employed to deepen our understanding of women's support strategies by giving women an opportunity to not only report their own strategies in depth (interviews) but also to comment on and respond to each other's experiences (focus groups).

The three participating community centres identified different cultural-linguistic groups as a priority: Spanish-speaking from Latin America and English-speaking from the Caribbean (centre 1); Portuguese-speaking from Portugal, Brazil, and Angola (centre 2); and Urdu-speaking from Pakistan and Dari-speaking from Afghanistan (centre 3).

University ethics approval was obtained for all aspects of the study.

Background

The findings reported here are from a community-based research project on mental health and well-being among women newcomers in Toronto. Community-based research is grounded in a commitment to research as a tool for social change. One of its principles is that members of the community in which the study is conducted are considered equal partners in the research process and play a leading role in identifying the issues and concerns to be addressed (Israel, Schulz, Parker, & Becker, 1998). Consistent with the principles of community-based research, the research team comprised academics, representatives of community agencies, and women from the communities of focus.

The research was initiated by a community partner, who approached one of the academics on the team requesting an examination of the barriers faced by female newcomers with respect to accessing and using mental health services in her clinic. The team was expanded to include other community centres with similar interests, academics, and community members from the identified communities. The research questions broadened as the project was discussed. Community and agency partners participated fully in designing the study and collecting the data. They provided input into data coding and analysis and into the preparation and delivery of dissemination materials (for both academic and community audiences). They co-led the design and implementation of a subsequent participatory project with community members to disseminate the findings to the Latin-American community; this resulted in a mental health guide for Spanish-speaking women that was designed, researched, and written by community members (Hynie & Viveros, 2010).

The present study consisted of interviews and focus groups with women newcomers and interviews with health and social service providers on issues of stress, social support, beliefs about symptoms of well-being and distress, and willingness to use primary mental health services for coping with distress. The findings on stress and access to

primary mental health services are reported elsewhere (Crooks, Hynie, Killian, Giesbrecht, & Castleden, 2011). In this article we concentrate on focus groups and interviews with community women regarding social support.

The interview questions and probes related to informal social support included the following:

- How have you dealt with these [previously discussed] problems or disappointments in the past?
- How are you dealing with your current biggest disappointment/problem?
- Do you count on any supports to help you face these disappointments or to help you resolve your problems?
- Are the strategies and sources of support that you use today similar to or different from the ones you used when you were back in your country?
- Are there supports that are not available to you in Canada but could help you confront your difficulties and problems with more confidence as they arise?
- If you get sick or if you are not feeling well, to whom or where do you turn for help?
- Do you think you would receive the necessary help in one of those situations [that you described earlier]?

Participants

Female newcomers who were over 16 years of age and were within their first 6 years of Canadian residency were targeted for recruitment. The length of residency varied: 6 years was chosen for recruitment because, in the province of Ontario, free settlement services (e.g., language classes) are offered for the first 3 years of residency; therefore, 6 years included the period when services are free and an equal period when they are not, and when settlement could thus become more challenging.

Posters were placed in the three centres, publicizing the study in the appropriate languages (e.g., English and Spanish in centre 1, Portuguese in centre 2, Urdu and Dari in centre 3) and distributed by workers in the centres who also orally described the study for eligible clients. Also, participants were asked to share information about the study with other women newcomers in their community. Interviewees were paid $20 for their participation and given bus fare, a snack, and free child care during the interview. Focus group participants were recruited in the same manner as the interviewees but were paid $50 for their participation in this longer protocol.

Interview participants (n = 35) had emigrated from Colombia (n = 6), Afghanistan (n = 5), various Caribbean islands (Grenada, St. Vincent, Virgin Islands, St. Lucia) (n = 5), Pakistan (n = 5), Angola (n = 3), Brazil (n = 3), Mexico (n = 3), Portugal (n = 3), Costa Rica (n = 1), and Cuba (n = 1). Focus group participants (n = 52) came from Pakistan (n = 10), Angola (n = 9), Brazil (n = 9), Portugal (mainland, n = 8; Azores, n = 2), Mexico (n = 5), Colombia (n = 3), El Salvador (n = 2), Jamaica (n = 2), Ecuador (n = 1), and Trinidad (n = 1).

Participant characteristics are presented in Table 1, collapsed across methods and cultural groups. Most participants were between 35 and 50 years of age and lived with members of their nuclear family. Several had at least some university education, but, despite high levels of education across the groups, most were not employed. About one quarter had precarious migration status in that they did not have permanent residency status in Canada (cf. Goldring, Berinstein, & Bernhard, 2007). The vast majority did not speak English as a first language and almost two thirds were from a visible minority (those from Angola, the Caribbean, Latin America, and Pakistan), based on the definition of visible minority used by Statistics Canada.[1]

Procedures

Interviews. Interviews were conducted at the offices of the collaborating community centres and lasted 1.5 hours on average. All but one were audiorecorded and transcribed. One participant did not wish to be audiorecorded so in this case the analysis relied upon the interviewer's detailed notes. Informed consent was obtained prior to each interview.

The interviews were conducted in each participant's first language using a semi-structured guide. The interview guide covered the process of translation and back-translation for each language. It consisted of six sections: (1) demographics and background information; (2) hopes and expectations for life in Canada; (3) challenges, adjustments, and difficulties faced since arriving; (4) coping strategies; (5) availability of social support and health/social services; and (6) descriptions of feeling good about oneself and of experiencing mental stress and distress.

Focus groups. Focus groups were conducted by a facilitator and a note-taker who were fluent in the participants' language. Three focus groups were conducted at centre 1, two with Spanish-speaking women

[1] "The *Employment Equity Act* defines visible minorities as 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.' Using this definition, regulations specify the following groups within the visible minority population: South Asian, Chinese, Black, Arab, West Asian, Filipino, Southeast Asian, Latin American, Japanese and Korean." (Chui & Maheux, 2011, p. 5)

Table 1 ***Demographic Characteristics***

		***N* = 87 (%)**
Age	19–35	29 (33.3)
	35–50	46 (52.9)
	> 50	10 (11.5)
Years in Canada	< 3	35 (40.2)
	3–6	34 (39.1)
	> 6	16 (18.4)
Marital status	Married	47 (54.0)
	Single/divorced	31 (35.6)
Children	0	10 (11.5)
	1–3	62 (71.3)
	4–5	13 (14.9)
Immigration status	Permanent	51 (58.6)
	Refugee	16 (18.4)
	Precarious[a]	15 (13.8)
Visible minority[b]	Yes	57 (65.5)
	No	30 (34.5)
First language	Language other than English	78 (90.0)
	English	9 (10.3)
Religion	Christian	67 (77.0)
	Muslim	20 (23.0)
Education	Less than high school completion	16 (18.4)
	High school completion	14 (16.1)
	At least some college/university	42 (48.3)
Employment	Employed	22 25.3)
	Not employed	50 (57.5)

[a] Those awaiting decisions on claims (e.g., on humanitarian and compassionate grounds) and those without official status.

[b] Based on Statistics Canada definition.

Note: Some data are missing as some participants did not respond to all questions.

from Latin America (n = 6, n = 5) and one with English-speaking women from the Caribbean (n = 3). Three groups were conducted at centre 2 in Portuguese, one each for women from Portugal (n = 10), Angola (n = 9), and Brazil (n = 9). Finally, one group was conducted at centre 3 in Urdu with women from Pakistan 3 (n = 10).

All but one of the focus groups were audiorecorded and transcribed; for the group from Portugal, the tape recorder failed and thus written notes were relied upon. Women provided oral or written consent before participating and completed demographic information sheets, which were kept separate from the consent forms to ensure anonymity.

The focus group guide was designed to explore in more depth the preliminary findings of the interviews. It probed (1) sources of support and information in the settlement process, (2) characteristics of health care in the country of origin, (3) knowledge about health care in Canada, and (4) how the women coped with stress and distress in Canada and in their country of origin. The focus groups lasted between 1.5 and 2.5 hours.

With respect to both the interviews and the focus groups, this article centres on issues of social support.

Data Analysis

Transcripts were translated and reviewed by a second first-language speaker to confirm the quality of each translation and, in the case of three Portuguese translations, were re-transcribed to improve accuracy. Transcripts were analyzed using NVivo, a qualitative data management program. Thematic analysis of the data set was employed (Aronson, 1994): Data were categorized according to themes (units that are identified from patterns within the data set), which were then refined, based on the literature, to those present in various interviews and to the study's overall purpose and objectives. Links between these themes were established in order to interpret the data and to transform the nature of the findings from descriptive to analytic.

One of the principal investigators and two members of the research team developed a coding scheme for the interviews and focus groups by reading two randomly selected transcripts from each data set, circulating them to the entire research team (including community and agency partners) for feedback, and then refining the coding scheme. Any issues encountered during the first stage of coding were discussed among the principal investigators and decisions were recorded and implemented during a second stage of coding. Throughout the analytical process, updates were shared with members of the research team, all of whom participated in the interpretation of the findings.

Results

Five kinds of informal support/social networks emerged as themes across the seven cultural groups: immediate family, transnational family, friendship networks, close friends, and community. Women also obtained support from community agencies, particularly those women who lacked informal support networks. A number of themes emerged across the different kinds of support. These included types of support given and received, the extent to which the support was reciprocal, gendered expectations about support, and perceived adequacy of the support. The sources of support are described below, and are discussed in terms of these themes. Because focus group participants provided demographic information on a separate survey, their comments are labelled by cultural group only, and not immigration status.

Immediate Family

Many of the women described family support as essential to their well-being. Family members provided all three kinds of support: instrumental support in the form of child care, housing, and money; relevant information; and the compassion and understanding that are associated with emotional support. Several women reported strong reciprocal relationships with their spouses. The following comment by a Latin-American woman sheds light on one pathway through which effective social support can improve health, in that the support she received from her husband helped her to engage in health promoting behaviours following the discovery that she had a health problem:

> *I take a lot of care . . . I can't work Saturdays and Sundays because I know that everything is about a balance in life. Here, you don't have that — but now I do. And my husband helps me too, but his problems affect me too, so I try to balance things.* (refugee from Colombia)

Gendered role expectations of women as support providers was evident in women's greater reliance on their female relatives, especially for emotional support, and in their emphasis on providing — and worrying about providing — support to members of their family. In the above comment, for example, the woman explains that her well-being is affected by that of her husband. Indeed, when asked about their own well-being, women often responded in terms of the well-being of their spouses and children.

Not all women reported positive experiences with support from their family. Some family members could not or would not provide the help that participants needed. Thus, the presence of family did not guarantee that women would receive the support that they desired. Moreover, some

women reported violence and abuse from spouses or boyfriends. These women were particularly vulnerable and isolated; they were forced to negotiate different cultural expectations about resolving family conflict and a foreign legal system (Haj-Yahia & Sada, 2008), often with limited knowledge of English, and to choose between their abusive partner and surviving alone in a new culture.

Transnational Family

Almost all of the women reported maintaining phone and mail contact with immediate and extended family members from their country of origin. While these family members were primarily sources of emotional support, they were also recipients of emotional support from the participants. Gendered expectations of support were evident not only in women's emphasis on providing emotional support for their family members but also in cases where the woman did not wish to burden her relatives with her problems and so did not share them, implying an inequality in reciprocity. Some women also provided instrumental support to transnational family members by sending them money, despite their own difficult financial circumstances. The participants seemed to view this as a natural expectation:

> *Life here is not a bed of roses, you know. Everything is expensive, but at least I am trying to help [my family back home] and the rest of the family; that is what I came here to do and that is what I will do.* (refugee claimant from Grenada)

Frequency of contact varied, with some women reporting that they spoke with transnational family members daily or weekly and others reporting infrequent or irregular contact. Frequency of contact typically decreased the longer the woman lived in Canada, sometimes because of the costs of long distance calls, sometimes because of time constraints; thus, this source of emotional support apparently diminished over time. However, there was no evidence that those women who provided instrumental support intended to reduce their contribution, which suggests increasing inequality in the reciprocity of the relationship.

Friendship Network

Women participated in friendship networks that provided needed informational support, instrumental support in terms of assistance with child care and with accessing resources and material goods, and emotional support. These networks seemed to fulfil roles that would have been associated with the extended family in the women's country of origin, as evident in a comment by a member of the Pakistani focus group: "Here we expect help from our community members and friends, while in

Pakistan our parents and relatives can help us." Most women reported that their friends were from the co-ethnic community and shared similar challenges and experiences and that they all helped one another, implying that these were reciprocal relationships. When discussing networks, the women did not mention gender explicitly.

Although social networks often played an important role in supporting these women, many women described having a much smaller network of friends in Canada than they had had in their country of origin. Moreover, they did not speak of receiving emotional support from these networks, which suggests that the networks were somewhat impoverished. For example, a woman from the Brazilian focus group remarked, "I think here we don't have many friends. We meet many people but work all day. Our life here is always running." Women also spoke about the limits of friendship and how the friendship network could not provide the same level of support as the extended family in their country of origin. For example, a woman in the Angolan focus group noted that "in a given moment someone can help you, but friends don't fill all the expectations you have or things that you need suddenly." Women acknowledged that the amount of support available was limited by the demands that their friends were facing themselves. As a permanent resident from Pakistan noted, "It also depends on the status of the other, how much help they can provide." Thus, these friendship networks were not perceived as a reliable source of support and may not have provided all of the types of support needed.

These networks were all co-ethnic in nature. The women's tendency to join co-ethnic friendship networks may have been a matter of preference as well as lack of opportunity. Many women did not speak English, which precluded their participation in English-speaking networks, and most were not employed and therefore had limited opportunities to meet new people (see Table 1). Also, some reported discrimination on the basis of language, immigration status, or race:

> *Sometimes you're walking down the street and somebody's watching you. They call the cops: "I see two black people walking" — like, you don't have to do nothing! [It's] because you're black.* (member of Caribbean focus group)

The women's reliance on co-ethnic networks is consistent with the research finding that immigrants rely heavily on co-ethnic networks and relationships to meet their support needs (Barnes & Aguilar, 2007; Hao & Johnson, 2000; Simich, Beiser, & Mawani, 2003). Cultural differences have been found in preferred patterns of support (Kim, Sherman, Ko, & Taylor, 2006; Mortenson, Liu, Burleson, & Liu, 2006; Procidano & Smith, 1997; Simich, Mawani, Wu, & Noor, 2004), and support that is culturally

appropriate and provided by someone with shared experiences has been found to be more effective (Barnes & Aguilar, 2007; Simich et al., 2003). However, reliance on co-ethnic networks limits newcomers' ability to build social capital (Sen, 2000) and thus may serve to restrict the ability of women newcomers to exert control over their life circumstances (Glanville & Bienenstock, 2009).

Close Friends

Some women reported relying almost exclusively on support from a small number of close friends, who were always other women and who typically were also recent newcomers, usually from the same ethnocultural community. The help provided included instrumental, informational, and emotional support. Women expected much more support from close friends than from friendship networks. In some cases support in these relationships seemed to be primarily unidirectional, while in others it was clearly reciprocal. In some cases a single friendship was reported as the only support the woman had to rely on, as shown in the following comments by a refugee claimant from Mexico:

> *I: She helped you. And do you still have this friendship now?*
>
> *R: Yes, of course, of course — I can't stop talking to her. She's a person who has helped me a great deal. She's helped me with the baby; when my baby was born she was there with me. She could be an angel from heaven — you say to yourself, wow!*
>
> *I: What are the sources of strength or support that you can rely upon to help you face your problems? You've already told me that one source of support is this woman. . . . Do you have other sources, either a place or other people?*
>
> *R: No, just her.*
>
> *I: You don't go to the centres any more?*
>
> *R: No, I don't go any more.*
>
> *I: You feel good just with her.*
>
> *R: Yes.*

Even when these women reported relatively small social networks, those with close friendships reported satisfaction with the support available to them, consistent with the research finding that it is the quality of support available, rather than quantity, that is more critical to health and well-being (Chandola, Marmot, & Seigrist, 2007). The conversation above also shows that women who found a reliable source of informal support stopped seeking formal support services (i.e., "from centres").

Community

Many women had received help from their co-ethnic communities and people in their immediate neighbourhood, particularly informational support, and a range of much appreciated instrumental support, from free meals at a local restaurant, to reduced rent, to a loan or gift of essential household items. Emotional support was typically not mentioned in this context unless the community in question was a religious community such as a church group; in these cases women reported receiving all three types of support.

Not all women reported positive experiences. Some viewed their co-ethnic communities as not very helpful, or as not organized or accessible, which suggests a lack of community-level social capital:

> *We didn't know if [any social service agencies] existed . . . we didn't know anything and there was no guidance . . . like, here in Toronto there are a lot of people from Pakistan. This building over there . . . is full of people from our country, one can ask about things from any one, but over there no one would tell us anything; it seemed as if we were in a jungle. Our cities — Lahore, Faisalabad — they were so good, people were so helpful. Whatever we need to do over here we do it ourselves, but at least someone should tell us how things work here. These were the problems.* (permanent resident from Pakistan)

The usefulness or desirability of support from their co-ethnic communities may have also depended on the types of assistance the women required. For newcomers struggling to adjust to a new community, support from co-ethnic community members may be particularly useful and desirable. For those with issues that they do not wish to have discussed in the community, or that they believe the community will be unable to address, such as marital problems or abuse (e.g., Haj-Yahia & Sada, 2008), co-ethnic community support may be less desirable or helpful.

Other cultural communities also offered assistance. For example, several women in the Brazilian community remarked that they received tremendous support from the Portuguese community, which in Toronto is an older and more established community. Support provision to communities was not discussed explicitly, although some women mentioned in passing that they did voluntary work with community agencies.

Although the women frequently described support from community members, they were unsure whether this support could be counted on when needed; it was often sporadic and unexpected. A permanent resident from Pakistan noted that when it came to providing needed help "they might do it . . . they might not." Thus, while co-ethnic communi-

ties may have been able to provide relevant support because of shared identity and experiences, this support varied considerably depending on the community in question and could not necessarily be relied upon. Since evaluations of perceived support are based on the expectation that support is available when needed, and since perceived support has a strong relationship to health and well-being (Lakey & Orehek, 2011), this finding suggests that community support for female newcomers does not promote health and well-being in the same way that other types of support do.

Social Isolation and Agency Support

Although the women spoke of mobilizing a variety of sources of social support, a common theme throughout was social isolation, associated with distress and feelings of helplessness, which is consistent with the literature linking social support and mental health (Cohen, 2004; Finfgeld-Connett, 2005). For example, one woman spoke of both her isolation and its toll on her well-being:

> *Ever since I got sick I have only been to my family doctor. They took my blood and it has been 3 weeks and I don't know my results. I don't know where else or who else to go to. These problems give me a lot of stress because if I get sick I ask myself where do I go and who do I speak to. An Afghan settlement worker . . . they helped me with my problems. I would go to them and tell them [about] my problem. They helped me because they are from my country.* (permanent resident from Afghanistan)

Two important themes emerge in this extract. First, in the absence of an informal support network, a professional care provider furnished both informational and emotional support in a satisfactory way. Second, the woman assumed that this support was offered because the care provider was from the same ethnic community.

A different perspective was provided by a woman from the Caribbean. This participant had family in Toronto but stated that if she needed help she would go to the local health centre rather than to friends or family members:

> *I: Are there any sources of strengths and supports that you rely upon to face your challenges?*
>
> *R: Basically, I pray, you know. . . . nobody is your friend if you get on your knees, because, basically, when you have your problems and you go to someone and say, "I need this and I need that," too many people hear about it on the street. . . . yeah, pray and [name of health-care centre] is there for counselling and advice.* (refugee applicant from St. Lucia)

There were individuals available in this woman's informal network, but the excerpt suggests that asking for help would result in her social isolation and thus the formal services available at the health-care agency were preferable, such as services provided by settlement workers, social workers, and nurses. Another study found that informal support was preferable to formal support (Finfgeld-Connett, 2005); however, this woman's comments seem to suggest that informal support was not really an option.

Not all experiences with community and government agencies were positive, but for many women community centres were the only source of informational, instrumental, and sometimes emotional support — or had been the only source when they first arrived. In many cases the participants had initially made contact with the centre to meet health or settlement needs but then realized that other forms of support could be accessed there as well. Often they reported an ongoing relationship with an individual at the centre, typically someone who shared their ethnic background, who became a central source of instrumental, informational, and emotional support. In these cases the agency support provider blurred the boundary between formal and informal support, a situation that may be necessary for the provision of effective emotional support (Lakey & Orehek, 2011) but that presents challenges around boundary issues and professional relationships (Repper & Carter, 2011).

As noted above, women also reported volunteering at these agencies, thus providing the same kind of peer support they themselves had received. Importantly, being able to offer as well as receive social support made a positive contribution to women's mental health, as noted in the following interview excerpt:

> *R: Since I started working here at [name of centre] as a volunteer doing the workshops, I have had an opportunity to meet Portuguese and Angolan people from the community. We learn a lot from each other. Sometimes what is right for me is wrong for them. We learn to respect the way other people live. This is very good for one's well-being. When you interact with someone else you are partaking in something.*
>
> *I: So you feel connected.*
>
> *R: Yes. I think it's good for the self-esteem. You feel needed and at the same time you are learning something.* (permanent resident from Angola)

This exchange speaks to the benefits that can be reaped when community agencies help to build peer-support networks, which provide not only culturally appropriate support but also opportunities for people to feel competent and valued.

Discussion

Across this varied group of newcomers, social support relationships and networks were shaped by social and structural variables inherent in the women's newcomer status, which may have contributed to lower perceived social support levels and unequal reciprocal relationships, and which in turn could have had consequences for their health and well-being. These women participated primarily in co-ethnic relationships, friendship networks, and communities. Even when they sought social support from care providers, they usually preferred co-ethnic staff. This could have been a by-product, partly, of social exclusion resulting from their migration status (e.g., those with precarious status might have had limits on their participation in society), ethnic or racial discrimination, or language barriers (Galabuzi & Teeklucksingh, 2010; Schellenberg & Maheux, 2007). However, social support is most relevant and helpful when it is provided by people from the recipient's cultural community (Simich et al., 2003); thus the building of reciprocal co-ethnic support relationships and networks ensures that the social support offered to and received by newcomers is appropriate and relevant. Reciprocal co-ethnic support networks also build social capital, allowing community members to assist one another in dealing with challenges (Boneham & Sixsmith, 2006; Wakefield & Poland, 2005).

However, although enacted support from friendship networks and the community could be generous and valuable, it was difficult to predict. Thus, although the women were grateful for support received, their perceived support from these sources was quite low unless they included close personal relationships. This finding is significant because, compared with enacted support, perceived support has more consistent associations with health and well-being (Lakey & Orehek, 2011). Newcomers' reliance on support networks consisting primarily of other newcomers can therefore be problematic, as the initial challenges of settlement can hinder one's ability to provide support to others (Stewart et al., 2008). This observation is borne out in the results of the present study. Moreover, communities that are excluded from the mainstream with its strong relationships are characterized by difficulty leveraging material benefits for their members (Sen, 2000), which in turn affects their ability to provide resources. Thus the development of reciprocal co-ethnic peer support networks should be encouraged, but only if the networks themselves and their members are provided with adequate personal and community resources.

There was also evidence of gendered support, with the women relying primarily on other women for support and feeling duty-bound to support family members both in Canada and in the country of origin.

Gendered patterns of unequal support provision can render mutual support networks and relationships harmful (Chandola et al., 2007), particularly for women with low levels of support and/or resources (Osborne, Baum, & Ziersch, 2009). For newcomer women, for whom expectations of support provision, especially by family members, can be too high, family relationships and social networks might be as much a burden as a benefit. Thus it cannot be assumed that the building of multiple reciprocal relationships will guarantee success in coping with the stresses of immigration. Attention must be paid to the resources available to the women engaged in such relationships (Armstrong et al., 2008).

Finally, women reported relying on and sometimes favouring primary care providers such as nurses and social workers for all kinds of assistance, including emotional support. This is a surprising finding, since the literature indicates a preference for emotional support by informal support providers (e.g., Finfgeld-Connett, 2005), which requires intimate relationships (Lakey & Oherek, 2011). However, the participants did appear to form meaningful relationships with primary care providers and to place their trust in these professionals to be available when needed. Thus primary care by nurses and other health-care providers may be an important form of social support for female newcomers, even though this type of support could require a commitment on the part of care providers and therefore might be difficult to develop and negotiate.

Limitations

Our sample was not large enough for between-culture comparison, although this would be an interesting consideration for future research. Also, while interviewing women in their first language serves to put them at ease and to ensure their full understanding of the issues being discussed, the interpretation of concepts may not always translate easily between cultures and languages. Finally, since participants were recruited through community centres we may have recruited women who were biased in favour of primary care providers. Also, we may have failed to reach those who were particularly isolated and did not know how to access resources at these centres; the responses of female newcomers who do not use these centres could be quite different from those reported here.

Conclusions

Women newcomers in Toronto, Canada, showed a clear preference for co-ethnic support networks, including co-ethnic primary care providers. Co-ethnic networks and communities provided much-needed enacted support to these women but were perceived as unreliable unless they

included close personal relationships. The reliability of such networks may be limited by the challenges associated with social, personal, and structural circumstances inherent in the migration experience.

These findings highlight the importance of health-care providers and health-care systems to the efforts of newcomers to rebuild their support networks. It is crucial that we support policies and practices that help newcomers to build personal and community resources and that we be mindful of recent newcomers' need for culturally sensitive support by primary care providers such as nurses.

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