women

MDPI

Systematic Review

A Qualitative Systematic Review of Experiences and Barriers Faced by Migrant Women with Perinatal Depression in Canada

Gil Angela Dela Cruz [1,2], Samantha Johnstone [1], Daisy R. Singla [3,4,5], Tony P. George [1,2] and David J. Castle [1,2,*]

[1] Centre for Complex Interventions (CCI), Centre for Addiction and Mental Health (CAMH), Toronto, ON M6J 1H4, Canada
[2] Department of Psychiatry, Temerty Faculty of Medicine, University of Toronto, Toronto, ON M5T 1R8, Canada
[3] Addictions Division, Centre for Addiction and Mental Health (CAMH), Toronto, ON M6J 1H4, Canada
[4] Campbell Family Mental Health Research Institute, Centre for Addiction and Mental Health, 60 White Squirrel Way, Rm 313, Toronto, ON M6J 1H4, Canada
[5] Department of Psychiatry, Lunenfeld Tanenbaum Research Institute and Sinai Health, Toronto, ON M5G 1X5, Canada
* Correspondence: david.castle@camh.ca

Abstract: Perinatal depression is the onset of depressive symptoms during pregnancy and up to one year after childbirth. Migrant women are at higher risk of experiencing perinatal depression due to numerous psychosocial stressors related to their experiences. This qualitative review aims to aggregate the experiences and barriers to care faced by immigrant and refugee women in Canada who have perinatal depression. Qualitative research can elucidate the barriers to treatment and culturally-impacted experiences of Canadian migrant women with perinatal depression. Following PRISMA and Joanna Briggs Institute (JBI) guidelines for conducting qualitative systematic reviews, 13 eligible studies representing 10 samples (N = 262 participants) were identified and included in this review. Participants included service providers, immigrant women, and refugee women. Three synthesized themes were identified by this review using the JBI meta-aggregative approach: (1) culture-related challenges; (2) migration-related challenges; and (3) service accessibility and quality. Within these themes were experiences of migrant women that encompass six categories: (1) conceptualization of perinatal depression; (2) childbirth-specific challenges; (3) migration-related challenges; (4) social isolation; (5) accessibility of services; and (6) quality of care. The role of family, cultural differences, financial challenges, and the effects of these on service accessibility are impactful in the experiences of migrant women. A greater understanding of the role of both culture and migration in the delivery of care, especially regarding service provider attitudes in more representative samples, is recommended.

Keywords: immigrant; refugee; migrants; perinatal depression; women; health care accessibility; socioeconomic factors; cultural competency

Citation: Dela Cruz, G.A.; Johnstone, S.; Singla, D.R.; George, T.P.; Castle, D.J. A Qualitative Systematic Review of Experiences and Barriers Faced by Migrant Women with Perinatal Depression in Canada. *Women* **2023**, *3*, 1–21. https://doi.org/10.3390/women3010001

Academic Editor: Mary V. Seeman

Received: 22 November 2022
Revised: 13 December 2022
Accepted: 16 December 2022
Published: 27 December 2022

1. Introduction

Perinatal depression, defined as depression during pregnancy and including the postpartum period (i.e., up to one year postpartum) [1] can lead to poorer short- and long-term health outcomes for the mother–child dyad, and increased maternal mortality [2,3]. Risk factors for perinatal depression include a history of depression or depressive episodes, lack of social support, low socioeconomic status, unintended pregnancy, intimate partner violence, lower education status, smoking, and single status [3]. The postpartum period has been acknowledged as a high-risk period for the development of mental illnesses (e.g., depression, psychosis) attributed to hormonal shifts, changes in sleeping patterns, and new stressors related to parenthood [1].

Migrants refer to people who are living outside their country of birth regardless of legal status (e.g., immigrants, refugees, asylum-seekers) [2]. In 2016, 21.9% of the Canadian

population were internationally born, with the proportion projected to grow from 24.5% to 30.0% by 2036 [4]. Around 200,000 migrants arrive in Canada every year, emphasizing the need to address migration-related health factors as well as the equity and accessibility of healthcare to this population [5]. In migrants, health is impacted by length of residence in a new country as well as lifestyle, social support, and exposure to new diseases [6]. The experience of resettlement during migration introduces numerous stressors, including acculturation stress, changes in social networks, change in financial stability, challenges in communication, and lack of access to necessary health services [7]. These stressors have an even greater impact on migrant families [1] due to specific migration-related stressors and risk factors such as less social support, greater number of life stressors, length of time in the host country, language difficulties, and uncertain legal status [2]. Importantly, migration-related factors may interact with sex/gender-based discrimination and biological hormone-related factors in a manner that complicates the experience of pregnancy and may contribute to the onset, experience of, and outcomes related to, perinatal depression. Postpartum stressors were exacerbated in migrant women during the COVID-19 pandemic due to poorer postnatal healthcare experiences (e.g., isolated birthing experiences, lack of interpretation services, virtual care), loss of informal support (e.g., limitations on in-person support, childcare burden), and anxiety and grief (e.g., fear of COVID-19, unmet expectations of birth), underscoring the need for investigation into experiences of perinatal depression in migrant women [8].

Qualitative research is a useful method to direct evidence-based practice and determine existing values in the scientific process whilst simultaneously giving voice to affected members of communities being studied. Indeed, qualitative methods allow for patient input in service provision, especially in populations that are difficult to reach, are underserved, and have low trust in research [9]. Thus, the purpose of this study is to systematically review the available qualitative literature regarding Canadian migrant women's experiences of perinatal depression and barriers to equitable treatment, and to identify overarching themes across samples.

1.1. Canadian Migrant Women and Perinatal Depression

The number of migrant women in Canada has been increasing since 1980, especially the number of women from underdeveloped and developing countries [10]. Migration has been linked to higher rates of perinatal depression, especially in refugee and asylum-seeking women compared to Canadian-born women [2,11–14]. A 2015 meta-analysis reported a 2-fold higher prevalence of depressive symptoms in immigrant women compared to non-immigrant women during the postpartum period [1].

Perinatal depression refers to the onset of depressive symptoms during pregnancy and up to one year after childbirth. Notably, migrant women experience challenges in accessing treatment for perinatal depression. For example, challenges in receiving diagnoses have been identified due to the cultural inappropriateness of some perinatal depression detection methods [15]. In terms of screening tools for perinatal depression, the Edinburgh Postnatal Depression Scale (EPDS) was developed specifically for postnatal women and found to be culturally sensitive across ethnic groups. However, factors that affect migrant women, such as education status and socioeconomic status, may affect differences in depressive-symptom reporting between White individuals and people of color [15].

1.2. Immigration-Related Factors Affecting Healthcare

Immigration-related stressors may constitute barriers to healthcare services. Factors such as racialization (i.e., the contradictory process by which groups of individuals are designated as a certain race and subjected to unequal treatment), discrimination, stigma, accessibility, and health inequities result in greater mental health challenges in migrants, especially in refugees, visible minorities, youth, and the elderly [11,16,17]. Barriers to access to mental health services are further exacerbated by challenges related to language barriers, cultural transition, and poor socioeconomic status [10,11]. Visible minority migrants

are clinically underserved, and migrants are less likely to access mental health services compared to White Canadians [16,17]. According to a recent scoping review [17], systemic factors, including service accessibility, legal status, and trust in the medical and legal systems, shape general mental health service usage among visible minority immigrants and refugees in Canada. Thus, further research into barriers to treatment for perinatal depression from the perspective of migrant women is warranted.

1.3. Associations between Migration and Perinatal Depression

Previous research has examined the needs, risk factors, and challenges faced by migrant women accessing mental health care in the context of perinatal depression [2,7,11,14]. For example, in 2010, a review [11] of qualitative research examining migrant women's help-seeking experiences identified several risk factors, including the feeling of social isolation and limited financial resources, as potentially contributing to the development of perinatal depression. Furthermore, other studies have found that visible minorities in America receive less mental health treatment compared to White Americans, even when controlling for factors such as type of mental health disorder, education, and income [18]. Challenges in accessing equitable health services are accentuated in migrant women due to language barriers, separation from extended families, and difficulties finding employment [11]. Tobin et al. (2018) examined the experiences of international migrant women with perinatal depression, specifically postpartum. The authors identified five themes: suffering in solitude, the invisible illness, cultural conceptualizations of perinatal depression, barriers to help-seeking, and facilitators to help-seeking. However, limited research has investigated the experiences of, and access to, treatment for perinatal depression in Canadian migrant women; accordingly, this review aims to synthesize the available qualitative literature and highlight potential overarching themes.

2. Objectives

This qualitative review explores perspectives on the experience of perinatal depression—including experienced barriers to care—as reported by migrant Canadian women and service providers working with them. Specifically, we aim to summarize:

(1) Perspectives of Canadian migrant women on the experiences and barriers to care associated with perinatal depression.

(2) Opinions on the delivery of mental health services to pregnant migrant women in Canada.

3. Results

3.1. Study and Sample Characteristics

This review included 13 publications presenting ten discrete participant samples, with the results from one sample having been presented across four separate papers [19–22]. In total, there were 262 participants across these studies, with data collection methods ranging from semi-structured interviews (n = 150), surveys (n = 100), and a focus group (n = 12). Four samples included only immigrant women, while three samples included both refugee and immigrant women; a further three papers interviewed community or health service providers working with migrant women. Most samples were diverse (i.e., women migrating from a range of different countries; n = 6), while two samples each included only women migrants from Syria and the Sub-Saharan region of Africa. Metropolitan study settings included Toronto (n = 7) and Vancouver (n = 2), as well as Saskatoon (n = 1), Montreal (n = 1), and London (n = 1). Larger regions like Niagara Region (n = 1), Alberta (n = 1) and British Columbia (n = 1) were also represented.

Confidence in the evidence for the synthesized findings identified in this review was assessed using the ConQual process [23,24].

3.2. Main Themes

As summarized in Table 1 and Figure 1, the three main synthesized themes identified regarding the experience of perinatal depression and help-seeking in Canadian migrant women were: (1) the interaction between culture and perinatal depression; (2) the interaction between migration-related stressors and perinatal depression; and (3) perinatal depression healthcare service availability and quality. These themes stem from six categories, namely: the conceptualization of perinatal depression, childbirth-specific challenges, migration-related challenges, social isolation, accessibility of services, and quality of existing care.

Table 1. ConQual Summary of Findings.

Systematic Review Title: Experiences and Barriers of Perinatal Depression in Migrant Women in Canada: A Qualitative Systematic Review Population: Migrant women or clinicians working closely with migrant women Phenomena of interest: Experiences and perspectives of perinatal women on depression Context: Canada					
Synthesized Findings	**Type of Research**	**Dependability**	**Credibility**	**ConQual Score**	**Comments**
Culture-related challenges	Qualitative—High	Downgrade one level—Moderate *	Remains unchanged **	Moderate	** All findings unequivocal.
Migration-related challenges	Qualitative—High	Downgrade one level—Moderate *	Remains unchanged **	Moderate	** All findings unequivocal.
Service Accessibility and Quality	Qualitative—High	Downgrade one level—Moderate *	Downgrade one level—Low ***	Low	*** Downgraded one level due to mix of unequivocal (U), credible (C), and not supported (NS) findings. U = 11, C = 1, NS = 1.

* The majority of studies (8 of 13) scored 3 out of 5 for questions relating to the appropriateness of the conduct of the research. The remaining five studies scored 4–5 out of 5 for questions relating to the appropriateness of the conduct of the research. ** Remains unchanged as all findings unequivocal. *** Downgraded one level due to mix of findings.

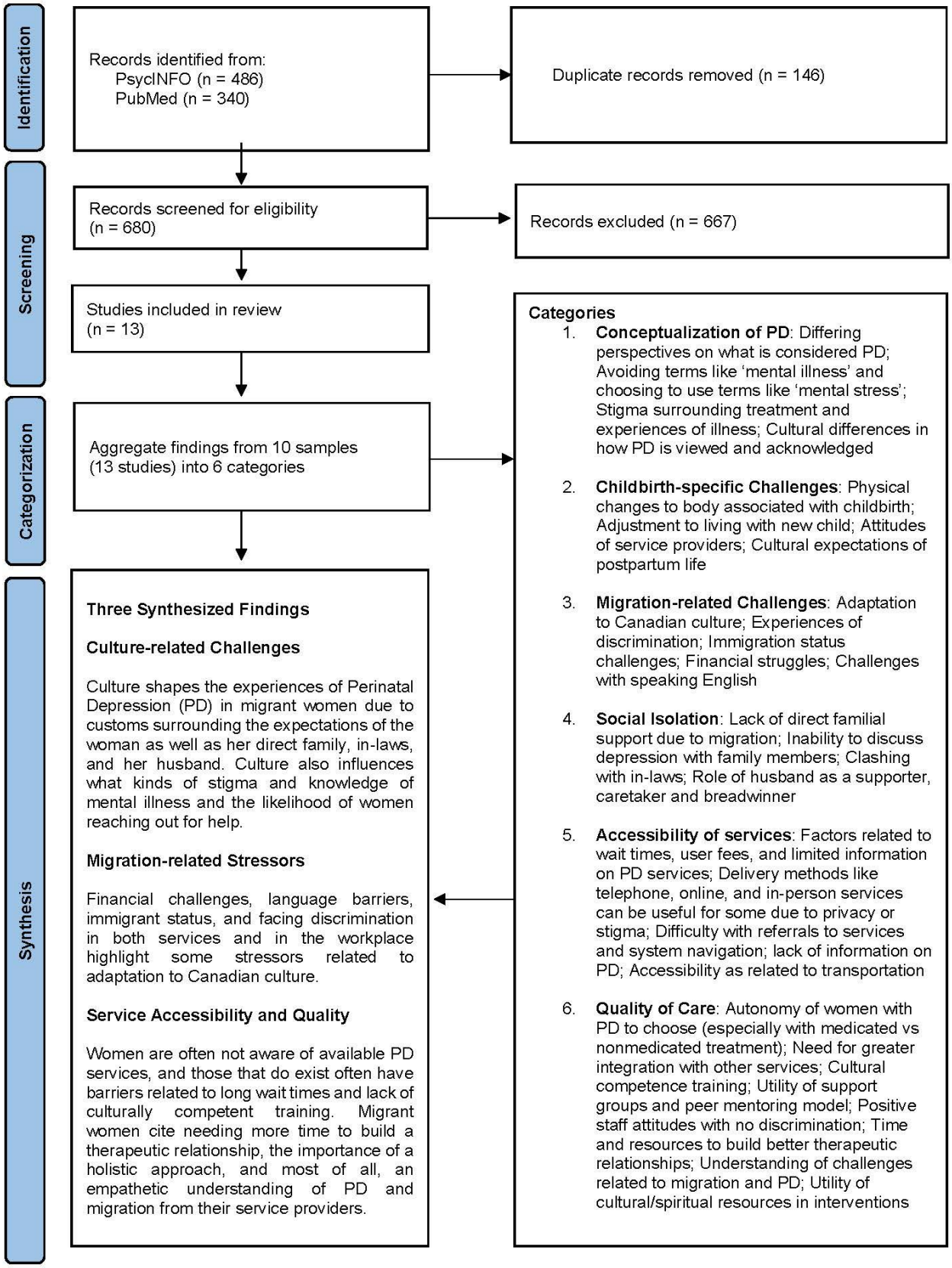

Figure 1. Flowchart for the process of meta-aggregation of qualitative study themes [25,26].

3.3. Theme 1: Culture-Related Challenges and Perinatal Depression

Culture is an overarching theme in all included studies. Many women's perceptions of perinatal depression are shaped by the culture that they come from and the existing Canadian culture surrounding perinatal depression. Syrian and African participants cited that maternal depression either "happens less" or "did not exist" in their countries of origin [21,27,28]. One Chinese participant discussed how physical problems are easier to talk about than mental problems [21]. Syrian women shared how terms like being "bored" or "tired" are often used to describe milder depressive symptoms, also attributing some of their experiences to biological factors such as hormones or recovery from childbirth [27,29]. This lack of discussion around postpartum mental health amongst migrant women's social networks has the additional effect of limiting migrant women's knowledge and interest in seeking help for their symptoms [28,30].

Intercultural mental illness-related stigma was commonly cited as a reason for not accessing mental health services, for fear of being considered unfit to be a mother [29], being called "crazy" [27], worry over gossip spreading to their social networks [21,31,32], taboo over reaching out externally for support with emotional distress [32], and cultural expectations to keep the peace and "save face" [21]. Healthcare workers discussed how women are more concerned about facing stigma when working with healthcare providers who are of the same culture, due to concerns over privacy and cultural stigma [32].

Stigma related to mental health is also prevalent within migrant women's family systems. Often, husbands, parents and in-laws of these pregnant and parenting women do not have a good understanding of postpartum mental health risk, or are unaware of perinatal depression entirely [22,29,33]. O'Mahony et al. (2013) discuss the experience of one participant whose mother discouraged her from visiting a psychiatrist because, "everybody feels like that so don't worry . . . you will become more depressed [if you go to the psychiatrist]." Her husband shared this sentiment, stating, "You will come out of it and not need medication." Reluctance to take medication was mentioned in multiple studies, with women concerned about stigma and pressures from family, in-laws, or partners [22,27,33], or being fearful of harm to their child [31]; some preferred more holistic treatments including spiritual care [28,30,34].

Culture also shapes the expectations women have for postpartum life. Two studies included in this review examined the experiences of both first- and second-generation immigrant women to Canada, emphasizing the differences in expectations of women who are better acculturated to "Canadian" culture compared to more recent immigrants [31,33]. First generation immigrant women often mentioned how difficult it was to manage without the extra community and familial support that they would have had access to in their country of origin [20,21,27,29–31,33]. On the other hand, second generation immigrant women faced the expectation that they had to be able to manage new motherhood on their own, with one participant from Italy discussing how she felt guilty for hiring a nanny [31].

In addition to these expectations and opinions from family members, the structure of the family may influence migrant women's experiences with perinatal depression. One study discussed how the upbringing of the father affected how involved he was in the raising of the child [33]. Increased spousal support has been mentioned as instrumental to managing perinatal depression [28,30]. Alternatively, spouses can have a negative effect on perinatal depression outcomes. Husbands play a key role in whether or not their wife seeks help for her perinatal depression [22,29,32,33]. One participant cited how her husband said, "You are behaving like an uneducated person" when discussing her challenges with perinatal depression [20]. Lack of spousal support may discourage these women from seeking help for perinatal depression. Additionally, intimate partner violence may be more normalized in some cultures [22], which may result in women fearing seeking help if their husband is not supportive. Beyond the role of the husband, tensions with parents and in-laws were discussed as adding greater stress to the mothers due to conflicts on parenting practices [31,33] and lack of understanding of perinatal depression [31,32].

Cultural expectations on child-rearing may differ between generations and impact on migrant women's ability to manage their perinatal depression symptoms.

3.4. Theme 2: Migration-Related Stressors and Perinatal Depression

Migration to a new country is associated with many challenges related to immigration status, financial changes, and language barriers, all of which may impact ability to acquire employment, housing, and healthcare. Financial challenges were cited by migrant women as a major stressor [30], notably impacting provision for the child but also affecting how the mother is able to cope with her perinatal depression [29,30]. Many women find themselves financially dependent on others, often their spouse [31,34]. This can be challenging emotionally and mentally, especially when the migrant woman is a working professional in her country of origin and is either unable to work or experiences job deskilling (i.e., lack of recognition of education or work experience) in their new country of residence [19,33].

Tied to employment opportunities and financial challenges are limitations related to immigration status. Some participants do not seek the healthcare services they need due to a lack of insurance and not being able to afford out-of-pocket expenses for health care [19,30]. One participant shared how she was unable to get a Papanicolaou smear because of the cost [19]. Additionally, women described how insecure immigration status impacted their help-seeking because of a fear of deportation, feelings of not being in control, and feelings of inferiority to Canadian citizens [19]. Some women felt trapped by their dependency on their husbands due to their status and finances, leading them to be more susceptible to abusive relationships [19,22].

Language difficulties present a very common barrier faced by migrant women. Self-advocacy is impeded due to an inability to voice concerns directly to service providers [22,29,30,32,34,35]. Participants in one study mention how not having "enough words to express yourself" is a challenge when speaking with service providers [30]. These language barriers are not limited to help-seeking and may also lead to challenges finding a job, further perpetuating aforementioned financial concerns [21]. Discrimination based on sex/gender, ethnicity, and migrant status can also affect the lifestyle of migrant women, resulting in poor treatment of women or their partners in settings such as the workplace [21]. This can potentially contribute to the development and onset of perinatal depression.

3.5. Theme 3: Service Accessibility and Quality

Structural and systemic barriers regarding the delivery of care to migrant women can impact their ability to access care for perinatal depression. Problems with accessibility of treatment are not unique to migrant women, but are arguably distinct from non-migrant Canadian women [34]. Factors such as lengthy wait times for services, inadequate funding for mental health services, user fees, and limited availability of psychiatrists are reported to result in migrant women being less likely to pursue much needed services, especially due to the time sensitivity of the perinatal period [30,34]. Besides the limited availability, many women are entirely unaware of the mental health services available for their perinatal depression [20,22,28–30]. One study discussed how the majority of interviewed women found the community resources available to them were helpful, but they were unaware of them and stumbled upon these services by chance [20]. Service providers discuss how system navigation is particularly challenging for migrant women because of them "not understanding the health-care system" and not knowing how to approach providers, causing some to "fall through the gaps" [34]. They further discussed how referrals alone were insufficient, and follow-ups were necessary to ensure migrant women receive the care they require [34]. Participants encouraged the utility of sharing information about perinatal services at hospitals or family practices, or through outreach advertising and support centers for new immigrants [29,30]. Several women mention how service providers should be actively reaching out to migrant women, especially because "we don't give much significance to that pamphlet [about perinatal depression] if she's not saying why it's so important" [28,30].

Other logistical barriers such as transportation and childcare also stand between migrant women and their ability to obtain healthcare. Costs of transportation to attend appointments (which may additionally carry a fee) can put an extra strain on migrant families with financial constraints [30,32,34]. Women in the reviewed studies shared their opinion on alternative delivery models of services (e.g., telephone, online, group-based supports, social media, community clinics, peer-mentoring, etc.) and how these may be useful for women concerned about anonymity [20,21,30,35]. The cost of employing a babysitter or challenge of finding someone to watch their child during sessions can discourage women from attending clinics [32,34]. This is further exacerbated in women who do not have legal status, as expressed by one participant, "when you're legal you can take the child to daycare . . . We want our papers so we can progress; not so we can leave behind or be a load to anyone" [19].

Finally, women shared their thoughts about how the quality of the care being received affected their experience of perinatal depression. A common thread across studies was the importance of positive interactions with service providers. Women shared that sometimes they did not have enough time with the service providers to get their feelings across [30]. Having conversations with staff who are patient and appear interested in helping was beneficial, whereas feeling discriminated against, or experiencing racism, was harmful [20,28,29,34,35]. Providers articulated the importance of informed decision-making and autonomy of the woman to choose the type of service they need [34], while the women themselves shared the importance of service providers having an understanding of the impact of migration on family circumstances, level of isolation, and empathy for women's' experiences [30,34]. One healthcare worker mentioned, "I've heard of [health and welfare providers] making threats to women about taking their baby away . . . they don't take the time to listen" [32]. Empathy for the experience of migration, paired with an understanding of perinatal depression and how different ethnocultural groups may view perinatal depression, may also be helpful in serving this population [22,34]. This is especially important for migrant women who need more integrated, collaborative services that utilize more holistic care and integrates culture-specific values [28,30,33–35].

4. Discussion

Discussions with 262 participants were aggregated in this systematic review, focusing on the experiences and barriers faced by migrant women in their experiences with perinatal depression in Canada. After aggregating the results from ten samples of women, the three most notable themes affecting perinatal depression are related to culture, migration, and accessibility. The impact of culture on the experience of perinatal depression was not surprising considering how previous research has identified this to be one of the most reported experiences in perinatal depression amongst migrant women [11]. A literature review conducted in 2010 also discussed how few studies examined the role that social support plays in women's desire and ability to seek and access mental health care services [11]. In the present review, the importance of social support was mentioned in all ten migrant women samples, either as a reference to the need of the mother's family to help with childrearing, challenges related to clashing with in-laws, or the role of the husband in helping manage the wife's depressive symptoms. These experiences are important to draw upon, especially since there is a relationship between increased risk of perinatal depression and lack of social support [11]. Furthermore, physical separation from their cultures and their support systems can cause women to feel overwhelmed [11]. Overall, culture and views on perinatal depression have been found to be key in how migrant women seek or complete treatment.

Healthcare providers and administrators should consider the importance of training and exposure to a wider array of cultures to improve the delivery of services to this population as well as that of the general population. This is especially important in the case of training non-specialist providers with no formal mental health training, such as nurses and midwives [36]. Multiple studies have shared the importance of compassionate,

empathetic care in order to ensure that women who are participating in these services feel welcome and heard. Previous reviews have recommended a change in policy to address health disparities, especially regarding discrimination against groups of immigrants, family reunification, and choice of residence of immigrants [5]. It has also been suggested that Canadian immigration laws are discriminatory in nature, perpetuating situations where migrant women are forced to remain dependent on their spouse or other family members, leaving them more vulnerable to intimate partner violence and perceived helplessness [11]. Moving forward, having a sensitivity to migration-related stressors as discussed in this review is key to providing effective care to migrant women.

4.1. Limitations

Limitations of this review include potential lack of representativeness, in that most included studies were conducted in large city centers like Toronto and Vancouver. The barriers to perinatal depression services will differ between migrant women living in close proximity to these city centers and those who are in suburban and rural areas. This is especially notable considering how transportation was cited multiple times as a barrier to attending treatment. Additionally, there was some selection bias present in the included studies, as many of the women recruited for these qualitative interviews already had access to services, limiting responses from women who did not. Due to the focus of this review on barriers experienced by migrant women to Canada, facilitators to mental health treatment access were not included.

Moreover, there are several limitations to how this review was conducted. Only English-language articles were included, which may limit any existing French literature on this topic, notably from Quebec. The only databases searched were PubMed and PsycINFO. It is also important to address how there are discrete, unique experiences of migrant women from different cultures; it is not possible to generalize the perspectives of all migrant women in Canada, especially factors influenced directly by culture.

A further limitation is that this review only identifies challenges that put migrant women at risk of perinatal depression. The findings may inform future research that identifies strategies for healthcare services to refine existing interventions or develop future programs addressing the key stressors identified in this review as related to perinatal depression in migrant women.

4.2. Recommendations for Future Research

Future research should study more representative populations to address the concerns of migrant women who are not situated in larger cities. It may also be beneficial to interview spouses and other key family members in order to get a more thorough understanding of the belief systems, types of dynamics at play at home, and a full scope of how perinatal depression is perceived by women and their family members. Additionally, it would be beneficial for future research and reviews to explore how to facilitate for care available for Canadian migrant women to be incorporated in future treatment (e.g., cultural perspectives on supporting the mother, other available resettlement supports).

5. Materials and Methods

This review was conducted following the Joanna Briggs Institute (JBI) Manual for Evidence Synthesis [37] and PRISMA 2020 [26], which provide guidance on systematically examining qualitative data using a meta-aggregative approach for evidence synthesis. Once studies were identified, themes were elucidated from the qualitative data, as in the Data Extraction section below.

5.1. Inclusion Criteria

Only peer-reviewed, English-language articles were eligible for this review. Studies were included if they fulfilled the following: (a) use of qualitative investigation (i.e., interview, focus group); (b) participants were migrant women or clinicians working closely

with migrant women; (c) assessed the experiences and perspectives of perinatal women (i.e., antenatal and postpartum women with depression during pregnancy and up to one year postpartum), as defined by Anderson et al. [2], and (d) study conducted in Canada.

In this review, migrants were defined as any person living outside their country of birth, irrespective of legal status (e.g., immigrants, refugees, asylum-seekers) [2]. Immigrants are migrants who move to another country voluntarily in the hope of achieving a better life; first-generation immigrants being those migrating to Canada within their lifetime, and second-generation immigrants being those whose parents immigrated to Canada [31]. Refugees typically are forced to migrate for fear of their safety. Asylum-seekers migrate to seek protection from a dangerous setting in their home country [27].

While sex can be defined as the biological aspects that influence one's physical development, gender can be viewed as the socio-cultural aspects that influence sex-biased interactions not necessarily consistent with sex [38,39]. In this review, the definition of "women" includes people who are pregnant or are mothers, rather than people who identify as women. While this definition may be more in line with the term "female" rather than "woman," the experiences of perinatal depression in migrant women occur in a context of gendered cultural experiences. We opted to use the term woman/mother for a more holistic representation of the phenomena being investigated. Limited research exists on the experiences of perinatal depression in transgender individuals, particularly those who have migrated to Canada. We encourage further investigation into barriers experienced by these individuals.

Studies were excluded if they: (a) were meta-analyses, reviews, or grey literature (e.g., theses, dissertations); (b) reported ethnicity rather than migrant status; (c) did not discuss perinatal depression specifically; or (d) had the wrong participant population.

5.2. Search Strategy

Search terms were identified after a scan of the literature and existing reviews on the topic. PubMed and PsycINFO were searched using terms such as "Canada," "postpartum depression," "barrier," "perspective," and "migrant"; the full list of search terms is provided in Appendix A. Articles were screened for eligibility based on title and abstract before reviewing relevant full texts. Figure 1 outlines the screening process, following the PRISMA 2020 guidelines [25,26]. There was no limitation on year of publication. This search was conducted on 2 July 2022.

After databases were searched, results were imported onto Covidence for screening [40]. Titles and abstract were examined for relevance, followed by a full text review of relevant papers conducted by two reviewers (GD & SJ). Reference lists of included studies and related reviews were also scanned for relevant papers. The full screening strategy is summarized in Figure 1.

5.3. Data Synthesis

Data extraction and synthesis was guided by Lockwood et al. (2020), using the JBI meta-aggregation approach, and dependability and credibility of the findings were verified using the ConQual Method (described below). Step 1 involved extraction of data such as sample characteristics, setting (city, province/territory), data collection method, focus of investigation, and author findings for each paper, as shown in Table 2. Study findings included any themes identified by the authors through thematic analysis. Step 2 involved the development of categories based on the similarity of concepts across studies. Studies were imported into NVivo (released in March 2020; QSR International) to identify the qualitative categories [41]. Step 3 was the identification of synthesized categories. The full review process including data synthesis is summarized in Figure 1.

Table 2. Main characteristics of the included studies.

Author, Year, [Reference]	Sample Characteristics	Sample Place of Birth	Setting	Qualitative Data Collection Method	Focus of Investigation	Author Findings on Perinatal Depression Experiences
Ahmed et al., 2008 [29]	n = 23 migrant women from NORMAP-ERS study	China (2), India (2), Pakistan (1), South America (3), Egypt (1), Haiti (1)	Toronto (Ontario), Montreal (Quebec), Vancouver (British Columbia)	Semi-structured interviews	Migrant women experiences of PPD and PPD services, barriers and facilitators to help seeking, and opinions on factors that contribute to PPD	In this sample, women cited causes of depression as: feeling "overwhelmed" by the new baby and childcare responsibilities, financial pressures, social isolation and separation from family, and physical changes (e.g., hormones, physical exhaustion)
Ahmed et al., 2017 [27]	n = 12 migrant women (8 pregnant, 4 postpartum)	Syrian	Saskatoon (Saskatchewan)	Focus Group (one; conducted in Arabic)	Syrian refugee women perceptions of maternal depression, social support needs, challenges, expectations, barriers to MHCs, and how common depressive symptoms are in this sample.	Women included in the sample considered depression to be more extreme cases, not including instances of them being 'bored' or 'tired', despite having high EPDS scores. Causes for maternal depression were attributed to health of the child, birth away from the family, and expectations on sex of child. These Syrian women also discussed how there is a strong familial support to postpartum women in Syria, describing this as a factor as to why they say maternal depression happens less in Syrian women.

Table 2. *Cont.*

Author, Year, [Reference]	Sample Characteristics	Sample Place of Birth	Setting	Qualitative Data Collection Method	Focus of Investigation	Author Findings on Perinatal Depression Experiences
Baiden & Evans, 2021 [28]	n = 10 immigrant postpartum women	Sub-Saharan region of Africa	Greater Toronto Area, Niagara Region, London (Ontario)	Semi-structured interviews (telephone or in-person)	Black African newcomer mother perceptions on postpartum mental health and MHC, impacts of culture on willingness to use MHC, and perceived barriers and facilitators	Women in this sample cited that anything stopping them from caring for their child properly caused "mental stress", a term preferred over "mental illness". Some women in this sample shared how some Black African women did not believe that mental illness exists. Willpower, faith in God, and overthinking were cited as perceived reasons for postpartum depression. Participants shared how they preferred spiritual care and spousal support over MHC when able.
Ganaan et al., 2019 [34]	n = 14 community and health services providers	Not specified	Scarborough, Toronto (Ontario)	In-depth semi-structured interview	Identify service provider perspectives on facilitators and barriers faced in accessibility of health-care services to women with perinatal depression.	Providers discussed the importance of understanding women's perspectives, especially the impact of immigration. Service providers highlighted challenges at the intrapersonal level (i.e., provider attributes), interpersonal level (i.e., relationship approaches, pivotal role of the PHC provider), organizational level (i.e., assessment approaches, addressing barriers to accessing care, supports

Table 2. *Cont.*

Author, Year, [Reference]	Sample Characteristics	Sample Place of Birth	Setting	Qualitative Data Collection Method	Focus of Investigation	Author Findings on Perinatal Depression Experiences
						and pressures for service coordination), system level (i.e., treatment availability, acceptability of treatment, health and immigration system mechanisms) and their vision for optimized service delivery model (i.e., strengthening professional capacity, accommodating diverse cultural needs, offering accessible integrated, multidisciplinary services).
Ganaan et al., 2020 [30]	n = 11 postpartum immigrant women	Bangladesh (2), China (2), Colombia (1), India (2), Jamaica (1), Pakistan (1), Philippines (1), Sudan (1)	Scarborough, Toronto (Ontario)	Semi-structured interviews	Identify immigrant women perspectives on what contributes to PPD, health service accessibility, and the role of MHCs in supporting immigrant women.	The women shared their experiences with PPD, including physical symptoms (exacerbating emotional health), feeling of isolation, financial stressors (related to spousal depression). In terms of MHC access, transportation (especially due to physical limitations related to childbirth), and limited English-language skills when accessing services. There are also barriers related to knowledge of available services, discomfort with care administered over the phone, and long wait times as additional challenges.

Table 2. *Cont.*

Author, Year, [Reference]	Sample Characteristics	Sample Place of Birth	Setting	Qualitative Data Collection Method	Focus of Investigation	Author Findings on Perinatal Depression Experiences
Mamisachvili et al., 2013 [31]	n = 17 immigrant women from Postpartum Support Program (9 first generation, 8 second generation)	Chile (1), Uruguay (1), Guatemala (1), Poland (1), Ethiopia (1), Rwanda (1), Hong Kong (1), Canada (8)	Toronto (Ontario)	Semi-structured interviews	Explore experiences of PPMP between first- and second-generation Canadian women and roles of culture in their experiences.	Both first- and second-generation immigrants experienced intergenerational conflict with parents/in-laws and mental health stigma/difficulties understanding PPMP. First generation women who were not 'fully acculturated' cited difficulties related to a lack of support that would be available to them in their home countries. Second-generation women experienced internalized common stereotypes on motherhood, expectations of managing everything without additional support, loss of sense of self.
Morrow et al., 2008 [33]	n = 19 immigrant women (18 first generation, 1 second generation)	Hong Kong (7), China (5), India (4), Taiwan (1), Uganda (1), Canada (1)	Vancouver (British Columbia)	Semi-structured interviews	Explore experiences of PPD, variables that women attribute to the PPD experience, the role of social networks, and supports sought by postpartum women.	Women used personal relationships and social networks to describe their depression, perceiving the depression to be situational/based on external events or relationships. Migration affected women's relationships with family and postpartum rituals. Financial challenges, lack of a social network, deskilling, and unstable housing all affected Chinese women's

Table 2. *Cont.*

Author, Year, [Reference]	Sample Characteristics	Sample Place of Birth	Setting	Qualitative Data Collection Method	Focus of Investigation	Author Findings on Perinatal Depression Experiences
						depression and their support seeking. Ideals of motherhood, high expectations, and lack of preparation were all reported as challenges. Conflict with in-laws and absence of direct familial support is also a challenge related to migration.
O'Mahony et al., 2012a [a] [22]	n = 30 migrant women with PPD within the past 5 years	Mexico (8), South America (4), Costa Rica (1), Philippines (1), South Asia (3), China (5), Middle East (6), Africa (2)	Alberta	Semi-structured interview	Migrant women's conceptualization of PPD, how services are used to cope with PPD, contextual factors influencing MHC experiences, and services/strategies that could address PPD care.	Four major themes were identified: conceptualization of PPD (cultural differences/stigma, difference in identifying emotional distress), challenges in seeking help (language skills, environment transitions, education level, unsettled immigration status, economic status, etc.), facilitating factors in help-seeking (spiritual and religious practices, resilience, etc.), and intervention strategies for PPD care and treatment
O'Mahony et al., 2012b [a] [20]					Contextual intersecting factors that affect help-seeking and PPD management in migrant women.	Formal support (unfamiliar with available PPD services, different health services), additional health care provider supports (difficulties regarding policy regulations and participation in postpartum support programs, less perceived

Table 2. *Cont.*

Author, Year, [Reference]	Sample Characteristics	Sample Place of Birth	Setting	Qualitative Data Collection Method	Focus of Investigation	Author Findings on Perinatal Depression Experiences
						control or access), support groups (not always helpful), telephone support (mixed reviews, beneficial for flexibility but too frequent), positive health care relationship (attitude, discrimination, superficial help, power imbalances), informal support (social support from family and friends, relationships with in-laws, emotional support), partner support
O'Mahony & Donnelly, 2013 [a] [19]					Explore the intersectional factors that contribute to care access and PPD experiences of migrant women.	Emotional and economic dependence on sponsors and precarious immigration status/irregular status led to reduced reporting of relationship and mental health difficulties due to vulnerability. Controlling husbands and domestic violence were cited as dangers that came from these vulnerabilities. A shift in roles from a skilled worker to a mother was a notable challenge, especially with cultural expectations of gender roles and what a 'good mother' should be like.

Table 2. *Cont.*

Author, Year, [Reference]	Sample Characteristics	Sample Place of Birth	Setting	Qualitative Data Collection Method	Focus of Investigation	Author Findings on Perinatal Depression Experiences
O'Mahony et al., 2013 [a] [21]					Social, cultural, political, historical, and economic factors in migrant women's mental health care experiences and services/strategies that address PPD care and treatment in migrant women.	Cultural influences in seeking support (beliefs, background, values, meaning of PPD, family involvement, stigma, community beliefs on mental illness as a whole), socioeconomic influence on seeking support (challenges in seeking employment, English fluency challenges, immigrant status, financial challenges, workplace discrimination, coping strategies), spiritual and religious beliefs (spirituality)
O'Mahony & Clark, 2018 [35]	n = 10 key informants (interviews), n = 100 mental health professionals (survey)	N/A	British Columbia	Document analyses, open ended interviews, surveys	MHC in the Interior Health Region of British Colombia, how immigrant women are screened for PPD treatment, how policy affects MHC of immigrant women in rural settings	Service providers identified the importance of telehealth as a facilitator for treatment. They spoke on how women may not attend mental health clinics due to cultural factors, lack of knowledge, distance, or location of the clinics. Barriers related to ease of access to services including language barriers and cultural differences were identified.

Table 2. *Cont.*

Author, Year, [Reference]	Sample Characteristics	Sample Place of Birth	Setting	Qualitative Data Collection Method	Focus of Investigation	Author Findings on Perinatal Depression Experiences
Teng et al., 2007 [32]	n = 16 healthcare providers	Canada (8), China (2), South Africa (1), Pakistan (1), Vietnam (1), Afghanistan (1), Hong Kong (1), India (1)	Toronto (Ontario)	Semi-structured interviews	Examine service provider perspectives on risk factors for PPD in immigrant women, barriers to accessing treatment for PPD, special needs and challenges of immigrant women, and the unique challenges of caring for these women.	Practical barriers (English fluency, difficulty accessing information, transportation) and culturally determined barriers (lack of understanding of PPD, wrong attribution of PPD to personal shortcomings, stigma, obligation to the family, limited social support/spousal support, tensions with in-laws) were highlighted by this study.

Abbreviation: NORMAP-ERS, Needs of Refugee Mothers After Pregnancy-Early Response Services; PPD, Postpartum Depression; MHC, Mental healthcare; PPMP, Postpartum Mood Problems. [a] Same sample; qualitative results reported in multiple papers.

5.4. ConQual—Assessment of Confidence of Evidence

Confidence of evidence for each major synthesized finding was evaluated using the JBI ConQual process [23,37]. The ConQual Summary of Findings contains the major themes of the review and how each synthesized theme is scored (Table 1). The JBI ConQual ranking ranges from 'high' for qualitative studies to very low for text and opinion papers. The ranking of each synthesized finding is affected by the dependability and credibility of the finding. Dependability describes the appropriateness of the conduct of the research with research aims and purpose. Credibility measures how many findings of each synthesized finding was included. Culture-related challenges and migration-related challenges were ranked as moderate while service accessibility and quality were ranked as low.

The JBI Qualitative Appraisal Instrument was used to assess the methodological quality of the included studies [42]; results are shown in Table 3. Seven out of 13 papers received a quality appraisal score of 8 or higher out of 10. Most studies did not include a statement locating the research culturally or theoretically, or the influence of the researcher on the research, and vice-versa.

Table 3. JBI Quality Appraisal Table.

Author, Year	Q1	Q2 *	Q3 *	Q4 *	Q5	Q6 *	Q7 *	Q8	Q9	Q10	Overall Appraisal Score (Out of 10)
Ahmed et al., 2008 [29]	*Unclear*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*No*	*Yes*	*No*	*Yes*	*6*
Ahmed et al., 2017 [27]	*Unclear*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*9*
Baiden & Evans, 2021 [28]	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*No*	*Yes*	*Yes*	*Yes*	*8*

Table 3. *Cont.*

Author, Year	Q1	Q2 *	Q3 *	Q4 *	Q5	Q6 *	Q7 *	Q8	Q9	Q10	Overall Appraisal Score (Out of 10)
Ganaan et al., 2019 [34]	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*Yes*	*Yes*	*Yes*	*Yes*	*9*
Ganaan et al., 2020 [30]	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*Yes*	*Yes*	*Yes*	*Yes*	*9*
Mamisachvili et al., 2013 [31]	*Unclear*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*Yes*	*Yes*	*Yes*	*Yes*	*8*
Morrow et al., 2008 [33]	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*Yes*	*No*	*Yes*	*8*
O'Mahony et al., 2012a [22]	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*No*	*Yes*	*No*	*Yes*	*7*
O'Mahony et al., 2012b [20]	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*No*	*Yes*	*No*	*Yes*	*7*
O'Mahony & Donnelly, 2013 [19]	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*No*	*Yes*	*Unclear*	*Yes*	*7*
O'Mahony et al., 2013 [21]	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*No*	*Yes*	*Unclear*	*Yes*	*7*
O'Mahony & Clark, 2018 [35]	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*No*	*Yes*	*Yes*	*Yes*	*8*
Teng et al., 2007 [32]	*Unclear*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*No*	*Yes*	*Yes*	*Yes*	*7*

* ConQual dependability questions.

6. Conclusions

This review focuses on qualitative studies on the perspectives and experiences of perinatal depression in Canadian migrant women. Three major themes were identified: (1) culture-related challenges; (2) migration-related stressors; and (3) service accessibility and quality, that all shape the ability of migrant women to manage their perinatal depression. From these themes, it became clear that the role of family is instrumental in the mental health of new mothers in a new country, especially in regard to the support of the husband, parents, and in-laws. Cultural differences and migration experiences result in unique experiences regarding linguistic barriers and financial challenges that must be addressed in the implementation of services for migrant women with perinatal depression. These challenges overlap with service accessibility as a result of lack of resources like childcare and transportation, as well as poor communication of services and need for better cultural competence in service providers. Moreover, further research with better representative populations should be conducted, notably in rural areas or areas with lesser access to services. More research regarding how these barriers and challenges may be addressed will be important for improving the outcomes of migrant women with perinatal depression.

Author Contributions: Conceptualization, G.A.D.C.; Methodology, G.A.D.C.; Investigation: G.A.D.C. and S.J.; Writing—Original Draft Preparation, G.A.D.C.; Writing—Review and Editing, S.J., D.R.S., T.P.G. and D.J.C.; Supervision, T.P.G. and D.J.C. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Informed Consent Statement: Not applicable.

Conflicts of Interest: Potential conflicts of interest (past 36 months: November 2022): DC has received grant monies for research from Servier, Boehringer Ingelheim; Travel Support and Honoraria for Talks and Consultancy from Servier, Seqirus, Lundbeck, Mindcafe, Psychscene, Inside Practice. He is a founder of the Optimal Health Program (OHP), and holds 50% of the IP for OHP; and is part owner (5%) of Clarity Healthcare. He is an unpaid Chair of an Advisory Board of an Australian not-for-profit institute specialising in psychedelic medicines research. He does not knowingly have stocks or shares in any pharmaceutical company. G.A.D., S.J., D.R.S. and T.P.G. declare no conflict of interest.

Appendix A. Full Search Terminology

(Canada OR Canadian) AND ("post-partum depression" OR depress OR "perinatal depression" OR mental health) AND (barrier OR perspective OR expectation OR chal-lenge OR qualitative) AND (migrant OR immigrant OR refugee OR "asylum-seeker").

References

1. Falah-Hassani, K.; Shiri, R.; Vigod, S.; Dennis, C.-L. Prevalence of Postpartum Depression among Immigrant Women: A Systematic Review and Meta-Analysis. *J. Psychiatr. Res.* **2015**, *70*, 67–82. [CrossRef] [PubMed]
2. Anderson, F.M.; Hatch, S.L.; Comacchio, C.; Howard, L.M. Prevalence and Risk of Mental Disorders in the Perinatal Period among Migrant Women: A Systematic Review and Meta-Analysis. *Arch. Women's Ment. Health* **2017**, *20*, 449–462. [CrossRef] [PubMed]
3. Ghahremani, T.; Magann, E.F.; Phillips, A.; Ray-Griffith, S.L.; Coker, J.L.; Stowe, Z.N. Women's Mental Health Services and Pregnancy: A Review. *Obstet. Gynecol. Surv.* **2022**, *77*, 122–129. [CrossRef] [PubMed]
4. Government of Canada, S.C. The Daily—Immigration and Ethnocultural Diversity: Key Results from the 2016 Census. Available online: https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025b-eng.htm?indid=14428-1&indgeo=0 (accessed on 4 March 2022).
5. Thomson, M.S.; Chaze, F.; George, U.; Guruge, S. Improving Immigrant Populations' Access to Mental Health Services in Canada: A Review of Barriers and Recommendations. *J. Immigr. Minor. Health* **2015**, *17*, 1895–1905. [CrossRef] [PubMed]
6. Lassetter, J.H.; Callister, L.C. The Impact of Migration on the Health of Voluntary Migrants in Western Societies: A Review of the Literature. *J. Transcult. Nurs.* **2009**, *20*, 93–104. [CrossRef] [PubMed]
7. Guruge, S.; Thomson, M.S.; George, U.; Chaze, F. Social Support, Social Conflict, and Immigrant Women's Mental Health in a Canadian Context: A Scoping Review. *J. Psychiatr. Ment. Health Nurs.* **2015**, *22*, 655–667. [CrossRef]
8. Stirling Cameron, E.; Ramos, H.; Aston, M.; Kuri, M.; Jackson, L. "COVID Affected Us All:" The Birth and Postnatal Health Experiences of Resettled Syrian Refugee Women during COVID-19 in Canada. *Reprod. Health* **2021**, *18*, 256. [CrossRef]
9. Cohen, M.Z.; Phillips, J.M.; Palos, G. Qualitative Research with Diverse Populations. *Semin. Oncol. Nurs.* **2001**, *17*, 190–196. [CrossRef]
10. Rezazadeh, M.S.; Hoover, M.L. Women's Experiences of Immigration to Canada: A Review of the Literature. *Can. Psychol. Can.* **2018**, *59*, 76–88. [CrossRef]
11. O'Mahony, J.M.; Donnelly, T. Immigrant and Refugee Women's Post-Partum Depression Help-Seeking Experiences and Access to Care: A Review and Analysis of the Literature. *J. Psychiatr. Ment. Health Nurs.* **2010**, *17*, 917–928. [CrossRef]
12. Brown-Bowers, A.; McShane, K.; Wilson-Mitchell, K.; Gurevich, M. Postpartum Depression in Refugee and Asylum-Seeking Women in Canada: A Critical Health Psychology Perspective. *Health Lond. Engl. 1997* **2015**, *19*, 318–335. [CrossRef] [PubMed]
13. Fung, K.; Dennis, C.-L. Postpartum Depression among Immigrant Women. *Curr. Opin. Psychiatr.* **2010**, *23*, 342–348. [CrossRef] [PubMed]
14. Tobin, C.L.; Di Napoli, P.; Beck, C.T. Refugee and Immigrant Women's Experience of Postpartum Depression: A Meta-Synthesis. *J. Transcult. Nurs.* **2018**, *29*, 84–100. [CrossRef] [PubMed]
15. Playfair, R.L.R.; Salami, B.; Hegadoren, K. Detecting Antepartum and Postpartum Depression and Anxiety Symptoms and Disorders in Immigrant Women: A Scoping Review of the Literature. *Int. J. Ment. Health Nurs.* **2017**, *26*, 314–325. [CrossRef] [PubMed]
16. Rousseau, C.; Frounfelker, R.L. Mental Health Needs and Services for Migrants: An Overview for Primary Care Providers. *J. Travel Med.* **2019**, *26*, tay150. [CrossRef] [PubMed]
17. Salam, Z.; Odenigbo, O.; Newbold, B.; Wahoush, O.; Schwartz, L. Systemic and Individual Factors That Shape Mental Health Service Usage Among Visible Minority Immigrants and Refugees in Canada: A Scoping Review. *Adm. Policy Ment. Health* **2022**, *49*, 552–574. [CrossRef] [PubMed]
18. Salameh, T.N.; Hall, L.A.; Crawford, T.N.; Staten, R.R.; Hall, M.T. Racial/Ethnic Differences in Mental Health Treatment among a National Sample of Pregnant Women with Mental Health and/or Substance Use Disorders in the United States. *J. Psychosom. Res.* **2019**, *121*, 74–80. [CrossRef]
19. O'Mahony, J.M.; Donnelly, T.T. How Does Gender Influence Immigrant and Refugee Women's Postpartum Depression Help-Seeking Experiences? *J. Psychiatr. Ment. Health Nurs.* **2013**, *20*, 714–725. [CrossRef]

20. O'Mahony, J.M.; Donnelly, T.T.; Raffin Bouchal, S.; Este, D. Barriers and Facilitators of Social Supports for Immigrant and Refugee Women Coping with Postpartum Depression. *ANS Adv. Nurs. Sci.* **2012**, *35*, E42–56. [CrossRef]
21. O'Mahony, J.M.; Donnelly, T.T.; Raffin Bouchal, S.; Este, D. Cultural Background and Socioeconomic Influence of Immigrant and Refugee Women Coping with Postpartum Depression. *J. Immigr. Minor. Health* **2013**, *15*, 300–314. [CrossRef]
22. O'Mahony, J.M.; Donnelly, T.T.; Este, D.; Bouchal, S.R. Using Critical Ethnography to Explore Issues among Immigrant and Refugee Women Seeking Help for Postpartum Depression. *Issues Ment. Health Nurs.* **2012**, *33*, 735–742. [CrossRef] [PubMed]
23. Munn, Z.; Porritt, K.; Lockwood, C.; Aromataris, E.; Pearson, A. Establishing Confidence in the Output of Qualitative Research Synthesis: The ConQual Approach. *BMC Med. Res. Methodol.* **2014**, *14*, 108. [CrossRef] [PubMed]
24. Munn, Z.; Barker, T.H.; Moola, S.; Tufanaru, C.; Stern, C.; McArthur, A.; Stephenson, M.; Aromataris, E. Methodological Quality of Case Series Studies: An Introduction to the JBI Critical Appraisal Tool. *JBI Evid. Synth.* **2020**, *18*, 2127–2133. [CrossRef] [PubMed]
25. PRISMA. Available online: http://prisma-statement.org/prismastatement/flowdiagram.aspx (accessed on 29 April 2022).
26. Page, M.J.; McKenzie, J.E.; Bossuyt, P.M.; Boutron, I.; Hoffmann, T.C.; Mulrow, C.D.; Shamseer, L.; Tetzlaff, J.M.; Akl, E.A.; Brennan, S.E.; et al. The PRISMA 2020 Statement: An Updated Guideline for Reporting Systematic Reviews. *BMJ* **2021**, *372*, n71. [CrossRef]
27. Ahmed, A.; Bowen, A.; Feng, C. Maternal Depression in Syrian Refugee Women Recently Moved to Canada: A Preliminary Study. *BMC Pregnancy Childbirth* **2017**, *17*, 240. [CrossRef]
28. Baiden, D.; Evans, M. Black African Newcomer Women's Perception of Postpartum Mental Health Services in Canada. *Can. J. Nurs. Res. Rev. Can. Rech. En Sci. Infirm.* **2021**, *53*, 202–210. [CrossRef]
29. Ahmed, A.; Stewart, D.E.; Teng, L.; Wahoush, O.; Gagnon, A.J. Experiences of Immigrant New Mothers with Symptoms of Depression. *Arch. Women's Ment. Health* **2008**, *11*, 295–303. [CrossRef]
30. Ganann, R.; Sword, W.; Newbold, K.B.; Thabane, L.; Armour, L.; Kint, B. Influences on Mental Health and Health Services Accessibility in Immigrant Women with Post-Partum Depression: An Interpretive Descriptive Study. *J. Psychiatr. Ment. Health Nurs.* **2020**, *27*, 87–96. [CrossRef]
31. Mamisachvili, L.; Ardiles, P.; Mancewicz, G.; Thompson, S.; Rabin, K.; Ross, L.E. Culture and Postpartum Mood Problems: Similarities and Differences in the Experiences of First- and Second-Generation Canadian Women. *J. Transcult. Nurs.* **2013**, *24*, 162–170. [CrossRef]
32. Teng, L.; Robertson Blackmore, E.; Stewart, D.E. Healthcare Worker's Perceptions of Barriers to Care by Immigrant Women with Postpartum Depression: An Exploratory Qualitative Study. *Arch. Women's Ment. Health* **2007**, *10*, 93–101. [CrossRef]
33. Morrow, M.; Smith, J.E.; Lai, Y.; Jaswal, S. Shifting Landscapes: Immigrant Women and Postpartum Depression. *Health Care Women Int.* **2008**, *29*, 593–617. [CrossRef] [PubMed]
34. Ganann, R.; Sword, W.; Newbold, K.B.; Thabane, L.; Armour, L.; Kint, B. Provider Perspectives on Facilitators and Barriers to Accessible Service Provision for Immigrant Women With Postpartum Depression: A Qualitative Study. *Can. J. Nurs. Res. Rev. Can. Rech. En Sci. Infirm.* **2019**, *51*, 191–201. [CrossRef] [PubMed]
35. O'Mahony, J.; Clark, N. Immigrant Women and Mental Health Care: Findings from an Environmental Scan. *Issues Ment. Health Nurs.* **2018**, *39*, 924–934. [CrossRef]
36. Singla, D.R.; Lemberg-Pelly, S.; Lawson, A.; Zahedi, N.; Thomas-Jacques, T.; Dennis, C.-L. Implementing Psychological Interventions Through Nonspecialist Providers and Telemedicine in High-Income Countries: Qualitative Study from a Multistakeholder Perspective. *JMIR Ment. Health* **2020**, *7*, e19271. [CrossRef] [PubMed]
37. Lockwood, C.; Porritt, K.; Munn, Z.; Rittenmeyer, L.; Salmond, S.; Bjerrum, M.; Loveday, H.; Carrier, J.; Stannard, D. Chapter 2: Systematic Reviews of Qualitative Evidence. In *JBI Manual for Evidence Synthesis*; Aromataris, E., Munn, Z., Eds.; JBI: Adelaide, Australia, 2020; ISBN 978-0-648-84880-6.
38. Becker, J.B.; McClellan, M.; Reed, B.G. Sociocultural Context for Sex Differences in Addiction. *Addict. Biol.* **2016**, *21*, 1052–1059. [CrossRef] [PubMed]
39. Sanchis-Segura, C.; Becker, J.B. Why We Should Consider Sex (and Study Sex Differences) in Addiction Research. *Addict. Biol.* **2016**, *21*, 995–1006. [CrossRef]
40. *Covidence Systematic Review Software*; Veritas Health Innovation: Melbourne, Australia, 2013.
41. *NVivo 2020*; ACM Press: New York, NY, USA, 2012.
42. Hannes, K.; Lockwood, C.; Pearson, A. A Comparative Analysis of Three Online Appraisal Instruments' Ability to Assess Validity in Qualitative Research. *Qual. Health Res.* **2010**, *20*, 1736–1743. [CrossRef]