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YAZDANI, Farzaneh, RASSAFIANI, Mehdi, TUNE, Kellie, POLLARD, Nicholas <http://orcid.org/0000-0003-1995-6902>, SAKELLARIOU, Dikaios, FANI, Mahdieh, NOBAKHT, Laya and FIRUZI, Sepide

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Review Article

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Immigration, Participation in Health Services and Social Occupations: A Literature Review

Farzaneh Yazdani[1], Mehdi Rassafiani[2,3], Kellie Tune[1], Nicholas Pollard[4], Dikaios Sakellariou[5], Mahdieh Fani[6], Laya Nobakht[7], Sepide Firuzi[8]

[1]Occupational Therapy Program, Faculty of Health and Life Sciences, Oxford Brookes University, Oxford, UK
[2]Occupational Therapy Department, Faculty of Allied Health, Kuwait University, Kuwait
[3]Iranian Research Centre on Aging, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran
[4]Occupational Therapy Program, Health & Wellbeing, Sheffield Hallam University, Sheffield, UK
[5]Occupational Therapy Program, Cardiff University, Cardiff, UK
[6]Faculty of Health and Life Sciences, Oxford Brookes University, Oxford, UK
[7]Department of Clinical Psychology, Islamic Azad University, Tehran, Iran
[8]Independent Clinician, Tehran, Iran

Corresponding Author: Farzaneh Yazdani, PhD, Associate Professor, Occupational Therapy Program, Faculty of Health and Life Sciences, Oxford Brookes University, Oxford, UK. Tel: +44-1865-285289, Email: fyazdani@brookes.ac.uk

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Abstract

Introduction: According to the World Health Organisation 'participation', meaning involvement in everyday occupations, has a positive influence on health and wellbeing and lack thereof can lead to negative health consequences. Occupational therapy scholars believe this phenomenon needs exploring with attention to context. Variability is apparent in the way participation has been addressed in the context of voluntary immigration. This review aims to identify how the concept of participation and its association with the health and wellbeing of immigrants is addressed in research literature.

Methods: A literature review method was applied. The data bases searched were: PubMed, ASSIA, CINHAL, PsycINFO, AMED, CRD, EBESCO Host, Sociological Abstract, Lexis and EMBASE. Articles that fulfilled all inclusion criteria were critically appraised in order to assess their quality. Sixteen articles from major related databases were included. Qualitative analysis was used throughout.

Results: Participation was mostly identified by measuring the number of attendances or self-report of attendance in health-related services or social occupations. Four themes were identified: outlook of participation, contributing factors to participation, approaches to studying immigrants' participation, and outcomes of participation.

Conclusion: Participation lacks a common and exclusive definition that considers both objective and subjective experiences. How immigrants' backgrounds and future perspectives affect what 'participation' means to them needs further exploration. The current publication has identified several contributing factors that need considering in health and social-related policies, plans and strategies. It is significant that enabling factors such as the positive attitude of immigrants, and providing support to immigrants can facilitate their participation pattern.

Keywords: Community Health Services, Culture, ICF, Delivery of Health Care, Occupational Therapy

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Introduction

The International Classification of Functioning, Disability and Health, known more commonly as ICF, provides a standard language and framework for the description of health and health-related states.[1] According to the, limitation in activity and restriction in participation are two important determinants of ill health and disability. The ICF defines participation as involvement in life situations and it highlights a direct relationship between health and participation in everyday life.[2] However, Hemmingsson and Jonsson[2] highlight that the ICF does not consider subjective experiences, meaning or autonomy and thus its definition of participation is limited. They argue that the ICF operationalises participation as observed performance. This operationalisation means that what is observed as participation may not be consistent with the subjective experience of participation, without a degree of

autonomy or choice that underpins the observed participation. Atkinson et al[3] point out that the definition of 'participation' often is unclear. Furthermore, the nature of participation varies according to setting and resource availability as well as social, cultural, political and economic contexts.[4]

Evidence supports that the issue of health and wellbeing in immigrants needs separate attention. Immigrants are subject to risk factors including exposure to disease, suboptimal living conditions, as well as stressors associated with their immigration and resettlement process. Furthermore, immigrants can experience social, cultural, legal, economic and linguistic barriers to participation in health and community services.[5-7]

Assimilation into the new diet and lifestyle patterns of the host country may also contribute to a decline in health outcomes for immigrant populations.[8] Bhopal[9] also highlights that some immigrants encounter direct and indirect discrimination enacted by the host health service. These issues present significant challenges in designing equitable and accessible health services. In the context of health care practice, encountering different cultural norms and standards is often a source of confusion and misunderstanding for both clients and the health care professionals.[10]

Hudelson et al[11] point out that securing equality in health services demands the consideration of immigrants' needs in all aspects of health care service planning, implementation and evaluation. The participation of immigrants in health and community services is an important step towards this goal.

Gallagher et al[12] point out that participation in daily occupations is necessary for health and wellbeing. Sheldon and Elliot[13] highlight that participation needs to be aligned with an individual's core strengths, needs, interests and values in order to facilitate motivation, commitment and wellbeing. The World Federation of Occupational Therapists Position Statement on Human Rights reiterates that 'people have the right to participate in a range of occupations that enable them to flourish, fulfil their potential and experience satisfaction in a way that is consistent with their background, life style and belief.'[14]

In spite of the significance of participation in determining health, this concept has been explored by researchers in different ways. Among different disciplines investigating this area, occupational science scholars are interested to explore the occupational life of a variety of groups to enrich the fundamental concepts of this discipline.[15] Occupational therapists have also shown more interest in studying immigrants' occupational life, which in turn informs their intervention plans.[16]

There seem to be some occupational therapy programmes across different countries with a considerable immigrant population that study issues around immigrants' occupational life and participation in a variety of life situations.[17] Up until now previous studies within the field of occupational therapy, in particular mental health, have shown several shortcomings in providing optimum intervention to immigrant clients, due to differences in world views between clients and staff about the concept of occupation, participation and their potential values.[18,19] The problem is that when looking at variety of disciplines, it appears that immigrants' participation has been identified differently across publications.

A wide range of factors is linked to immigrants' participation in community, social and health services. To establish a basis for further exploration of the concept of participation within the context of voluntary immigration, the authors of this paper planned a literature review to provide a review of the current situation within the literature in order to create evidence that facilitates further studies.[20] Therefore, this review aims to identify how the concept of participation and its association with the health and wellbeing of immigrants is addressed in research literature.

Methods

A systematic literature review was applied as the method of study. The researchers intended to undertake a review of the current state of published papers in relation to the concept of 'participation' and in the context of 'immigration' to answer the question: 'How have published articles addressed participation of immigrants in health-related services and social-related occupations?'

The review was conducted in a systematic way to ensure a good quality review. This approach is explained by Aveyard[21] as a review that applies a systematic approach but is not as detailed as a systematic review. In order to ensure that the steps of the literature review were applied systematically, Aveyard[21] and the Centre of Reviews and Dissemination (CRD) guidelines[22] were consulted to inform the research process. The authors reviewed research relating to first generation voluntary immigrants across ten databases.

Search Process

Articles were identified through electronic searches that were carried out between February and May 2015. To ensure credibility, various databases, which would potentially cover both health and social perspectives of health, were used for the literature search[23]: PubMed, ASSIA, CINHAL, PsycINFO, AMED, CRD, EBESCO Host, Sociological Abstract, Lexis and EMBASE. The search key words and databases are presented in Table 1.

Different operations were applied in combining these keywords in different databases. All search fields (e.g. title, keywords, abstract etc) were selected in all databases. The basic search function was used in PubMed and PsycINFO, with the 'related terms' search function activated. The advanced search function was used in CINAHL, utilising the Boolean/Phrase search mode. No time limit was applied in searching articles in any of the databases. The bibliographical details of articles that were identified through the searches were exported into Endnote. The details included the title, keywords and abstract, where available. Appropriateness for inclusion was judged by the criteria listed above.

Inclusion Criteria

For inclusion in the review, articles had to demonstrate an explicit focus on participation as the primary outcome – including participation in all aspects of health care, or social/community participation – and discuss factors affecting

Table 1. Databases and Key Words Used in This Review

Databases		Assia, CINHAL, PsychINFO, Pubmed, Medline, CRD, EBESCO Host, Sociological abstract, Lexis & EMBASE
Keywords		
	Group 1	(Foreign national or Foreign* or Expat or Expatri* or Immigr* or Emigr* or Migration or Migrant* or Settl)
	Group 2	(Social Participa* or community Participa* or Social engage* or community engage* or Social Involvement* or community Involvement* or Social Activit* or community Activit* or Social Inclu* or community Inclu* or Social Exclu* or community Exclu* or Social Contribution* or community Contribution* or Social Integrat* or community Integrat* or Occupational Participa* or Occupational engage* or Occupational Involvement* or Occupational Activit* or Occupational Inclu* or Occupational Exclu* or Occupational Contribution* or Occupational Integrat*)
	Group 3	(Health or Wellbeing or Well-being or well being or Flourish* or Euaidmon* or quality of life or Qol or life satisfaction).

participation or the outcomes of participation. Articles also had to be written in English and published in a peer-reviewed journal accessible through electronic databases.

In spite of limitations in the definition of participation based on the ICF, this definition was adapted and modified. The definition states that participation is 'involvement in a life situation'.[1] This definition was assumed to underpin the way participation is understood in health care. Occupational therapy has a core focus on the concept of participation. However, few studies explore immigration and participation in the occupational therapy or occupational science literature. The occupational therapy definition of participation includes subjective as well as objective experiences.[24] Therefore, studies needed to focus on participation defined as 'attending or involvement to a life situation,' with either a subjective or an objective view of participation, in order to be eligible for inclusion in the review. The 'immigrant' also is defined as 'a person who has come to a different country in order to live there permanently.'[25] The status of immigrants was defined as voluntary, rather than that of asylum seekers, refugees or political immigrants. Therefore, throughout this paper, immigrants refer to people who voluntarily immigrated.

Exclusion Criteria

The review excluded studies that focused on immigrants with less than five years' residency in their host country; second generation immigrants; studies that included non-voluntary immigrants (such as political immigrants, asylum seekers, refugees); or studies focused on internal migrants. The reason for excluding non-voluntary immigrants was that their situation is different from voluntary immigrants and needs to be addressed differently. The services available and the mechanism of access can vary considerably for voluntary and non-voluntary immigrants. A scoping review confirmed that voluntary immigrants are less of a focus in existing research. Furthermore, newly arrived immigrants were excluded as they are in a state of transition and therefore their characteristics can be different.[26]

Excluded studies also included those that focused on health migrants (i.e. people accessing international health or community services and people who migrate with the sole purpose of accessing health services) and those concerned with children or families rather than adults. Studies that focused on service providers or that were not directly focused on participation or the factors affecting participation were also excluded. The review did not consider case studies, PhD dissertations or unpublished reports.

Finally, participatory action research (PAR) was also excluded because the aspect of participation under consideration refers to participation in research projects, while in this study the inclusion criteria was related to the concept of participation in either health-related or social occupations. However, some of the papers did look at participants in greater depth in the context of health services and social occupations because of the flexible nature of PAR and the wider range of strategies applied in study design. The data collection[27] meant that data extraction and the quality check of the PAR studies needed a different approach. The decision to exclude PAR was taken during the initial screening of titles and abstracts. The researchers thought it deserved a separate review (which is in progress) as more focus was needed on the study design in particular and impacts on the outcome that were not relevant to this paper. In addition, the concept of participation in the research project was a mediating factor in relation to further participation in other situations.

The bibliographic databases revealed 4766 articles overall. After removing duplicates and initial screening, 980 titles and abstracts were screened for inclusion; 99 of these studies were discussed with the principal investigator to ensure parity in the application of the concept of participation, in particular, and other inclusion criteria. On completion of the screening process, 60 studies were retrieved for a quality check; of these, 16 were selected based on their quality and relevance in relation to the question of the study.

The process of the review is presented in Figure 1. To ensure the credibility of the study, adoption of a well-established study design was required.[23] To address this, a team of 4 researchers and 4 research assistants contributed to this review. Peer scrutiny was implemented by the team members at all stages, from the data search to synthesising the knowledge. Five members of the team were occupational therapists with experience in research methods, the topics related to immigration and social participation, or both.[22] The research assistants were an occupational therapist, experienced in the immigration issues, health and social participation and research method; 2 clinical psychologists; and one medical doctor familiar with the research method. The role of the research assistants was to double check the data exclusion and extractions against the defined criteria. All research assistants were given an initial tutorial about the work process and frequent debriefing was planned between the main investigator and her team. Reflexivity and peer review checks were applied throughout the study. A systematic process was used and informed by constant reflection and

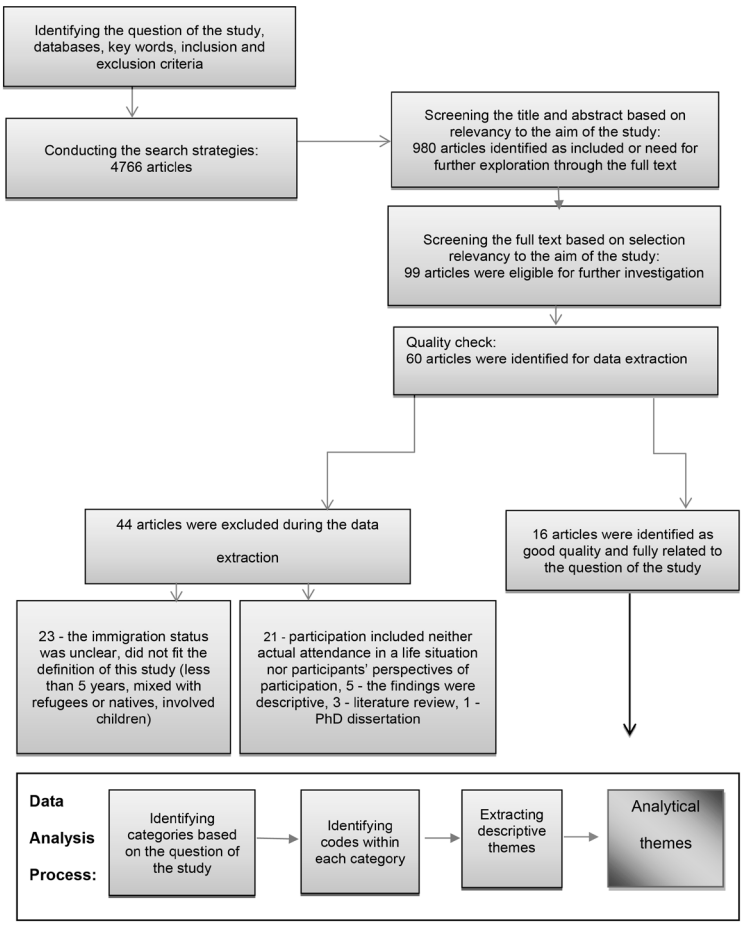

Figure 1. Identification, Eligibility and, Inclusion Process of the Research Articles.

peer checking as demonstrated in Figure 1. Each step of the process was completed by 2 persons (MF and KT), and monitored and double-checked by the principal investigator of the study (FY). A fourth (NP) contributed to the writing of the paper and in particular the discussion per his experience of the topic.

Titles and abstracts were randomly divided between authors MR, FY and KT for screening. An audit process was built in to the screening process as all titles and abstracts were screened by the first author (FY). The full text of potentially eligible studies was retrieved and assessed for eligibility by one of the three review authors. Any uncertainty about the eligibility of a particular study was discussed with the first author.

Whether the article addressed participation or not needed to be decided by an expert. This was because the word participation was not directly used in most studies and the criteria for inclusion specified the study needed to address attending a life situation. The first three authors involved in the search, quality check and data extraction were occupational therapists with between 10 and 25 years' experience as academics and researchers in occupational therapy. The included studies reported on the experience of adult immigrants. The age range was between 18 and 80 years. Only one of the papers included a sample of children and adults together. However, only the findings of the adults reported in the paper were considered in this literature review.

Further details about the demographic characteristics of the participants in the studies are presented in Table 2.

Quality Assessment and Data Extraction

Articles that fulfilled all inclusion criteria were critically appraised in order to assess their quality. Thomas and Harden[28] suggest that in order to avoid drawing unfounded conclusions, the quality of the papers needs to be checked. Aveyard[21] and the CRD guidelines[22] were used to inform the quality assessment and data extraction tool to identify the weaknesses and strengths of the articles. The quality of the papers also needed to be taken into account during the literature synthesis. No articles were rejected as a result of this process. Quality assessment and data extraction was undertaken by KT, SF and MR. All of the quality assessments were audited by the first author (FY) to check for consistency using the following criteria:

A – No or few flaws: The study's credibility, transferability, dependability and confirmability is high: Include

B – Some flaws, unlikely to affect the credibility, transferability, dependability and/or confirmability of the study: Include

C – Some flaws that may affect the credibility, transferability, dependability and/or confirmability of the study: The inclusion or exclusion of these papers was negotiated between the reviewers and first author.

D – Significant flaws that are very likely to affect the credibility,

Table 2. Demographic Characteristics of Participants in Studies in This Review

No.	Author and Year	Study Method	Immigrants' Origin Indicated in the Article	Country of Immigration	Gender
1	Amankwah et al[30]	Survey	Minorities	Canada	Female
2	Devlin et al[38]	Qualitative	Somalia	USA	Female
3	Evenson et al[29]	Survey	Latino	USA	Female
4	Hansen et al[40]	Survey	Non-western	Denmark	Both
5	Hofstetter et al[44]	Survey	Latino	USA	Both
6	Juarbe et al[37]	Descriptive	Mexico	USA	Female
7	Knipscheer et al[31]	Survey	Mediterranean	Netherlands	Both
8	Kwok et al[32]	Qualitative exploratory	Chinese-Australian	Australia	Female
9	Lai et al[35]	Survey	China	Canada	Both
10	McMullin et al[42]	Qualitative exploratory	Latino	USA	Female
11	Kim et al[45]	Qualitative descriptive	Korea	USA	Male
12	Suto[34]	Ethnographic & critical theory	Philippines, Mexico, Guatemala, Iran, Taiwan, Ukraine, India, Bosnia, Panama	Canada	Female
13	Terry et al[41]	Qualitative exploratory	Asia	Australia	Both
14	Tirodkar et al[43]	Qualitative	South Asia	USA	Both
15	Walseth[39]	Qualitative	Turkey, Pakistan, Morocco, Iran, Syria, Gambia, Kosovo	Norway	Female
16	Weltin et al[36]	A mixed-convergent parallel designed intervention	Marshall Islands	USA	Both

transferability, dependability and/or confirmability of the study: Exclude

Following appraisal, data were extracted in accordance with Thomas and Harden's[28] methods. For the purposes of this review, data were defined as the published results of the studies examined. This included the studies' analyses and interpretations rather than participants' quotes, which were considered as raw data. Different segments of text under the headings of 'method', 'results' and 'findings' were treated as data and pasted onto a Google spreadsheet. The discussion sections of all articles were also reviewed as sometimes it included results. Coding was informed by the content of the articles and in accordance with the aim of the study. Codes were then categorised based on the main ideas that naturally emerged from the codes into descriptive themes. Themes were identified through a process of mapping across the categories and reviewing them several times (Figure 2).

Data Analysis

Applying qualitative analysis techniques, the data were analysed by 2 of the researchers who are occupational therapists and experienced in topics related to health and social participation. The first stage was to read all extracted data and code them based on the salient information in the articles. Each of the codes addressed a specific issue. New codes were added as data were analysed. In total, 105 unique codes were developed.

The next stage was to synthesise the descriptive themes into analytical themes that would offer an answer to the review question.[28] These descriptive themes remained very close to the data and offered an overview of the findings of the reviewed studies.[28]

Analytical themes do not merely describe but go 'beyond the findings of the primary studies and generate additional concepts, understandings or hypotheses'.[28] These themes are often abstract and rather than offering a detailed or thorough description of data, they provide an answer to specific review questions.[28] In this literature review, there were seven issues reported in the papers; under further investigation, these fell into 4 analytical themes. Figure 2 represents the process of moving from descriptive to analytical themes.

Results

In all the included articles, immigrants were from countries in Asia, Africa, South America, the Pacific region or Eastern Europe who had immigrated to the United States, Canada, Australia or a country in Western Europe. There was diversity in the immigrants' ethnicity, health and social beliefs, and cultural values.

The results of the review were synthesised into 4 broad themes, with 2 sub-themes for theme one and 2 as follows.

Theme 1: The Outlook of Participation

The word 'participation' was not directly used in the majority of the studies. However, studies were selected according to the reviewers' interpretation of 'attending to a life situation' informed by the ICF,[1] as stated above. The included studies addressed participation in a variety of forms and from different outlooks. Therefore, attending a health or community setting to receive services, or attending any kind of activities individually or in groups were considered as attending a life situation. The life situations depicted in the studies were divided into 2 sub-themes.

Sub-theme 1a. Attending Health Services

To address immigrants' health-related issues, some of the articles reported immigrants' participation in helath care services (cancer screeining and mental health support services) and the related factors. Some were related to health beliefs, the percived value of attending health care services

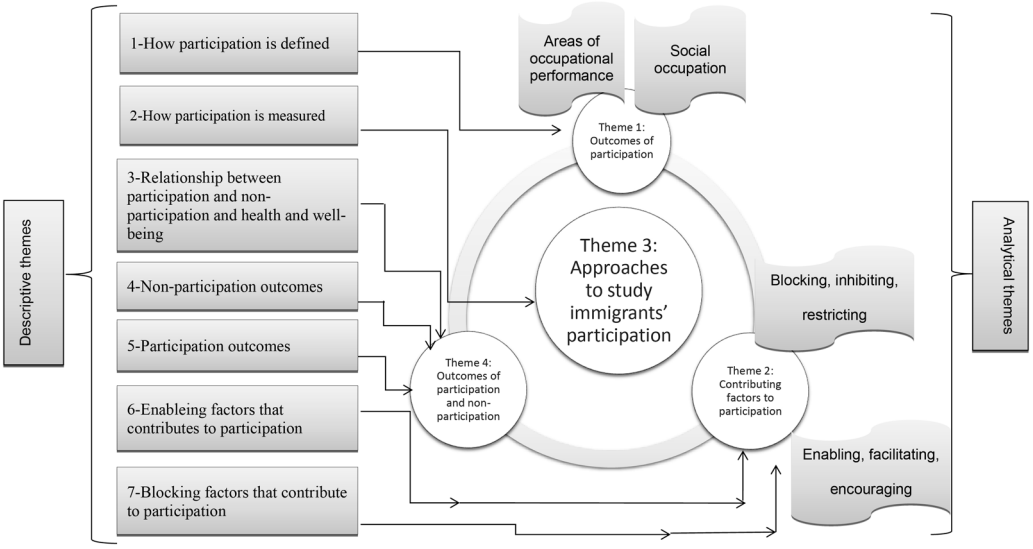

Figure 2. Relationship Between Descriptive and Analytical Themes.

and expression of interest in participation in the provided health care in the host country.

Sub-theme 1b. Attending Social Occupations and Group Activities

Some of the studies looked at the health value of attending social occupations and activities within groups and/ or the immigrants' beliefs about them. The social occupations included in these studies were smoking in gatherings, attending church, drinking within a social group, and physical and sporting activities. The range of immigrants' participation in activities is presented in Table 3.

Theme 2: Contributing Factors to Participation

In the context of studying participation, all papers looked at what could contribute to this phenomenon in the context of immigration. There was a wide range of personal and social factors which were mentioned in the literature as contributing to immigrants' participation in health-related services or social occupations. Two sub-themes emerged from this theme related to the contributory factors that could potentially motivate participation.

Sub-theme 2a. Enabling, Facilitating, Encouraging, Supporting Factors

Some important factors in facilitating participation were the individuals' attitudes towards the services provided, such as a personal desire to exercise,[29] their beliefs about the health care services of the host country and concepts of agency in health-related activities such as health-related help seeking versus fatalism.[30-32] Family attitudes and support were also important.[33,34] For women in particular, their spouses' attitudes or permission were important factors, which may help or hinder participation.[35]

A stable life situation after immigration was an enabling factor for participating in more social occupations and health-related services,[34] as was having financial support or the time available.[35] Free access to services such as cancer screening,[32] and accessibility in terms of transport and language support services were all considered as enabling factors.[36] Understanding the language and having cultural familiarity were important in recognising opportunities for activity,[33,37] as were people's exposure to positive experiences suggested by others, particularly other immigrants.[29]

Sub-theme 2b. Blocking, Inhibiting, Demanding, Restricting Factors

Environmental factors such as complicated transport systems, travel distances to facilities, the climate and lack of supportive services were the restricting factors in relation to participation.[34,35,38] Lack of support from family was a common barrier, especially for women.[33,39] Personal factors such as a lack of confidence in the ability to use the language, or to understand the government or health system of the host country acted as inhibiting factors.[33,35,40] Perceived rejection and isolation by host communities was another obstacle to participation, in particular with regard to taking part in community activities. Immigrants' personal values and beliefs attributed to certain activities could be an inhibiting factor to their participation.[34,41]

Theme 3. Approaches to Study Immigrants' Participation

In the reviewed articles, researchers examined the participation of their sample in different ways. Health-related service participation was mostly identified by measuring the number of attendances in health-related services offered to the sample.[33,42] Other studies explored or measured participation via interview or questionnaire.[30-32,35,40,42,43] Other kinds of participation involved attendance at a social event, doing something with others or attending an activity that may include another person.[29,34,36,37,39,44]

Almost all the health-related service participation studies had considered participation through an objective method of attendance and dropouts. Other studies had applied

Table 3. Aspects of Participation/Non-participation in Each Study

No	Author and Year	Aspects of Participation	Modes to Identify Participation
1	Amankwah et al[30]	Cancer screening	Self-report: questionnaire
2	Devlin et al[38]	Physical activity	Self-report
3	Evenson et al[29]	Physical activity	Self-report: interview/questionnaire
4	Hansen et al[40]	Health beliefs	Self-report: interview
5	Hofstetter et al[44]	Church attendance	Telephone interview
6	Juarbe et al[37]	Physical activity	Self-report: questionnaire
7	Knipscheer et al[31]	Mental health-related help-seeking behaviour	Self-report
8	Kwok et al[32]	Cervical cancer screening	Self-report: interview
9	Lai et al[35]	Concept of health service barriers	Self-report: questionnaire
10	McMullin et al[42]	Health related (Pop smear)	Attendance
11	Kim et al[45]	Smoking group	Attendance
12	Suto[34]	Leisure activities	Self-report: interview
13	Terry et al[41]	Physical engagement	Self-report
14	Tirodkar et al[43]	Views on concepts of health and disease	Self-report: interview
15	Walseth[39]	Sport club (immigrant specific)	Attendance
16	Weltin et al[36]	Gardening	Observation, informal interview

different methods to identify participation. The most common technique was participants' self-reporting on their involvement or non-involvement in a life situation, which was identified by the researcher. For instance, they were asked to fill in a form to show how many times they had attended a religious activity during a certain period of time.[44] There were fewer studies to investigate the meaning of participation for participants and their subjective experience of attending a life situation. Table 4 demonstrates the distribution of research reports based on their approach to interpreting participation.

Theme 4: Outcomes of Participation

While 'contributors' were factors related to the initiation of participation, 'outcomes' were explained as the consequences of participating or not participating. The outcomes of participating were presented directly in some of the research. Examples of positive outcomes of participating in health care-related programmes were participants' attendance in services to receive health care, or demonstrate further help-seeking behaviours.[29,38,43] Through involvement with health care programmes, immigrants would receive more services and their health issues might be picked up earlier.

Most of the studies, however, had obtained their data about perceived outcomes from participants' stories and responses to interview questions. Some of positive outcomes which were identified as positive outcomes were: experiences of positive subjective wellbeing, feeling competent, being able to cope with the unfamiliar, valuing participation as to help for stress reduction, supporting formation of group identity and socialising as oppose to isolation that could be a risk factors to health and wellbeing. These studies also indicated that changes in attitude towards participating in particular activities that (1) were indicated to have positive effects on health and wellbeing, (2) raised awareness of the bio-psychosocial risk factors to health and illness, are contributing factors in participating in health-related services.[29,34,38] While participating in some activities were deemed to have a positive impact on health and wellbeing, such as physical activities,[38] participating in other activities were considered to have both negative and positive consequences. For example, drinking and smoking could be seen as negatively related to health but positively related to socialising and psychological wellbeing. Among a group of people from a similar immigrant background, participating in group-drinking activities might enhance a sense of security and belonging but could also lead to alcoholism or addiction.[45]

Discussion

Occupational science and occupational therapy scholars have expressed a need for the study of occupational participation with attention to context. However, in relation to exploring participation and associated factors related to health in the context of immigration, only one of the included articles was conducted by occupational therapists.[34]

The results of this review revealed 4 main themes. Theme one and three show that papers reported studies that had approached immigrants' participation in community and health services by studying their attendance at a variety of health service or community-related activities. The factors that contribute to immigrants' participation in activities were identified and measured in various ways. Some of the health-related services had used attendance as an identifying indication of participation.[33,42] Others had applied interviews or self-report questionnaires to study participants' knowledge, and attitude towards and participation in health care services.[30-32,35,37,40] Participation in community and social occupations was mostly identified through questionnaires or interviews, in either self-reported data or narratives that were later interpreted in these studies.[29,37,38,40,43] It seems there was no consensus in either the definition or the way the concept of participation was approached and measured within the context of immigration studies. The findings of this literature

Table 4. Contributing Factors to Participation/Non-participation in Various Studies

No.	Author and Year	Enabling, Facilitating, Encouraging, Supporting Factors	Blocking, Inhibiting, Demanding, Restricting Factors
1	Amankwah et al[30]	NA	Belief
2	Devlin et al[38]	Positive impact of group, observational learning, in improvement self-efficacy	Cultural, religious, available cultural environment, like only women, low self-efficacy, transportation, fatigue, weather or climate, gender and resource barrier
3	Evenson et al[29]	High self-efficacy, knowing or seeing people doing exercise, physical environment factors, availability of physical space	Low self- efficacy, low interest in physical activity less available sport places
4	Hansen et al[40]	There is no evidence	Linguistic barriers , less likely to report that their own effort is important in maintaining good health
5	Hofstetter et al[44]	NA	Religious belief was correlated to smoking
6	Juarbe et al[37]	NA	Cultural barriers, social and physiological factors
7	Knipscheer et al[31]	NA	Positive attitude towards western professional system
8	Kwok et al[32]	Doctor's recommendation, a female Chinese doctor performed the exam, receiving a reminder letter and the absence of cost for screening participation, free access to services facilitates cervical screening, previous experience with health care services, access to a regular physician, appropriate education, language preference	Cultural beliefs, promiscuity, fatalism, lack of knowledge, misconceptions, pap smear as a diagnostic test—role of signs and symptoms, low perceived personal risk of cancer, embarrassment during screening, sexual connotation of screening, physical pain of screening, doctor's insensitivity to women's needs for modesty, lack of child care, access to transportation
9	Lai et al[35]	The availability of the confidant e.g. providing transportation, information or interpretation, spousal support	Bad experience heard from others, professionals are too busy, not satisfied with the service, too long waiting list, inconvenient office hours, complicated service procedures, too expensive, language and cultural barriers, not trust to professionals, lack of transport, weather conditions/ cold, length of residency/short
10	McMullin et al[42]	NA	Limited knowledge about cervical cancer and Pop smear, believes (1. Caused by trauma, several sexual activity, poor hygiene) about cervical cancer, manifestation related to the severity of the problem
11	Kim et al[45]	Previous familiar activity, mean for cultural gathering, belief about boosting confidence, unfamiliar with new culture and activity, sticking to the known, repeating the familiar, experiencing competence with the familiar, wellbeing maintenance with success, being occupied with lower demand activity	Need for gaining new skills, engaging in new activities
12	Suto[34]	Ability to share with family, same language, reducing stress, helping with coping and anxiety and depression	Financial difficulties, lack of family support, perception of not being recognised by the new community, cultural barriers and accessibility, language appropriate in health services, mistrust
13	Terry et al[41]	Physical environment, relaxed lifestyle, less congested, no pollution	Recruiting male participants was challenging due to work commitments and language barriers unaware of what activities are available, where to go for physical engagement, participating in physical engagement alone, the cost of physical activity participation and the perceived dangers associated with some physical activities such as swimming at the beach, wood fire pollution
14	Tirodkar et al[43]	Psychosocial factors, i.e. positive attitude, lack of stress	Men tended to say either 'no' or 'maybe' more frequently than women, stress, depression/ negative thoughts, feelings of isolation/social isolation
15	Walseth[39]	Sharing environment with other immigrants, being identified as an immigrants team, similarities of being immigrants: norms, values	Out group antagonism and marginalisation of outsiders as barrier for newcomers
16	Weltin et al[36]	Specific, objective, external conditions that enable one to seek care, such as having health insurance. Garden, location/ accessibility, face-to-face meetings, easy travel distance, encouragement (diabetic nurse) educator, reasonable advice, social and cultural support	No health insurance, too expensive/ co-pays and sliding fees were costly, language barriers, forgetfulness or misunderstanding of the health care system, postal orders often failed to find the correct recipient, low income

review support Atkinson and colleagues'[3] point of view about lack of clarity in the definition of participation.

It appears that in most studies the act of doing something was taken as an indication of participation but this may not necessarily be the subjective experience of the participants. This clearly confirms Hemmingsson and Jonsson's[2] critique of the concept of participation being simplified to the involvement of people in life situations as defined by the ICF.[1] Their critical analysis of the ICF definition of participation identified major shortcomings regarding the subjective experience of meaning and autonomy. The importance of studying immigrants' lived experiences in their new context has also been emphasised in studies by others.[46,47] As the ICF is widely encouraged to be applied in health care settings, there seems a need for further exploration of the concept of participation within the ICF. In occupational therapy practice, understanding participation from clients' perspectives, what it means to them individually and collectively, is necessary to ensures client-centred practice[47] and this does not seem possible if only the ICF perspective of participation is considered.

Theme 2 indicates the significance of 2 main sets of factors contributing to participation. The first relates to immigrants' previous experience of living in their home country. The second relates to the current environment of

the country of immigration. This is similar to Pooremamali et al[18] who highlight the confusion experienced by young immigrants with mental health problems between the culture of family and health care professionals within the host country. Understanding the interaction between the person, occupation and environment is fundamental to understanding clients' occupational life. Environment, in particular, has a significant influence on enabling or disabling clients' occupational participation.[48]

Immigration makes a dramatic change in people's environment in most cases.[49] Understanding immigrant clients' interaction between their previous and current environment has a big impact on understanding participation in different areas of occupation, individually and socially. Sakellariou and Pollard[50] emphasise exploring occupation beyond the individual and the power imbedded within the family and public life of a person's occupational life. They argue that occupational therapy practice would benefit from further research in understanding the contributors of occupational participation beyond the individual level. In the context of immigration, the previous elements of a client's world need to be studied hand in hand with the current ones. Evidence supports that culturally adapted occupational therapy interventions have been successful in helping immigrant clients with mental health to managing their new situation.[18]

There has been great emphasis on cultural sensitivity[51] and culturally responsive care[52] during the past decades, but none of the studies seemed to have paid attention to the details of the quality of culturally adopted health care services. Several studies considered diversity in nationalities, ethnicity and religion, and culture in the sense of beliefs and life patterns, as obstacles to the provision of health services.[30,32,35,42,53] However, none has studied cultural differences as an empowering or enabling factor in the social and community participation of immigrants.[18,19,34,54] The concept of culture also appears to have been simplified. The depth of the concept of culture with "… shared experience and meaning, as well as process involved in creating, ascribing and maintaining meaning to objects and phenomena in the world."[55] does not seem to have been explored in the papers included in this review. From an occupational therapy perspective, culturally responsive care requires understanding clients, and their view and experiences of occupation.[55] In the context of immigration, this would also mean recognition of clients' resources, personally and collectively.

Theme 2 also shows contributing factors to participation and their interaction creates complex relations with elements from not only their past and present, but also the uncertainties of their future.[37,38] As an essential part of any occupational therapy plan, goal setting is related to a client's history, and current and future perspectives of themselves[56]; therefore, the fact that immigration contributes to uncertainty about the future could have a strong implication for occupational therapy intervention planning. Occupational therapists need to explore what the client's perspective of themselves as an occupational being is; what is meaningful to them as well as how they relate themselves to the past and new context, which capacities they have to meet the demands of their world and what they need to learn. Successful occupational therapy intervention for immigrant clients has proven to be where special attention to the clients' narratives has enabled them to find themselves within their past, present and future as an occupational being.[18]

There are studies that support that immigration could be turned into a positive experience for clients and be employed as an enabling factor, instilling hope for the future.[57,58] Conversely, viewing immigration as a negative characteristic of a client could create an obstacle in establishing trust and building a therapeutic relationship, which is one of the central aspects of occupational therapy intervention.[59]

Theme 2 also shows that in the review, studies mostly emphasised immigrants' perceptions or evaluations of the availability of the resources and facilities for participation. However, it was not clear whether immigrants were aware of the actual availability of services. It was also unclear if what the supporting services claimed to offer immigrants (e.g. interpreters or group facilitators) was recognised as supportive by the immigrants themselves. As in other studies,[5,6] this review identified issues around factors such as accessibility, language barriers and the complexity of systems. Similar to a report of other immigrant studies,[60] theme 2 demonstrates that immigrants often did not feel confident, secure and able to take the initiative in seeking information. The issue here is the level of initiation required for raising awareness about health and social care services. From an occupational therapy perspective, not only is the meaning of participation in occupation and perceived supportive factors necessary to motivate people for participation,[61,62] but also knowledge of the context in which any activity happens is essential.[63]

Theme 2 also indicates how most immigrants feel secure, supported and at ease within their own community groups. From the occupational therapy perspective, identifying communities where the client feels supported could be seen as an enabling factor for participation in a variety of occupations.[4] As Atkinson et al[3] argue, the definition of 'community' is unclear and therefore considering clients' perspectives of what community means to them is significant too.

Theme 2 also identifies many negative contributing factors originating from immigrants' personal, family and social backgrounds. Some immigrant communities regard particular activities as stigmatised. This can be a strong restricting factor for social and sometimes participation in health-related services. Personal and social beliefs about health and health behaviour are significant in encouraging or inhibiting participation. Therefore, it appears that no matter what the blocking, inhibiting or facilitating and encouraging factors are exactly, they play a strong role in enabling or empowering a person to react to them.

Theme 4 discusses the outcome of participation in health services and community and social groups. The findings indicate that outcomes that had been reported within these studies represent different aspects of health: physical health, and subjective and psychosocial health. Participation in all above areas were mostly associated with physical and

psychosocial health, or perceived as a positive outcome of participation from the immigrants' point of view. From the occupational therapy perspective, facilitating participation within the communities and groups familiar to immigrants would benefit both aspects of health. However, limiting immigrant participation to only familiar groups would deprive them from learning from and integration with the host community. For immigrants to feel at ease in another community there is perhaps a reciprocal need for each to learn about the other. Isolated activities should not jeopardise opportunities for a climate of cohesion for both immigrants and non-immigrants. Clients need to be encouraged and supported to join other social groups in order to experience a variety of occupational opportunities. Through this, clients are challenged to reflect on their ability to respond to different context.[64] This crucial idea of creating balance between participating in familiar and unfamiliar occupations had not received attention in the reviewed papers.

The principal investigator of this study, who is an immigrant herself, also had some anecdotal evidence that supports the findings of this study. For instance, the principal investigator used to receive several emails from immigrants from the Middle East who requested advice about their health problems. One repeated reason expressed in these contacts was, "They don't understand our culture!". This evidence was reported as part of the process of constant reflection and in discussion with the other author involved in analysis to monitor the impact of the researchers' experience in analysing the data.

Another point to consider is further studies have been published since the initial literature review was undertaken. As immigration is an ongoing area of interest and investigation within social and health-related disciplines, the transferability of these findings should take into consideration the date the data collection was completed (2015).

Limitations

The method applied for this study was a literature review in a systematic manner.[21] There were limitations in the search for sources of data and it only covered electronic databases and ones that were most directly related to the topic of investigation. The exclusion criteria limited the study to particular methodologies and therefore the findings of this study are limited to the included articles. Another limitation is the context of each study. The host countries in the included studies were varied in regards to their laws, social policies, culture and customs, and these may influence the immigrants' participation in the health services and social-related occupation. Therefore, this issue should be considered when interpreting the findings in this paper and planning for future studies. The 2 researchers who conducted the analysis were immigrants and reflective commentary and discussing the finding were used to enhance the trustworthiness of this study.[23]

Similar to most qualitative studies, the issue of transferability needs to be considered through specific attention to the contexts in which the findings of this literature review could apply.[65] This review included papers from a diverse group of immigrants and host countries (Table 2). While some of the findings could apply to most immigrants, regardless of this diversity, others should be interpreted and applied to other contexts carefully.

Several strategies for triangulation, data presentation, analysis method etc were applied to enhance the conformability. The research team were selected based on their expertise to enhance the dependability of the research.[23] However, the fact that interpretation of participation was the responsibility of the researchers added to the limitations of this study and weakened its duplicability.

Constant discussion, and triangulation were also helped to reflect on the potential impact of the experiences of the authors who themselves were immigrant on their data analysis. This appeared to help better understanding the mentioned points in the studies.

As a recommendation for future research, the main researchers of this paper have begun conducting a literature review of immigrants' participation in PAR to explore the diverse methods applied and their outcomes.

Conclusion

The findings of this literature review indicate that the concept of participation as a determinant of health needs further exploration. This concept, in the context of immigration in particular, proved to be complex and requiring more attention. In relation to immigrants' participation and the association with health and wellbeing, the studies identified several factors, which need to be taken into consideration in health and social-related policies, plans and strategies. There is a need to study immigration from the subjective perspectives of immigrants and service providers (occupational therapists in this context) who might/might not be immigrants themselves. To facilitate understanding of immigrants populations therefore, expanding the topics related to understanding 'others' and their occupational world into the occupational therapy seems to be necessary addiction to the occupational therapy curriculum.

Authors' Contributions

All authors significantly contributed towards this study.

Review Highlights

What Is Already Known?

WHO emphasizes the significance of 'participation' as an outcome of health intervention. Evidence shows the health problems of immigrants.

What This Study Adds?

The review creates evidence about challenges in participation in health services and community related activities in the context of immigration. The review highlights the barriers and facilitators to immigrants' participation in health services and community related activities.

Conflict of Interest Disclosures

The Authors declare that there is no conflict of interest.

Ethical Approval

Not applicable.

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