

***“This is what labels you”*: examining the structural context
of how limited English proficiency and experiences with
interpretation services interact to shape health and health
access for im/migrant women in Metro Vancouver, British
Columbia**

by

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Ethics Statement

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Abstract

Considerable research has documented negative health outcomes of ‘language barriers’ for im/migrants in destination countries. There is a crucial need for research underpinned by structural and intersectional frameworks that center im/migrant women’s lived experiences to inform interventions that move beyond the individual-level towards systemic, equity-oriented change.

This study analyzed qualitative data from focus groups (4, N=29) and individual interviews with im/migrant women (N=49) and providers (N=10) conducted from July 2018 – February 2020 in Metro Vancouver, British Columbia.

Moving beyond conceptualizations of language as a ‘barrier’, narratives revealed how unmet communication needs for im/migrant women operated as a form of systemic discrimination. Responsibility for communication often rested on im/migrant women, relegating them to a second tier of care. Best practices for interpretation included a holistic approach that went beyond availability of language-concordant options towards im/migrant-sensitive models that accommodate converging effects of language, im/migration status, systemic racism, and gender.

Keywords: language barrier; immigrant and refugee; sexual and reproductive health; social determinants of health; interpretation; migrant health; healthcare access

Dedication

This thesis is dedicated to all of the im/migrant women who participated in this project, and who shared their stories, experiences, and insights hoping to improve the health of their communities.

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This work was only possible due to the thoughtful collaboration of our community partners, including Watari, Sanctuary Health, MOSAIC, and Pacific Immigrant Resources Society (PIRS). In particular, I am grateful for the engagement and commitment of the members of these organizations to pursuing ethical and accountable research that seeks to resist structural harm.

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List of Acronyms

BC	British Columbia
CGSHE	Centre for Gender and Sexual Health Equity
HIV	Human Immunodeficiency Virus
IRIS	Evaluating <i>I</i> nequities in <i>R</i> efugee and <i>I</i> mmigrant Women’s Sexual Health Access project
PLS	Provincial Language Service
SRH	Sexual and Reproductive Health

Glossary

Im/migrant

We use the term ‘im/migrants’ to include the diversity of refugee, immigrant, and migrant women born in other countries who entered Canada, inclusive of long-term and recent arrivals, refugees, asylum seekers, economic, and undocumented im/migrants. (IOM, 2019)

Precarious Status

Precarious status in Canada includes “documented” but temporary workers, students, and refugee applicants, as well as unauthorized forms of status, such as visa and permit overstayers, failed refugee claimants and undocumented entrants. (Goldring et al, 2007)

Chapter 1.

Introduction

1.1. Rationale

Communication between patients and clinicians is the cornerstone of health care provision, and has impacts on both clinical outcomes and patient satisfaction.^{1,2} Multiple groups within the colonial borders of Canada experience challenges with communication in health care settings, including people with disabilities who require communication aids,³ First Nations, Métis, or Inuit people who speak their original languages,⁴ and immigrants and refugees who do not speak French or English - the official languages of Canada after colonization by French and English settlers.⁵ This thesis acknowledges the historical and ongoing colonial process occurring in Canada, one aspect of which was a deliberate strategy to eradicate First Nations, Métis, or Inuit languages and culture, as a genocidal tactic that was particularly employed through the residential school system,⁶ and which continues to impact the health of Indigenous people in Canada.⁷ In the process of colonization, European settlers created a border over existing Indigenous nations that continues to be used to regulate entry to and exit from what is now called Canada.^{8,9} Non-Indigenous people who cross this colonial border from another country and who reside in Canada are considered immigrants or migrants, and while they can and do benefit from settler-colonial structures in Canada, their movement is also linked to colonial processes globally,¹⁰ and they experience inequities in health, including health access in Canada, related to language and communication.

In the context of inexorably increasing global migration in the face of ongoing colonial practices, climate change, globalization, and political instability,¹¹ Canada remains an important destination for im/migrants. Over the past five years, the federal immigration targets have continued to grow, with Canada receiving 341,000 immigrants (via permanent residency) last year with planned increases in economic immigrants and refugees.¹² As migration patterns have shifted, so has the diversity of the population, with

60% of im/migrants speaking a non-official first language. In the 2016 Canadian Census, almost one-quarter (22.3%) of respondents reported speaking a language other than English or French (the official languages in Canada) at home.¹³ In the province of British Columbia (BC), one of the top three destinations for all im/migrants in Canada, 15.6% of respondents spoke a non-official language most often at home, rising to 25.4% in the Metro Vancouver Area, where English is the most widely spoken official language.¹⁴ Among im/migrants, language abilities are diverse, with specific groups such as refugees, recent immigrants and those with precarious status (e.g. refugee claimants, temporary foreign workers, undocumented) less likely to speak English than those arriving in the economic class.^{15,16}

In Canada, as elsewhere, im/migrants have both opportunities and distinct challenges, and many face marginalization as a result of structural forces such as poverty, immigration status, racism and xenophobia. When considered as a singular category, some studies of immigrants have described higher health status among immigrants at time of arrival in Canada, compared with people born in Canada (i.e., known as the '*Healthy Immigrant Effect*'), followed by a decline in health status over time after arrival.¹⁷ However, this relationship is not consistent across the heterogeneity of migration pathways, statuses, and health issues. Im/migrants are a highly diverse population, amongst whom health inequities are strongly shaped by social and structural determinants, whereby im/migrants who are racialized, more recent arrivals, and forced migrants (e.g., refugees) and those with precarious im/migration status experience magnified health inequities, and often severe barriers to health care.¹⁸⁻²¹

Importantly, women represent approximately half of the im/migrant population globally, and one in five women in Canada is an im/migrant, most of whom are of reproductive age (i.e., ages 15-49).^{11,22} Despite the potential for improved access to safety and economic opportunities upon arrival to Canada, increasing evidence suggests that im/migrant women in Canada may experience a number of important sexual and reproductive health (SRH) inequities, including inadequate prenatal care,²³ increased postpartum health concerns (particularly psychosocial),²⁴ increased odds of unintended pregnancy²⁵, and reduced cervical cancer screening.²⁶ There is a crucial need to better

understand the systemic and structural factors shaping im/migrant women’s health in Canada, particularly in the context of SRH care, to advance health equity and ensure that Canada’s purportedly ‘universal’ system is accessible and responsive to im/migrant women’s diverse needs and lived experiences.

Research has previously identified ‘language barriers’ as a key factor shaping im/migrant health inequities; the role of patient-provider language differences in influencing both access to care and health outcomes for im/migrants underscores the fundamental role of effective communication in health.^{2,5,27} Language can be understood as a necessary but not sole component, of communication. The formal “Communicator” competencies for physicians in the U.S. and Canada focus on a number of components (e.g., active listening, non-verbal communication) as essential to patient-clinician communication; yet, they do not mention what language the communication takes place in. Despite decades of data linking ‘language barriers’ to inequities in health and access to care, im/migrants continue to experience poor health outcomes related to lack of appropriate communication support, including increased clinical errors, increased hospital readmission, and reduced quality of care and patient satisfaction.²⁸⁻³⁰ Previous research has further demonstrated the cost-effectiveness of interpretation³¹ and the impact of diverse forms of interpretation (including ad hoc and professional) on quality of care.^{28,30} Providing appropriate interpretation or language-specific services is also essential for upholding informed consent within and beyond healthcare settings.³²

Addressing im/migrants’ language-related needs within healthcare is particularly salient in the context of SRH care,³³⁻³⁵ which requires nuanced, culturally tailored, confidential, and sensitive communication.³⁶ Where emerging research describes health inequities for im/migrant women complicated by structural determinants of health – including refugee status,³⁷⁻³⁹ precarious status,⁴⁰ racialization,¹⁹ and poverty⁴¹ – a fulsome description of how these interact to shape care is needed in the Canadian context. Further, marginalized im/migrant women have largely been excluded from health research,^{42,43} which may contribute to continuing inequities. Despite extensively documented negative health outcomes of ‘language barriers’, few systemic policies in Canada address this barrier, and in the face of this persistent discrepancy, existing

discourse⁴⁴ indicates a need to recognize speaking a non-official language as a broader structural determinant of im/migrant health.

1.2. Using structural determinants of health and intersectionality frameworks to consider the role of speaking a non-official language on health access and outcomes for im/migrant women

This thesis was informed by two primary conceptual approaches. First, Stonington et al., among others, have advanced the concept of *structural determinants of health* which provides a useful rubric for identifying and intervening in the systemic processes that ultimately shape the health of individual people.⁴⁴ This approach builds upon decades of work describing social determinants of health^{45,46} – i.e. how social circumstances such as poverty predict poor health outcomes – and argues that understanding how these circumstances are produced by social structures provides the basis for intervention at these root causes of health inequities.⁴⁷ This conceptualization of social structure accounts for the ways that social systems (e.g. economic policies, immigration system) interact with categories of oppression such as race, gender, class, and immigration status to determine social conditions and ultimately health access and outcomes.⁴⁸ As im/migrants in Canada may experience marginalization related to precarious status, limited English or French proficiency, racialization, and poverty, this framework allows for a deeper understanding of the contextual factors producing their inequitable health outcomes. Language is infrequently identified in scholarship on structural determinants of health, however Stonington, et al, include ‘language barriers’ as an example in their definition:

“By “social structure,” we mean durable patterned arrangements — from language barriers and social hierarchies to policies, economic systems, and other institutions (such as judicial systems, and educational systems) — that produce and maintain social inequalities and health disparities, often along the lines of social categories such as race, class, gender, and sexuality.

While their approach points to ‘language barriers’ as reproducing inequities, they do not go on to interrogate the inception of the barrier itself. Similarly, research on ‘language barriers’ in im/migrant health services research has identified the gap between policy

(e.g. hospital policy⁴⁹ or US federal law⁵⁰) and practice, where language barriers are persistently associated with poor health outcomes; and a recent scoping review on patient experience included discrimination and structural barriers that impacted the experience of patients with limited English proficiency.²⁹ Yet, to my knowledge, a structural analysis has seldom been applied to consider root causes, such as xenophobia and immigration policy, as they interact with language to produce the barrier.

In studies on immigrant or migrant health that have considered structural contexts, limited English proficiency is a consistent feature, but rarely the focus of the research. An ethnography with migrant farmworkers in the US considered the structural context of migrant health and called for researcher to “find ways to explore the implications of racism and anti-immigrant prejudices in the development and maintenance of health disparities.”⁵¹ Other work in the local context with im/migrant sex workers points to the language barrier’s intersection with criminalization and role in limiting support services, and calls for more complex structural analysis of im/migrant health inequities to support rights-based policy intervention.¹⁹ Building on that work, to inform interventions that meaningfully address the health needs of im/migrants speaking a non-official language in Canada, an understanding and consideration of the influences of structural determinants such as immigration policy, racism and xenophobia, gender inequities, and income inequality as they interact with language is warranted.

Meaningful implementation of the structural determinants of health framework, however, requires an understanding of how these interact to shape the particular circumstances of health care and health care access for im/migrant women. Crenshaw’s theory of *intersectionality* presents a useful lens for articulating the ways in which structural forces converge to shape situations where people sitting at intersecting axes of oppression (e.g., race and gender) experience qualitatively unique challenges. Crenshaw described the application of this approach using the example of Black women and women of color experiencing intimate-partner violence. They struggled with violence support services primarily organized by white feminists, and conversely the lack recognition of gendered violence in anti-racist movements – both of which failed to understand the unique set of challenges faced by Black women and women of color and thus excluded

them from appropriate intervention. She offered this framework as an analytical tool to guide responsive intervention design stating, “converging systems structure the experiences of battered women of color in ways that require intervention strategies to be responsive to these intersections.”

Though intersectionality remains under-utilized in immigrant health research, immigration experience has been considered as a dimension of intersectional analysis in some health research,⁵² including research employing an intersectional lens to move beyond simple cultural explanations for im/migrant health inequities towards articulating the role of converging structural determinants shaping im/migrant health outcomes.^{53,54} Although intersectionality has been employed to contextualize some health and social outcomes faced by im/migrant women, including gender-based violence⁵⁵ and settlement and integration experiences,⁵⁶ to my knowledge, intersectionality has not yet been applied to analysis of the impact of speaking a non-official language on health services delivery. Employing intersectionality in this analysis establishes a foundation for responsive intervention development that centers the context of impacted groups in the design, implementation, and delivery of health services to ameliorate health inequities.

These two frameworks provide a critical approach for investigating the role of speaking a non-official language and interpretation services in health care delivery for im/migrant women. Moving beyond more individualistic conceptualizations of ‘language barriers’, these frameworks can facilitate a nuanced understanding of how systemic refusal to meet communication needs for im/migrants in Canada may, in turn, reproduce or amplify health inequities experienced by im/migrants at converging axes of oppression, including gender, racialization, poverty, and precarious im/migration status. As such, they provide an ideal lens for generating a more nuanced and robust understanding of how speaking a non-official language and experiences with interpretation services contour health and health access for im/migrant women.

1.3. Research Objectives

These frameworks account for the fact that marginalized im/migrant women have largely been excluded from health research, despite serious health inequities, and in turn centers their experiences in the process of identifying appropriate interventions. Therefore, this thesis explicitly aims to mobilize community-based knowledge to address effects of converging axes of marginalization (e.g., gender, racialization, and structural determinants of health inequities (e.g. immigration status) that disproportionately impact im/migrants speaking a non-official language.

Employing a structural and intersectional lens, this thesis draws on im/migrant women's lived experiences and the perspectives of im/migrant-serving service providers, with the ultimate aim of informing multi-level interventions that are responsive to the communication and interpretation needs of im/migrant women. In doing so, this work explicitly seeks to advance interventions that move beyond the individual-level towards systemic, equity-oriented change. The specific objectives of this thesis were to:

- 1) Characterize the structural context of how speaking a non-official language operates to shape access to and experiences of sexual and reproductive health care amongst im/migrant women in BC; and,
- 2) Evaluate how communication and experiences with interpretation services interact with converging structural determinants (e.g., im/migration status, gender, racialization) to shape im/migrant women's health and health care in BC.

1.4. Research Methods

This study drew on qualitative data collected by the Evaluating *Inequities in Refugee and Immigrant Women's Sexual Health Access (IRIS)* project, a community-based mixed-methods project based in Metro Vancouver, BC, from July 2018 to February 2020. The study holds ethical approval through the Simon Fraser University (SFU) and Providence Health Care/University of British Columbia (UBC) harmonized ethics review boards. All procedures were conducted in accordance with ethical standards outlined in the Declaration of Helsinki.

1.4.1. Study Setting

Metro Vancouver is a top destination for im/migrants in BC.⁵⁷ Primary care in BC is principally provided in community-based fee-for-service offices and requires referral to specialist care. While a few health authority-funded im/migrant-specific clinics provide transitional primary care to limited numbers of marginalized im/migrants (primarily refugees), and there are some multi-lingual clinicians proficient in the languages of larger im/migrant groups, there remain important gaps in im/migrant-competent healthcare services in the province.⁵⁸⁻⁶⁰ Importantly, a pilot program providing phone interpretation (Provincial Language Service [PLS]) free of charge to all community-based family physicians in the province is ongoing, but uptake has remained generally low.⁶¹ Beyond primary care, PLS both in person and over the phone is available to clinicians who request it in most hospital and health authority settings, including public health, in BC.⁶²

1.4.2. Community Engagement

The IRIS project is underpinned by a deep commitment to meaningful community engagement with local community-based organizations providing direct services to marginalized im/migrant women. To ensure that the interpretation and findings resonate with the community and participants, and following ethical community-based approaches to research with im/migrants,^{43,63-65} we employ three overlapping, iterative feedback and engagement mechanisms: 1) ongoing discussions with community partners, 2) sharing findings directly with participants, and 3) purposive *member-checking interviews*⁶⁶ (N=15 to date). These mechanisms serve to validate and inform findings as they emerge, and to elicit suggestions for pragmatic, local intervention.

1.4.3. Data Collection

Phase 1: The IRIS project began with community consultations from July 2018 – October 2018 with im/migrant women and community-organizations (4 focus groups, N=29) to establish research priorities, deepen research partnerships, and guide development of the research process.

Phase 2: From December 2019 – February 2020, we conducted semi-structured, in-depth, individual interviews with im/migrant women (N=49) and service providers (N=10) across Metro Vancouver. Interviews with im/migrant women were conducted by multilingual, community-based staff with lived experience of migration, who were well-known and trusted in the community. These community-based research team members underwent training in qualitative interviewing, confidentiality, and data management protocols. The service provider interviews were conducted by me (in my role as a peer family physician providing care to im/migrant populations) as well as by other trained qualitative interviewers.

Eligible im/migrant women were self-identified women (cis and trans) of reproductive age (ages 15-49) who had recently migrated to Canada (approximately the last 5 years), and able to provide informed consent. *Eligible service providers* were health, education or community organization workers who worked directly with im/migrant women in Metro Vancouver.

Recruitment for interviews was supported through local connections and community partners, and aimed to *purposively sample*⁶⁷ a range of experiences (e.g., younger vs. older women, time in Canada, migration journeys). Sampling aimed to reach underrepresented perspectives, as well as groups served by our community partners, including im/migrant women with precarious status and resettled refugees. We took into account the composition of local refugee arrivals (e.g., Syria, Eritrea, Afghanistan, and Iran) and the Temporary Foreign Worker Program (e.g., Mexico, India, and Guatemala). Service providers were selected to cover a range of community and health service roles. Sampling proceeded iteratively, with subsequent sampling for interviews being informed by preliminary findings and data as they emerged.

Im/migrant women participants were invited to complete interviews or focus groups in their preferred language* (to date, this has included Spanish, English, Tigrinya,

*The only exception was the use of translators for initial focus groups including women from varied linguistic backgrounds and countries (i.e., reflecting the context of most federally funded settlement programs in BC, such as those supporting two of our community partners). For these, the translators were trusted staff of the organizations where the focus groups took place, and well known by the participants.

Dari, Farsi). They were given \$40 honoraria in recognition of their time, expertise, and travel, as well as supported with childcare as needed. Interviewers explained the purpose of the study, the voluntary and confidential nature of participation, its risks and benefits, and obtained written informed consent prior to participation. Interviews and focus groups were audio recorded with consent and lasted 60-90 minutes. The research team developed a detailed referral resource with community partners, which was used to respond to participants' needs as they arose during the research process. Interviews followed a detailed, semi-structured interview guide which was designed to elicit participants' perspectives regarding structural determinants of im/migrant women's SRH service needs; service provider interviews included similar domains in relation to their professional experiences working with im/migrant women. All participants who completed in-depth interviews completed a brief interviewer-administered socio-demographic questionnaire to contextualize the interview sample.

1.4.4. Data Analysis

Interviews were simultaneously transcribed and translated into English by multilingual transcriptionists. Transcripts were cleaned and accuracy checked by a separate community-based research team member. Analysis of focus group and interview transcripts occurred alongside data collection and employed a team-based approach, with academic and community-based research team members contributing to coding, analysis, and development of materials (plain language summaries and short videos) for member checking interviews and to elicit community feedback on preliminary findings.

Coding and analysis were managed in NVivo v.12 (QSR, AUS). The coding team drew on a structural determinants of health framework and used content analysis to generate the initial codebook, which was iteratively refined using a combination of inductive coding to group data and deductive coding based on the conceptual framework. The coding team met regularly to discuss definitions, the boundaries of the codes, and establish inter-coder reliability.

For this analysis, I conducted a refined coding and synthesis of the data to shed light on how unmet communication needs contour experiences of care for im/migrant

women. I extracted the data coded under *language issues*, removed all of the other coding, and inductively coded it again, drawing on the central codebook as relevant, but introducing new codes specific to communication experiences. Focused coding and synthesis in this stage drew on the critical approach within constructivist grounded theory^{68,69} where I continually moved between data and possible theoretical explanations while maintaining a critical stance considering power, historical context, and injustice. This process was deeply informed by the frameworks of intersectionality,⁷⁰ to recognize the operation of multiple axes of oppression, and structural determinants of health,⁴⁴ to link this context to health outcomes.

1.5. Structure of Thesis

This thesis contains five chapters: this introductory chapter (**Chapter 1**), an expanded review of the literature (**Chapter 2**), two empirical research manuscripts that address the research objectives (**Chapters 3, 4**), and a discussion chapter (**Chapter 5**).

The literature review chapter (**Chapter 2**) provides an expanded review of the peer-reviewed literature on language and im/migrant health, and the structural context of im/migrant health inequities that underpinned the rationale, methodology, and conclusions for the overall project.

Chapter 3 is prepared as a manuscript addressing Research Objective 1: To characterize the structural context of how speaking a non-official language operates to shape access to and experiences of sexual and reproductive health care amongst im/migrant women in BC. **Chapter 4** is a manuscript addressing Research Objective 2: To evaluate how communication and experiences with interpretation services interact with other converging structural determinants (e.g., im/migration status, gender, racialization) to shape im/migrant women's health and health care in BC. Both manuscripts use qualitative data from the IRIS project, as described in the methods in Chapter 1.

The thesis closes with a discussion chapter (**Chapter 5**) which synthesizes the results and offers recommendations for future research and intervention to address

systemic discrimination on the basis of language spoken for im/migrant women. This chapter also includes additional details on key strengths and limitations, including my reflexive observations on the research process, which should be taken into consideration in the interpretation of results and conclusions.

Chapter 2.

Literature Review

To set the context for this thesis, this literature review aims to: 1) describe the background of immigration and language diversity in Canada, and 2) examine interactions of language and health for im/migrants, particularly im/migrant women's sexual and reproductive health.

2.1. Immigration in Canada

Global migration is steadily increasing.¹¹ With forced migration at record levels,⁷¹ Canada's immigration targets continue to grow,⁷² evoking the crucial importance of ensuring that its health system is responsive and accessible to the needs of a diverse population. Following 'Operation Syrian Refugee' – a dramatic resettlement of 26,172 refugees from Syria over 4 months ending in February 2016⁷³ – the federal government has gradually increased its planned immigration targets for permanent residents in the economic, family and refugee classes.⁷² Canada received a record 341,000 immigrants in 2019, with planned increases for economic immigrants and refugees going forward.^{12,74} Within Canada, British Columbia remains in the top three destination provinces for im/migrants, receiving over 50,000 immigrants last year, the majority of whom settle in urban centres such as the Lower Mainland (e.g., Vancouver, Burnaby, Surrey).^{12,57,75}

Im/migrants in Canada are a highly diverse population, coming from over 70 countries in pathways including economic and family classes, refugees, refugee claimants, temporary foreign workers, and undocumented migrants. This thesis uses the umbrella term *im/migrant* to encompass the diversity of refugee, immigrant, and migrant people born in other countries who entered the colonial borders of Canada, inclusive of long-term and recent arrivals, refugees, asylum seekers, economic, and undocumented im/migrants.⁷⁶ Approximately half of this heterogenous group identify as women, and most identify as racialized minorities.^{22,42} Also within this population, certain groups, including refugees, refugee claimants and precarious im/migrants, experience

simultaneous marginalization related to poverty, racialization, and fear of immigration enforcement.^{15,16,21,77}

In Canada, those who immigrate under economic and family classes, as well as sponsored refugees landing as permanent residents, have ostensible access to most benefits and rights that Canadian citizens receive, including health care coverage.⁷⁸ Despite Canada's role as a purportedly 'universal' healthcare system, a significant population of im/migrants with *precarious status* (i.e., temporary workers, students, refugee applicants, those without status such as visa or permit overstayers, denied refugee claimants, and people whose entry into Canada is undocumented)⁷⁹ experience gaps in healthcare access, as well as other rights and opportunities. While over 70% of economic migrants come from just three countries (India, China, Philippines), countries of origin for refugees and refugee claimants vary widely, often related to geopolitical events (e.g. the Syrian war).⁸⁰ Over the past five years, the cumulative top three countries of origin for resettled refugees were Syria, Eritrea, and Democratic Republic of Congo.⁸¹ Temporary migrants also make up a substantial proportion of migrants in BC and other Canadian provinces. The stated purpose of the Temporary Foreign Worker Program is to allow employers to fill jobs that cannot otherwise be filled by a qualified Canadian; in BC, most of those jobs are in the agricultural sector, with the top 3 countries of citizenship for permit holders in 2019 being Mexico, India, and Guatemala.⁸²⁻⁸⁴

2.2. Language Diversity among Im/migrants in Canada

Given the context of migration to Canada, almost one-quarter (22.3%) of the respondents of the 2016 Canadian census reported speaking a non-official language at home.¹³ In the province of British Columbia, where English is the most widely spoken official language, 15.6% of the respondents reported speaking a non-official language most often at home, rising to 25.4% in the Metro Vancouver Area.¹⁴ Further, as migration patterns shift, the proportion of the im/migrant population speaking an im/migrant first language has dramatically increased. The 2016 Canadian Census found that over 70% of immigrants surveyed spoke a non-official first language ('mother tongue'), whereas a century ago, the reverse was true and "more than 70% of the foreign-born population

reported English or French as a mother tongue.”⁸⁵ Aligning with the demographic contexts of the various immigration pathways, over half of people reporting a non-official first language in Metro Vancouver spoke Chinese (Mandarin and/or Cantonese), Punjabi, or Tagalog; however, over 475,000 people (45%) spoke other non-official languages.¹⁴

Among im/migrants, official language abilities vary, where nearly half report speaking English or French at home.⁸⁵ This varies by migration duration, with data showing that those who arrived within the last 5 years are much less likely to speak an official language in Canada.⁸⁵ This also differs by immigration pathway, with evidence showing that refugees and those with precarious status are less likely to speak English than those arriving in the economic class.^{16,20} Complicating the context of speaking a non-official language in Canada, as elsewhere, marginalized im/migrants experience distinct challenges, including those related to income inequality, immigration status, racism and xenophobia.^{21,77,86} Refugees to Canada are not only less likely to speak an official language than economic immigrants,^{16,85} but are also disproportionately racialized relative to the Canadian-born population (78% of all refugees in Metro Vancouver and 93% of recent refugees are a ‘visible minority’), and low income (non-refugees make 174% more than recent refugees).¹⁶ Im/migrants with precarious status are similarly racialized and speak non-official languages, but are additionally excluded from social entitlements including health care and often report high levels of unmet health needs.^{18,79,87}

2.3. Structural context and health impacts of ‘language barriers’ for im/migrant women

For several decades, researchers and advocates have detailed the problems of ‘language barriers’ in health care, emphasizing the fundamental role of communication in health outcomes.^{2,5,27} This extensive body of work arises from attempts to understand and address persistent health inequities faced by im/migrants throughout the United States and Canada. Numerous population based studies in Canada have examined the ‘Healthy Immigrant Effect’, a phenomenon where immigrants appear on average to arrive with better health than the Canadian-born population (e.g. lower chronic disease, better

reported mental health, and better self-reported health) that then precipitously declines over the course of years spent in Canada to converge or even lower health status.¹⁷ In keeping with the diversity of immigration contexts, health status and outcomes are complicated by diverse – yet interconnected – factors including immigration pathway, socioeconomic status, racialization and experiences of discrimination. A deeper look at the ‘Healthy Immigrant Effect’ found that despite overall lower all-cause mortality, immigrants had higher cause-specific mortality for certain conditions (HIV, hepatitis, diabetes), while refugees experienced higher mortality rates among immigrants.⁸⁸ This may be related to the highly contested ‘medical inadmissibility’ requirements of the economic immigration programs where people can be excluded based on “excessive demand on health or social services.”^{89–91} Refugees are exempt from the medical inadmissibility criteria, and are additionally prioritized based on “vulnerability” (e.g., need for urgent protection, persecution on the basis of their sexual orientation or gender identity expression) which may underlie substantial health needs.^{92–94} Across pathways, racialization and discrimination produce rapid declines in health status for im/migrants,⁹⁵ further complicated by socioeconomic status – which is particularly challenging for precarious im/migrants who may be excluded from state-funded health and social services and vulnerable to labor exploitation.^{15,20}

Decades of data exist on the importance of language in shaping these inequitable health outcomes. The lack of appropriate communication support for im/migrants has been linked to increased clinical errors, longer hospital stays, increased risk of hospital readmission, and reduced quality of care and patient satisfaction.^{5,29,96–98} In contrast, studies investigating use of interpreter services have found that they improve communication and satisfaction, improve clinical care, and are relatively low cost.^{31,99,100} There are important differences between interpreters, where ad hoc interpretation is associated with increased errors of clinical consequence, and avoidance of sensitive issues (e.g., domestic violence, substance abuse, psychiatric illness, and sexually transmitted diseases), especially when children were the ad hoc interpreter.³⁰ This difference may also impact the quality of informed consent.³² In the U.S., failure to provide interpretation is considered discrimination under the Civil Rights Act, and required by federal services such as Medicaid,⁵⁰ but professional medical interpretation

is still not effectively and reliably provided across the health system.^{101,102} While it is clear from other settings that policy alone does not adequately address this disparity, the absence of federal or professional standards for use of medical interpretation in Canada represents a concerning policy gap warranting further attention.¹⁰³

The persistent failure to address the interpretation and communication needs of im/migrants in the context of healthcare delivery has specific implications for SRH care for im/migrant women in Canada. Previous inequitable health outcomes documented for this group include inadequate prenatal care,²³ increased postpartum health concerns (particularly psychosocial),²⁴ increased odds of unintended pregnancy²⁵, and reduced cervical cancer screening.²⁶ Research on im/migrant women's health has described 'language barriers' as a central determinant of access to and experience of healthcare, particularly in the context of sexual and reproductive health needs,³³⁻³⁵ which typically require nuanced, culturally tailored, and sensitive communication.³⁶ As among all im/migrants, health inequities for im/migrant women are further complicated by structural determinants of health such as refugee status,³⁷⁻³⁹ precarious status,⁴⁰ racialization,¹⁹ and poverty⁴¹ – all of which may be perpetuated by the systemic failure to accommodate their communication needs.

2.4. Taking responsibility for communication in health care to improve health intervention

Immigration has played, and continues to play, an integral role in the fabric of Canadian life, yet health inequities linked to unmet communication needs endure and are further contoured by structural determinants of health which deeply impact im/migrant women. It has been firmly established in physician competency frameworks in the U.S. and Canada that communication between patients and providers is the cornerstone of health care provision, and has impacts on both clinical outcomes and patient satisfaction.^{1,2} The "Communicator" role is one of seven core competencies within the CanMEDS framework for certifying physicians in Canada¹⁰⁴. The U.S. Accreditation Council for Graduate Medical Education (ACGME) has a similar core competency of "Interpersonal and Communication Skills", which informs all graduate and continuing

medical curricula.¹⁰⁵ For physicians in practice, improving communication is a risk management strategy advised by the Canadian Medical Protective Association (CMPA).^{106,107} While medical accreditation and medico-legal bodies have developed frameworks for assessing communication as a core competency for practicing physicians, with articulated standards for responsible and ethical communication, they surprisingly do not explicitly include patients speaking non-official languages. In this thesis, I consider language as a necessary but not sole component of communication. The formal “Communicator” competencies expand and define these other components (e.g., active listening, non-verbal communication) as essential to patient-clinician communication; yet, they do not mention what language the communication takes place in, presumably because they assume it to be in English or French.

Despite an extensive body of knowledge on im/migrant health inequities, the importance of clinician-patient language divergence, and interpretation provision, there remains a persistent lack of policy or systematic implementation of context-appropriate interpretation for people speaking non-official languages. To overcome this persistent gap and address inequities with implementation of meaningful communication in healthcare, this thesis seeks to inform a more nuanced and robust understanding of how the structural context of speaking a non-official language and using interpretation services shapes health care, including health access, for im/migrant women.

Chapter 3.

***“This is what labels you”*: Language as an intersectional determinant of experiences within and beyond the health system for im/migrant women in Vancouver, British Columbia**

3.1. Introduction

For several decades, researchers and advocates have detailed the problems of “language barriers” in health care, emphasizing the fundamental role of communication in health outcomes.^{2,5,27} Despite decades of data on the importance of clinician-patient language divergence to health outcomes, im/migrants[†] continue to experience poor health outcomes related to lack of appropriate communication support, including increased clinical errors, increased hospital readmission, and reduced quality of care and patient satisfaction.^{28–30}

Canada’s immigration targets have been steadily growing, with 341,000 immigrants arriving last year,^{12,74} of whom approximately half are identified as women, and most identify as racialized minorities.^{22,42} Almost one-quarter (22.3%) of the 2016 Canadian census respondents reported speaking a language other than French or English (the official languages of Canada) at home.¹³ In the province of British Columbia (BC), 15.6% reported speaking a non-official language most often at home, which increased to 25.4% in the Metro Vancouver Area. Despite the robust linguistic diversity of the population and popular portrayals of Canada’s health system as universal and inclusive, provision of formal language support through professional medical interpretation services for people speaking a non-official language is not routine practice, nor mandated by policy in Canada or BC.¹⁰³

[†] We use the term ‘im/migrants’ to include the diversity of refugee, immigrant, and migrant women born in other countries who entered Canada, inclusive of long-term and recent arrivals, refugees, asylum seekers, economic, and undocumented im/migrants. (IOM, 2019)

In Canada, as elsewhere, marginalized im/migrants experience distinct challenges, including those related to poverty, immigration status, racism and xenophobia.¹⁵ Im/migrants who are racialized, recent, refugee, and precarious thus experience additional barriers to care.¹⁸⁻²¹ Refugees to Canada are less likely to speak an official language than economic immigrants,^{16,85} are disproportionately racialized relative to the Canadian-born population (78% of all refugees in Metro Vancouver and 93% of recent refugees are a ‘visible minority’), and low income (non-refugee populations make 174% more than recent refugees).¹⁶ Im/migrants with precarious status[‡] are similarly racialized and speak non-official languages, but are additionally excluded from social entitlements, including health care, and often report high levels of unmet health needs.^{18,79,87}

An intersectional framework that accounts for the convergence of multiple axes of oppression – including gender, race, class, and immigration status – is necessary to understanding how language operates to influence im/migrant health.⁷⁰ If language is viewed solely as an individual-level “barrier,” proposed interventions may be too narrow or inappropriately place the locus of responsibility on im/migrant patients. While infrequently applied in im/migrant health services research, intersectionality has been employed to contextualize im/migrant women’s experiences of Gender Based Violence⁵⁵ or settlement and integration.⁵⁶ Some health researchers have mobilized this framework to move the field of im/migrant health research beyond simple cultural explanations to articulating the role of structural determinants in im/migrant health outcomes,^{53,54} but it has not been consistently applied to analysis of the impact of language spoken on im/migrant health services delivery.

In this context, one in five women in Canada are im/migrants,¹⁰⁸ and despite residing in a country with a publicly funded health care system where access barriers should be limited,¹⁰⁹ im/migrant women in Canada experience a range of negative health outcomes, including inadequate prenatal care,²³ increased postpartum health concerns (particularly psychosocial),²⁴ increased odds of unintended pregnancy²⁵, and reduced

[‡] Precarious status in Canada includes “documented” but temporary workers, students, and refugee applicants, as well as unauthorized forms of status, such as visa and permit overstayers, failed refugee claimants and undocumented entrants. (Goldring et al, 2007)

cervical cancer screening.²⁶ Among im/migrant women, disparities in contraceptive need, maternal morbidity, and health access are complicated by structural determinants of health such as refugee status,^{37–39} precarious status,⁴⁰ racialization,¹⁹ and poverty.⁴¹ Research on im/migrant women’s health has described ‘language barriers’ as a central determinant of access to and experience of healthcare, particularly in the context of sexual and reproductive health (SRH) needs,^{33–36} which typically require nuanced, culturally tailored, and sensitive communication.³⁶ Meaningful provision of sexual and reproductive health (SRH) care – including via pregnancy, abortion, family planning, and cervical cancer screening services – requires clear communication and timely interaction with the health care system.

Despite decades of work describing negative health outcomes for im/migrants due to ‘language barriers’, those barriers persist, with particular impact on im/migrant women. Within this important body of work, few studies have considered the structural context and nuances of how speaking a non-official language operates to shape healthcare experiences of im/migrant populations, especially from an intersectional lens and centering the experiences of those most affected. In BC, the most widely spoken official language is English.¹⁴ In order to identify more effective opportunities for intervention, we conducted a community-based qualitative study with marginalized im/migrant women to characterize the structural context of how limited English proficiency operates to shape access to and experiences of sexual and reproductive health care amongst im/migrant women in BC.

3.2. Methods

This study drew on qualitative data collected by the Evaluating *Inequities in Refugee and Immigrant Women’s Sexual Health Access* (IRIS) project, a community-based mixed-methods project based in Metro Vancouver, BC, from July 2018 to February 2020. The study holds ethical approval through the Simon Fraser University (SFU) and Providence Health Care/University of British Columbia (UBC) harmonized ethics review boards. All procedures were conducted in accordance with ethical standards outlined in the Declaration of Helsinki.

3.2.1. Study Setting

Vancouver, British Columbia is the third largest city in Canada, and its Metropolitan area (including Surrey, Burnaby, Richmond) is a top destination for im/migrants.¹¹⁰ The two largest immigrant groups are economic immigrants from India and China; however, im/migrants in BC are highly diverse, and the province remains a key destination for refugee claimants, resettled refugees. BC also employs about a quarter of all Temporary Foreign Workers in Canada.^{81,111}

Primary care in BC is principally provided in community-based fee-for-service offices, following the gatekeeper model, where specialized services are accessed through a referral from a primary care clinician.¹¹² Im/migrants in BC face barriers to accessing both primary care and specialist services due to communication challenges and physician payment models.^{59,60} The regional health authority with the largest im/migrant population funds three im/migrant-specific clinics that provide transitional primary care to a limited number of marginalized im/migrants (primarily refugees), and a few other im/migrant focused fee-for-service clinics operate around the Lower Mainland of Vancouver.⁵⁸ There are some multi-lingual clinicians proficient in languages of larger im/migrant groups (e.g., Punjabi and Chinese),¹¹³ but there is no systematic approach towards managing communication with patient-provider languages are not concordant.

A pilot program of providing phone interpretation (Provincial Language Service [PLS]) free of charge to community-based family physicians in one region of BC found that uptake was low; however those who used the service found it feasible, acceptable, and improved communication especially for visits on sensitive issues.⁶¹ From that pilot, PLS was extended across the province to community-based family physicians, yet uptake remains low outside of heavy usage at a few particular clinics (*personal communication*). Beyond primary care, PLS both in person and over the phone is available to clinicians who request it in most hospital and health authority settings, including public health, in BC.⁶²

3.2.2. Data Collection

We began with community engagement with local community-based organizations providing direct services to structurally marginalized im/migrant women (Watari, Pacific Immigrant Resources Society, MOSAIC). We held community consultations from July 2018 – October 2018 with im/migrant women and service providers (4 focus groups, N=29) to establish research priorities and guide development of the research process. The focus groups took place in trusted community organization spaces, where the focus groups with service providers included staff with lived migration experience who spoke English as an additional language; and, the focus groups with im/migrant women participants took place in Spanish, Tigrinya, and Dari with interpretation from staff known to the participants. Next, we began hiring and training women with lived experience of migration as research staff, including as multilingual qualitative interviewers. The multilingual, multicultural (“community-based”) research team members underwent training in qualitative interviewing, confidentiality, and data management protocols. From December 2019 – February 2020, this team conducted semi-structured, in-depth, individual interviews with im/migrant women (N=49) and service providers (N=10) across Metro Vancouver.

Recruitment strategy for im/migrant women focused on respectfully engaging perspectives underrepresented in the literature and those experiencing added structural marginalization, including people with precarious status (refugee claimants, undocumented, and temporary foreign workers) and resettled refugees. Study outreach was shaped by the communities served by our partners, as well as the population background of resettled refugees arriving over the past 5 years (e.g., Syria, Eritrea, Democratic Republic of Congo, Iraq, Afghanistan).⁸¹ Though federal statistics do not report granular provincial-level breakdowns, most French-speaking im/migrants (i.e., Democratic Republic of Congo) land in the francophone province of Quebec,⁸⁵ and local agencies include Iran as a top country of origin for resettled refugees in BC.¹¹⁴ Within the Temporary Foreign Worker Program, the top 3 countries of citizenship for permit holders in 2019 were Mexico, India, and Guatemala.⁸²⁻⁸⁴ Recognizing the considerable focus occurring after the federal resettlement of >25,000 Syrian refugees in 2015-2016,^{73,115} we

turned to local community partners and community connections working with precarious migrants (e.g. Spanish-speaking from Latin America) and with other groups of refugees (e.g. from Eritrea speaking Tigrinya, Afghanistan speaking Dari, and Iran speaking Farsi). Recruitment proceeded through community partners, community connections, and study posters that aimed to represent a range of experiences (e.g., younger vs. older women, time in Canada, migration journeys) within a *purposively selected*⁶⁷ sample. Service providers were selected to cover a range of immigration and health service roles, including community-based healthcare providers experienced in working with im/migrants, and community outreach workers, and teachers. Sampling proceeded iteratively, with subsequent sampling for interviews being informed by preliminary findings and data as they emerged.

Eligible im/migrant women were self-identified women (cis and trans) of reproductive age (ages 15-49) who had recently migrated to Canada (approximately the last 5 years), and able to provide informed consent. Our recruitment criteria explicitly excluded questions about immigration status, so that potential participants did not have to disclose their immigration status as a condition of participation in this study. However, our approach of collaborating closely with grassroots direct-service organizations serving this population resulted in a high representation of im/migrants with precarious status, refugees, and/or racialized participants. Similarly, language spoken was not an eligibility criterion, but was shaped by the recruitment strategy and the languages represented by the community-based research team members and recruitment materials (study flyers, community presentation) in Spanish, Farsi, Dari, Tigrinya, and English. *Eligible service providers* were health or community organization staff who worked directly with im/migrant women in Metro Vancouver.

Im/migrant women participants were invited to focus groups by trusted community organization staff or offered interviews by trained interviewers with lived migration experience in their preferred language (Spanish, English, Tigrinya, Dari, Farsi). They were given \$40 honoraria in recognition of their time, expertise, and travel, as well as supported with childcare as needed. Interviewers explained the purpose of the study, the voluntary and confidential nature of participation, its risks and benefits, and obtained

written informed consent prior to participation. Interviews and focus groups were conducted in the participant's preferred language, or with a translator familiar to the participants, audio recorded with consent, and lasted 60-90 minutes. Translators were only used in the focus groups and participants knew them as trusted staff of the organizations where the focus groups took place. The research team developed an active referral resource vetted by community partners to respond to participants' health and social needs as they arose during interviews. The research team also conducted the service providers interviews, along with the first author in her role as a family physician providing care to im/migrant populations.

Interviews followed a semi-structured interview guide eliciting participants' perspectives regarding im/migrant women's SRH service needs; experiences with health and social services in Canada, including barriers and facilitators faced across the arrival and settlement process and for different types of care; im/migration background; structural determinants of im/migrant women's' health care access and experiences, and recommendations for improving access to health services for im/migrant women. Service provider interviews included the above domains in relation to their professional experiences working with im/migrant women. All participants who completed in-depth interviews completed a brief interviewer-administered socio-demographic questionnaire to contextualize the interview sample (e.g., ethnicity, time spent in Canada, comfort speaking English).

3.2.3. Data Analysis

Multilingual transcriptionists simultaneously transcribed interviews verbatim and translated them into English. Transcripts were then de-identified and accuracy checked by a separate community-based research team member. All participants were assigned unique codes upon recruitment and all personal identifiers removed during transcription and cleaning. Analysis of focus group and interview transcripts occurred alongside data collection and employed a team-based approach with academic and community-based research team members contributing to coding, analysis, and development of materials (plain language summaries and short videos) for member checking interviews and to

elicit community feedback on preliminary findings. While undertaking the interpretation of the results, the members of the coding team reflected on their positions as researchers and members of im/migrant communities, as well as the complexity of working with translated text.

Coding and analysis were managed in NVivo v.12 (QSR, AUS). Drawing on intersectional and structural determinants of health frameworks, the coding team used content analysis to generate an initial set of codes and describe key themes based on participants reflections and experiences (e.g. language barriers, health care experiences). The codebook was developed and iteratively refined using a combination of inductive coding to group data and deductive coding using themes that arose out of the initial IRIS consultations (e.g., migration timing, discrimination) and conceptual frameworks (e.g., policies and enforcement, im/migration status, gendered power dynamics). The coding team met regularly to discuss definitions, the boundaries of the codes, and establish inter-coder reliability. As data collection proceeded alongside analysis, the coding team followed a structured, collaborative process with detailed notes on meetings, discussions and coding approaches to allow for rich discussion of alternative explanations for findings, examination of negative or contrary findings, and both addition of new codes and refined definition of existing codes. In this phase of analysis, participant experiences involving language or communication concerns were coded under '*language issues*' using the definition: "Barriers and facilitators related to communication in daily life and in accessing health, social and settlement services (e.g., language barriers with health care professionals, experiences with interpreters/translation services, access to English schools, level of English)."

In the next stage of analysis, I conducted more refined inductive coding and synthesis of data on 'language issues' to shed light on how communication with limited English proficiency shapes access to and experiences of SRH care in BC. First, I extracted all of the data coded under *Language Issues* and removed all of the other coding to review the grouped data and inductively coded it again, drawing on the central codebook as relevant (e.g. discrimination, provider competencies), but introducing new codes specific to communication experiences (e.g., interpreter/interpretation

characteristics, barrier/facilitators to English classes). Next, I grouped the codes under related themes (Interpretation Nuances, Learning English). Focused coding and synthesis in this stage drew on the critical approach within constructivist grounded theory^{68,69} where I continually moved between data and possible theoretical explanations while maintaining a critical stance considering power, historical context, and injustice. This process was informed by the frameworks of intersectionality,⁷⁰ and structural determinants of health,⁴⁴. In practice, intersectionality was applied to recognize situations where the operation of multiple axes of oppression (e.g. gendered health needs and xenophobic discrimination) created qualitatively unique challenges for participants as they moved through health and social interactions. Applying the structural determinants of health framework alongside this context allowed for exploration of the relationship of income inequality, immigration policy and resulting immigration status, and health system organization to specific health outcomes for im/migrant women.

3.2.4. Member-checking process

To ensure that the interpretation and findings resonated with the community and participants, and following ethical community-based approaches to research with im/migrants,^{43,63–65} we undertook three overlapping feedback and engagement mechanisms: 1) ongoing discussions with community partners, 2) sharing findings directly with participants, and 3) purposive member-checking interviews.⁶⁶ As preliminary findings emerged, we shared them with partner organizations and elicited their feedback. The research team also developed a process to produce accessible, short videos that reviewed high-level findings in plain language with graphics aiming to visually represent the community and research process.

For the first wave of preliminary findings (including some from this analysis), we reviewed the video with community partners, then translated them with text and voice-over in the languages of the participants. Starting in small batches, community-based interviewers then began progressively sending the private video link to all participants who had consented to follow up. The video invites participants to text, email or call to share feedback on the findings or the video, and then offers any of those interested the

opportunity to do a follow up ‘member-checking’ interview. Additionally, the community-based interview team purposively invited follow up interviews from participants whose perspectives might expand the analysis either through a unique viewpoint, unexpected experience with migration or SRH care, or might be experiencing a change in im/migration status or health status (i.e. before and after a pregnancy). These mechanisms served to validate and inform findings as they emerged, and to elicit suggestions for pragmatic, local intervention.

3.3. Results

3.3.1. Socio-demographic characteristics

This sample was composed of 49 im/migrant women and 10 service providers. The mean age of im/migrant women participants was 30.6 years (range 18-41) and a mean time in Canada of 2.8 years (range 0.25 – 12) [Table 1]. A majority of the im/migrant participants (73%) spoke Spanish as a primary language. Similarly, most of the participants identified as Latina (65%), with 8% identifying as Afrolatina or Negra. The service providers interviewed spanned a diversity of professions including clinicians (nurses and nurse practitioners) with experience working in im/migrant-specific settings that provided interpretation and community organization staff.

3.3.2. Thematic results

Im/migrant women and service providers all discussed the wide-reaching impact of limited English proficiency on access to and experiences of health care. Inability to communicate in English operated as a pervasive form of systemic discrimination in women’s lives, posing structural challenges at every turn as they tried to meet basic needs and navigate healthcare and social systems (e.g., education, employment, immigration) in Canada. These challenges due to language shaped decision making about when and how to seek care, often resulting in deferred, delayed, or compromised care, particularly for sexual and reproductive health needs. The pervasive refusal to accommodate interpretation needs within the Canadian health system placed a distinct burden on

im/migrant women and their families, ultimately limiting access to health care and social support.

3.3.3. Ripple effects of limited English proficiency across health system interactions

Impacts on care-seeking

Communicating with limited English proficiency had a widespread influence that prevented or delayed participants from accessing the health care system, resulting in unmet health needs and negative health outcomes including omitted Pap tests or delayed emergency visits (Table 3.2). Inability to communicate sometimes meant that they deferred or avoided seeking care altogether, and at other times, missed or delayed bloodwork, imaging or specialist care ordered by clinicians (Table 3.2). One woman speaking Spanish explained: *There are many things that we can't say, that we can't ask, and we don't go because we don't speak the language.*

This struggle to communicate had particular relevance for SRH needs, including pregnancy, family planning, and cervical cancer screening. For some, the communication struggle occupied so much thought and energy that SRH concerns fell to the wayside. Others discussed the stigma accompanying sexual health discussions, and how the anticipated difficulty of these conversations without the capacity for meaningful communication meant they were avoided, despite the participants' wishes to attend to their SRH needs (Table 3.2).

Communication struggle within clinical care

Within clinical encounters, participant experiences varied according to whether and how clinicians accommodated communication needs. In the absence of interpretation support, the struggle to communicate often meant only simple issues were addressed (Table 3.2) or clinician's guidance was incomprehensible, even for simple issues like a child's cold. Where participants found clinics or clinicians who used interpreters or were at least willing to slow down to communicate, language concerns were somewhat mitigated. Having a language concordant health care provider was described as "lucky"

and in some cases, could be empowering. For one Spanish-speaking woman who had struggled with finding pregnancy care while uninsured and fearful, having a language concordant clinician who understood intersections of immigration status and health was:

“Fundamental. That was fundamental that she spoke my language and knew everything, and her confidentiality. She was on my side, she was completely on my side, and she was willing to help me with or without insurance.”

When professional interpretation was available, the mode of interpretation (e.g., phone, in person) interacted with the cultural context like the dialect of the interpreter or coming from the same small ethnocultural community to influence how effectively participants felt they could communicate their health needs (Table 3.2). They frequently ended up using ad hoc interpreters (e.g. spouses, children, friends, bystander) for visits, sometimes because health providers required this as a precondition for visits (Table 3.2). This meant complex negotiations with family or friends, and providers raised concerns about confidentiality, accuracy of communication, and informed consent, especially in the context of SRH needs.

Ripple effects across health system interactions

Beyond individual clinical encounters, having limited English proficiency presented a pervasive challenge at every point of interaction with the health care system. Rather than a static “barrier”, im/migrant women’s lived experiences articulated the multiple ways the inability to communicate in English contoured interactions and produced linked challenges at every juncture – encompassing appointment booking, transportation, registration, clinical interactions, laboratory and imaging visits, and follow-up with healthcare providers, especially provision of test results by phone (Table 3.2). One Spanish-speaking woman summed up this recursive quandary: *“they told me about a clinic, but I have to call, and I can’t do that because I don’t speak English.”*

These linked challenges were especially evident with pregnant women, for whom adhering to standard antenatal care recommendations including frequent prenatal visits, blood tests, and imaging was particularly difficult as a result of limited English proficiency (Table 3.2). Care providers also perceived the complexity of system

navigation for women struggling to communicate in English. Experienced im/migrant health clinicians articulated the persistent challenges they faced in trying to support navigation in the health system outside of their care. For example, they expressed serious concerns about harmful outcomes resulting from referrals to specialists or community supports where interpretation was unavailable, and often spent considerable extra time in negotiation with other services (e.g., emergency room) to encourage use of available translation services. One nurse practitioner described a situation where a person with a miscarriage was sent to the emergency room and called back to the clinic desperately seeking help to understand what was going to happen to her:

“As a provider – knowing that you tell people to go to [emergency room] when this is going on, but then to know that they are not going to get the care that they deserve, or that should be standard of practice – it is really hard to then continue to feel confident to continue to tell them to go to [emergency room] if you are bleeding this much.”

3.3.4. Intersectoral and intersectional effects of language on other health determinants

Interpersonal communication is a fundamental necessity, and participants described how challenges with communication in English extended beyond the health sector to interactions with other services and systems such as immigration, employment, food security, and education.

Access to social protections

The omnipresent struggle with limited English proficiency made meeting basic daily needs precarious because entry into the systems addressing them often require forms or appointments, all in English. For example, a participant described being turned away from the food bank because she could not complete the entry form in English, and was left searching for someone who could accompany her to clear this administrative bar in order to meet her essential human need. With food security arising at the intersections of poverty and im/migration precarity, the refusal of an organization – whose main purpose is to address food security – to address her communication needs ultimately worsened her food insecurity (Table 3.3).

For participants with secure immigration status in Canada, accessing already-limited government services for new im/migrants was often challenging as this required knowledge of available programs, and usually a detailed application, both of which were often delayed or missed altogether because participants were unable to advocate for themselves in English. Without someone with language skills to support them through this navigation, they were excluded from social entitlements, further entrenching their poverty and daily stresses (Table 3.3).

Similarly, many described how the expectation of medical offices that patients secure their own interpretation often meant asking a spouse or friend to leave work, thus losing a day's wages which they could ill afford, and reinforcing the financial precarity arising from their struggle to find well-paid work as marginalized im/migrants. Employment was fraught with complications due to language ranging from being unable to work with previous skills to not being able to find any job at all, as this woman speaking Farsi explained:

“For example, I prepared my resume one or two months ago despite it wasn't done right and I learned about it later. I was walking in [local mall], I held it in my hands, I was thinking: “god, where to go, how should I start?” It was really hard for me. What should I say? Do you need a worker? How to say “a worker” in English? [laughter]. It was really hard for me... Finding a job and making a resume... none worked in the end.”

Psychosocial and economic stress

Im/migrant women nearly universally described the devastating psychosocial burden of struggling to communicate within a system that did not provide adequate interpretation across a range of essential services and supports. For participants already stressed by the demands of taking care of their own and their family's basic needs, living in a new place and navigating new systems, communication burdens magnified stress related to day-to-day activities (e.g., taking transit) as well as interactions with healthcare and other support services (e.g., applying for disability benefits). On top of the added stress of constantly struggling to communicate, misunderstandings often occurred, sowing confusion and fear (Table 3.3). One Spanish-speaking woman struggling with poverty due to her precarious immigration status described her harrowing experience of

being in the hospital with a significant pregnancy complication. She understood that she might have to abandon necessary care due to her inability to pay, despite residing in a country that prides itself on health access regardless of ability to pay:

“On the second day, a finance person came from the hospital and, well in that moment, I did not understand. [...] imagine it, my belly, full of cables, and syringes. This woman comes in with an attitude that was...with little tact in that moment, and the little that I understood, because the conversation was in English, was that she wanted to know how we were going to pay.”

Difficult interactions in English with government bureaucracies, in particular, the immigration system, were amplified by their relationship to personal safety and security. For example, one participant speaking Spanish worried about whether their English proficiency would determine their chances of staying in Canada:

“We didn’t know much about [becoming a] refugee, we only wanted to leave [the home country] because of the threats that we were experiencing. Once we arrived here, we talked to lawyers. We don’t speak English, neither my husband nor I. The lawyers told us that we needed a person who would sponsor us, a sponsor who would want to sponsor us with the level that we have right now, without English. [...] But in general, the sponsors need a level of English that we don’t have, and we didn’t know anyone who could sponsor us or even just my husband.”

Racism, xenophobia, and precarious status

The linked struggles of communicating with limited English proficiency – connecting experiences of healthcare, school, employment, and even public transit – converged with instances of overt xenophobia and discrimination to intensify harm. Within routine interactions, such as the receptionist at a clinic or riding the bus (Table 3.3), xenophobic experiences that targeted people speaking other languages continually reinforced a message that they were unwanted in Canada or undeserving of the usual standard of care. Participants worried that their limited English would draw unwanted attention, identifying them as newcomers or not-belonging in Canada (Table 3.3); this was further exacerbated by additional fear that speaking certain languages, such as Spanish, might signal undocumented status:

The fear is there from when you lose your status. And the fact that you are unable to speak English is very limiting. Why? Because you need to be able to communicate through an interpreter and you draw more attention. And it's like if you go to a health centre and they say "Why don't you speak English? Why are you in this country if you don't speak English? Why are you here?" And the reality is that yes, going there, I perceived that they would not open their doors and I felt a lot of fear. It was practically that, that by asking for medical attention it was a button to be sent home instead of to receive medical attention. (Woman speaking Spanish)

3.3.5. Creating Agency: learning English and finding community

Learning English and gendered impacts

Participants urgently wanted to learn English as a way to reduce these harms and ease the immense stress of navigating these communication struggles. They saw the process of learning English and taking English classes as extremely valuable and inextricable from their access to health care and social participation (Table 3.4). Although participants desired to learn English – as in other aspects of their lives in Canada – there were barriers to enrolling in classes, such as long waiting lists for publicly available classes or fees for private classes. Gendered barriers, such as lack of childcare and classroom restrictions prohibiting infants or breastfeeding (Table 3.4), further delayed access to the gateway of English proficiency for im/migrant women, in turn impacting other important life chances:

"... because my son is very young, I can not go to the LINC [Language Instruction for Newcomers to Canada] program due to day care. [...] I am waiting for LINC, that is why I haven't applied for citizenship yet. [...] If Allah is willing, when my son grows, I have to go to LINC and do the entry exam, to get my English Level maybe four, maybe I pass, but I have to attend the class for six months. After taking my English level, I will apply for citizenship." (Woman speaking Dari)

Finding Community

In the context of constrained access to broader social supports, accessible English classes became more than a place to learn a language and grew into a site of health and other critical information exchange. Some agencies offered specific low barrier programs for im/migrant women, regardless of immigration status, that allowed children and had

flexible drop-in policies. Others brought in health curricula, so participants learned about health promotion, family planning, and public health while learning English. Informally, participants used this opportunity to meet other parents learning English, and traded information on where to find supportive clinicians or community organizations, and which clinics were lower barrier or were safe to access without fear of status-checking. While the burden of struggling with communication in English in order to access health care and social supports took a toll on the participants, they resisted with strength and agency both personally and within their networks to find opportunities of mutual support (Table 3.4).

3.4. Discussion

There are pervasive and intertwining interactions between communicating with limited English proficiency in British Columbia and structural contexts that influence every interaction and point of entry into health care, with particular impact on sexual and reproductive health care for im/migrant women. These findings move beyond health research that has traditionally framed language as an individual-level “barrier” within clinical care, by demonstrating how language intersects with other axes of oppression – including racism, immigration status, poverty – to shape interactions and access to healthcare and social supports for im/migrant women. The systemic refusal to accommodate communication needs for people speaking languages other than English amplifies these intersections for im/migrant women, with serious health implications. Contextualizing these findings with a structural and intersectional lens reveals the ‘language barrier’ as a form of xenophobic discrimination that routinely neglects im/migrants communication needs and consigns people with limited English proficiency to a second tier of health care within an aspiring universal system.

These findings expand and contextualize existing work that identifies the role ‘language barriers’ play in inaccessible or compromised care for im/migrants.^{28–30,116} They describe how the pervasive refusal to accommodate communication needs constrained participants’ abilities to access basic services such as health, education, employment, and immigration. These patterns of neglect were not siloed but rather

interacted and were mutually reinforcing, ultimately creating a pervasive struggle that entangled participants at every turn as they tried to meet essential needs for themselves and their families. The tremendous burden of this pervasive discrimination fed into an urgent desire to learn English and shaped the role of English classes into a lifeline, as well as a site of other knowledge exchange and agency to counter the persistent difficulty accessing other social supports. Ultimately, these narratives reflect that what has for decades been framed as a ‘language barrier’ may be more accurately understood as a form of systemic discrimination.

Despite being a publicly funded system, in which most of the population is presumed to have access to health care, no legislation or formal policy exists in Canada to require language interpretation (other than sign language) in health care settings.^{103,117} In contrast, interpretation needs are more recognized and addressed by other nations, including the U.S., which protects interpretation needs under the U.S. Civil Rights Act and via federal mandates requiring provision of interpretation by healthcare providers receiving federal funding (e.g. Medicaid)⁵⁰, though this is not enacted system-wide due to the patchwork nature of the U.S. health system.^{49,118}

Whereas literature from Canada and other similar destination settings describes communication with limited English proficiency as a barrier to healthcare access, few studies have identified language as a broader, intersectional determinant of health or within a larger context of discrimination.²⁹ Yet, these findings show that im/migrants trying to use the system “get the message” that they are considered less deserving, and the persistent failure of the health care system to attend to communication needs underscores this interpretation. This study joins an extensive body of literature in Canada that describes persistent health inequities related to unmet interpretation needs.^{28,35,96,97,119} Relegation to this second tier of health care characterized by inadequate communication is further enforced by multiple axes of structural marginalization (e.g., precarious status, racialization, poverty) as well as the sensitivity of sexual and reproductive health. Further, this discrimination is not limited to health care, but is woven into the systems of daily life needs (school, work, government agencies, transit).

3.4.1. Strengths and limitations

This research analyzes qualitative data that are by design not generalizable, but rather intended to generate a rich description of participants' narratives through open-ended interviewing and focus groups. A strength of this qualitative study was a rigorous team-based analytic approach, allowing for diverse perspectives on definitions of codes, in depth discussion and consensus-building to develop clear and thoughtful boundaries of codes, and richer consideration of alternative explanations for findings as they emerged. Limited sample diversity might be a limitation, but we elected to prioritize underrepresented perspectives of marginalized im/migrant women above a commitment to maximum diversity. Our sample was not designed to represent the full spectrum of im/migrants in our region, and reflects oversampling of precarious migrants in our region, the majority of whom are in the Latin American community. This study was grounded in community collaboration which supported rapport and sensitive engagement with structurally marginalized im/migrant women, who were purposively sampled in view of previous underrepresentation in research;⁴² a strength, given high levels of unmet need and the ethical imperative to ensure that those most impacted are engaged within research.¹²⁰ Further, we sampled smaller proportion of service providers, to add context but not overshadow participant voices; a weakness may be the lack of provider diversity, where we sampled only people with either lived experience or extensive experience working with im/migrants in supported settings. The first author is a physician working with im/migrant communities and recognizing her positionality and to mitigate role confusion or risk confidentiality breaches with patients, she avoided direct involvement with recruitment or interviews, and only viewed de-identified transcripts.

Grounded in inclusive and critical frameworks of intersectionality and structural determinants of health, the overall findings are relevant to the development of theoretically informed policy and practice changes in other settings where im/migrant women facing structural marginalization encounter challenges accessing and using health services. Further, policy recommendations developed from this research aimed at addressing barriers for those with immense structural risk would still likely benefit other people who immigrate to Canada.

3.4.2. Recommendations

We recommend universal provision of interpretation with training and implementation support, widespread support for low-barrier language classes, and identifying and addressing structural vulnerabilities in health care. To untangle these struggles with communication, health care decision-makers in Canada should consider *at minimum* universal implementation of interpretation across the spectrum of health care services (reception, pharmacy, imaging, labs, clinical encounter). Moving forward from promising pilots, for example, where provision of free phone interpretation to community physicians was acceptable but underutilized⁶¹, any implementation requires ongoing training for all health care staff on why, how, and when to use available interpretation systems.

Participants affirmed these approaches, suggesting universal language and communication support at baseline, but also linked this to social participation (e.g., volunteer conversation programs). Given that programs of this type have existed in piecemeal and pilot form for decades in Canada, we further suggest systematic implementation of low-barrier, community-responsive language classes with stable funding wherever im/migrants reside. Finally, understanding the convergence of limited English proficiency, discrimination, and structural determinants, health systems at all levels from training to practice can incorporate education on structural vulnerability¹²¹ in clinical practice and join in current efforts to understand and address systemic racism, xenophobia, and colonialism to support meaningfully universal health access.

3.4.3. Conclusions

Women communicating with limited English proficiency in BC are challenged by multiple axes of oppression that result in limited access to and experiences of health care as well as education, employment, immigration, and other basic needs. These experiences combined with the lack of systemic measures to support equitable communication for im/migrants articulate the profound institutional discrimination built into our health care systems. To effectively address these harms, the “language barrier” needs to be re-conceptualized according to the ways it operates as a broader structural determinant of

health. This process necessarily centers the voices and perspectives of those most affected – in this case, structurally marginalized im/migrant women.^{42,63} We recommend interventions that provide for communication needs in a structurally competent context to reduce discrimination and health inequities for im/immigrant women.

3.5. Acknowledgements

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Tables and Figures

Table 3.1. Participant Characteristics

Participant Characteristics [±]	N=49
Age in years, mean (range)	30.6 (18-49)
Primary Language, n (%)	
Spanish	36 (73)
Dari/Farsi	12 (24)
Other (English, Tigrinya)	1 (2)
English Language Comfort [§]	
Uncomfortable*	27 (55)
Comfortable**	22 (45)
Years in Canada, mean (range)	2.8 (0.25-12)

Participant Characteristics [±]	N=49
Ethnicity ⁺⁺	
Afghan/i	6 (12)
Latina ^{§§}	32 (65)
Afrolatina/Negra	4 (8)
Iranian	4 (8)
Other (African, Mediterranean, Caribena, Mixed)	4 (8)
Provider Characteristics	N=10
Clinicians (Nurses, Nurse Practitioners)	4
Community Organization Staff	6

[±]excludes focus group participants who spoke a variety of languages including, but not limited to, English, Spanish, Dari, Farsi, and Tigrinya.

[§]Self-assessed responses on a 5-point scale from Very Comfortable to Very Uncomfortable to the question: "How comfortable do you currently feel with [speaking, reading, writing] English?"

^{*}includes responses: Very Uncomfortable, Uncomfortable, Not Very Comfortable

^{**}includes responses: Very Comfortable, Comfortable

⁺⁺includes responses to the question: "What ethnicity(s) do you identify with? Please check all that apply."

^{§§}Latina: includes Mexican, Colombian, Guatemalan, Honduras, Venezuela

Table 3.2. Ripple effects of limited English proficiency across health system interactions

Impacts on care-seeking
<p><i>However, the truth is that I repressed myself because of the language. I said to myself: "They speak English there, and they won't understand me, and how will I...So the truth is that I didn't go there at the moment, and the kid spent like 3 days in that condition..." (Woman speaking Spanish)</i></p>
<p><i>The [investigations ordered by a clinician] were \$300 I think they told me, and I said: "no, no, where would I get that money from, I don't have it". So I tried to look for a different option, but I can only speak Spanish, I don't know English, not yet, so that made things more difficult. I didn't have a place to go. Maybe there were other places, but without speaking the language it was very hard to get to know about them. (Woman speaking Spanish)</i></p>
<p><i>"...it is complicated for me to come here where [the doctor] is, because she only speaks English, and she doesn't understand me. So, explaining to a person that only speaks English, how can you explain to her that you need a Pap smear? Not even with gestures she will understand[...] because in fact, once I came and she didn't understand me, so <u>me fui en la luna</u> because I didn't understand her and she didn't understand me..."(Woman speaking Spanish).</i></p>

<p>Communication struggle within clinical care</p>
<p><i>They haven't been able to explain, I think, because we don't speak the same language. They just tell me the basics. They say that I'm ok but I feel that they haven't been able to explain me things in depth, because we can't communicate well.</i> (Woman speaking Spanish)</p> <p><i>Because I experienced that when I had like a first meeting with a doctor, so there was interpreter with me, and she was also from Afghanistan and she was like knowing me very well. And I was not feeling very comfortable when the doctor asked me questions so, I was not feeling comfortable to like share everything in front of that person.</i> (Woman speaking Dari)</p> <p><i>Like honestly here, there's not really like Spanish doctors. Like barely. And there's like a lot of Spanish people here, I guess. And they're- They don't- Like they go, and they don't even know what to say like, how to describe what they feel and stuff. They have to either take somebody or like, try and explain it. [...] If I was in school or something, my mom would like, sometimes she would cry cause she didn't speak English, she didn't know how to explain to other doctors or like, anyone else.</i> (Woman speaking Spanish)</p>
<p>Ripple effects across health system interactions</p>
<p><i>"Especially studies for women, which are so delicate, almost always we all get scared... And then I think – they're going to call me, and I'm not going to understand, oh no..."</i> (Woman speaking Spanish)</p> <p><i>"But they used to send us to different places for different examination, and at that time my husband used to work, and I had two young kids, we had no one to take care of my kids. They used to say it was your problem that you became pregnant or wanted to become pregnant. I used the bus and sky train to go to different places for different examination, sometimes they sent me to 3-4 different places for examination in one day. Sometimes I ended up going to the wrong place and they told me that I had to do this examination first then the other second. That was a little challenging."</i> (Woman speaking Dari)</p>

Table 3.3. Intersectoral and intersectional effects of language on other health determinants

Access to social protections
<p><i>I don't speak English and I had to go with a person that spoke English the first time, because there was a form that needed to be filled out, we couldn't fill it out with the translator. So, my husband couldn't miss a day of work, because him missing a day of work is a lot of money for us being three and he is the only one who works, er so they never gave me that help. [...] Yes, it is from a food bank. But they never gave it to me, when I went to [community agency], and so the lady called, and she said that I didn't speak English, and they told her that, no, that I needed to find someone with whom to go with who spoke English. (Woman speaking Spanish)</i></p> <p><i>Well at arrival, we were in the [community agency], and unfortunately our case worker was Arabic-speaking so we couldn't even establish any sort of good relationship... and we had to speak English and well we knew none of it and I don't think that she knew English very well either.. because she would make a lot of mistakes, like the documents that she prepared for us had a lot of mistakes, she couldn't understand what we wanted. [...] I don't know what happened for us to end up with this Arabic-speaker, so we couldn't take advantage of any of the services there. (Woman speaking Farsi)</i></p>
Psychosocial and economic stress
<p><i>“So, I understood one thing and they were doing another thing. So, then I thought “what is going on. Is this dangerous?” So, language, at the moment in which they were not explaining to us what could happen or what was happening, that was very, very hard.” (Woman speaking Spanish)</i></p>
Racism, xenophobia, and precarious status
<p><i>Well, yes, because sometimes I am on the bus and I am with my daughter and she only talks in Spanish and there are people that do not like that. Some people start saying “shut up baby” or things like that, like insult her, and I do not like that because she is a girl, she doesn't know. Sometimes, too, because I feel that... that people look at you weird, like if you were less. (Woman speaking Spanish)</i></p> <p><i>First, because you come to a new place you do not know the customs, primarily the language. That is what labels you, not knowing how to speak English, and coming to a place where you find few people that speak Spanish so communicating is very hard. Meeting other people... you do not know how they will receive you. Being able to interact... trust, because there are some very delicate things about your life that you cannot tell to everyone. So, it is very hard. (Woman speaking Spanish)</i></p>

Table 3.4. Creating Agency: learning English and finding community

Learning English and gendered impacts
<p><i>I downloaded an app and have been studying there a bit during my free time. I do feel more confident now than when I arrived. Although, I do have more to learn. Actually, we are looking for a school or any English classes because we know that...well, you need English for everything, to go anywhere, especially now with the baby. (Woman speaking Spanish)</i></p> <p><i>Newcomer women fresh comer, a major problem we had on early days that, if you have underage child, a breastfeeding child or you are pregnant, the chance of study will be a little restricted for you, For example; until your child uses a diaper you do not have the permission to attend school. (Woman speaking Dari)</i></p>
Finding community
<p><i>We also have a group just for women, not Mexican, but Latin women, and we share a lot of things there. All of us have kids of around the same ages, they are all from 2018 or 2019, and that is very nice because we are here without a family, without people who can help us, and to share with them in your language, to share your grandma's recipe, things like that, that helps you to be calmer and to feel better. (Woman speaking Spanish)</i></p>

Chapter 4.

“The language is the main problem to every other problem”: Informing intersectional approaches to interpretation and health service delivery for im/migrant women in Canada

4.1. Introduction

Canada received a record 341,000 immigrants last year, amidst increasing federal targets for economic immigrants and refugees.^{12,74} Over 60% of this growing population speak a language other than French or English (the official colonial languages of Canada) at home, which has increased as migration patterns shift.⁸⁵ Among immigrants, language abilities are diverse, with specific groups such as refugees, recent immigrants and those with precarious status[§] less likely to speak English, which is the most widely spoken official language in the province of British Columbia.^{16,85,122} These im/migrant^{**} groups experience simultaneous structural marginalization related to poverty, racialization, and fear of immigration enforcement.^{16,21,77} Im/migrants who are racialized, recent, refugee, and precarious thus experience severe barriers to health care,^{18–21} which may be amplified by limited English proficiency.

As the population of people speaking languages other than English grows and diversifies, so do communication challenges in health care encounters. Related research by this team found that what has for decades been framed as a ‘language barrier’ may be more accurately understood as a form of systemic discrimination (*see chapter 3*). In this context, patient-provider language differences have a range of concerning health outcomes, including increased clinical errors, reduced preventative cancer screenings, and increased medical readmission, as well as reduced patient satisfaction.^{28,30,41} In

[§]Precarious status in Canada includes “documented” but temporary workers, students, and refugee applicants, as well as unauthorized forms of status, such as visa and permit overstayers, failed refugee claimants and undocumented entrants. (Goldring et al, 2007)

^{**} We use the term ‘im/migrants’ to include the diversity of refugee, immigrant, and migrant people born in other countries who entered Canada, inclusive of long-term and recent arrivals, refugees, asylum seekers, economic, and undocumented im/migrants. (IOM, 2019)

particular, sexual and reproductive health (SRH) for im/migrant women may have cultural complexities that interact with language, especially when no interpretation is provided or family members are interpreting,^{33,36} with repercussions for confidentiality and informed consent.¹²³

Communication between patients and providers is the cornerstone of health care provision, and has impacts on both clinical outcomes and patient satisfaction.^{1,2} The “Communicator” role is one of seven core competencies for certifying physicians in Canada, as well as in the United States (US);^{104,124} and, improving communication is a risk management strategy advised by the Canadian Medical Protective Association (CMPA).^{104,106,107} While they identify communication as a core competency for practicing physicians with articulated standards for responsible and ethical communication, they do not specify the language in which communication takes place. In this work, we considered having a shared language as a necessary but not sole component of communication, following the medical competency frameworks which expand and define contextual components (e.g., active listening, non-verbal communication) as essential to patient-clinician communication. Despite this professional imperative to ensure communication in health care encounters, there is no formal policy mandating health system responsibility for communication in providing health care to people speaking a non-official in Canada.¹⁰³

Decades of research demonstrates the harmful health outcomes of unmet communication needs for im/migrant patients,^{28,35,96,125} and calls for broad implementation of interpretation in health care visits. Further studies review the cost-effectiveness of interpretation³¹ impact of diverse forms of interpretation (including ad hoc and professional) on quality of care,^{28,30} and implications for informed consent.³² Yet, despite the clear link between limited English proficiency and poor health outcomes, in addition to evidence for effectiveness of interpretation provision, professional medical interpretation is still not effectively and reliably provided across the health system.^{28,102} Over half of im/migrants to Canada are self-identified women, most of reproductive age, whose SRH needs (e.g., pregnancy, cervical cancer screening, family planning) may require contact with the health care system in Canada.²² To overcome this persistent gap

and effectively implement meaningful communication in this context, we need a clearer conceptualization of how communicating with limited English proficiency interacts with health service provision, particularly for im/migrant women.

We lack contextual information on patient and provider experiences of interpretation and how it impacts communication which accounts for structural processes, especially within SRH care. Kimberlé Crenshaw described the utility of the framework of intersectionality for intervention design, where discrete feminist or anti-racist interventions fail to address the specific needs of Black women and women of color; noting that, “these converging systems structure the experiences of battered women of color in ways that require intervention strategies to be responsive to these intersections.”²⁶ This framework accounts for the fact that marginalized im/migrant women have largely been excluded from health research, despite serious health inequities,^{27,28,27,28} and in turn centers their experiences in the process of identifying appropriate interventions. Therefore, we take an approach that explicitly aims to mobilize community-based knowledge to address effects of converging structural determinants of health (e.g., gender, racialization, immigration status) as operationalized through communication with limited English proficiency. To inform effective implementation of interpretation, we aimed to evaluate im/migrant women’s and provider’s experiences with interpretation using an intersectional lens, considering the interplay between language needs and other structural determinants to shape im/migrant women’s health and care outcomes.

4.2. Methods

This study drew on qualitative data collected by the Evaluating *Inequities in Refugee and Immigrant Women’s Sexual Health Access (IRIS)* project, a community-based mixed-methods project based in Metro Vancouver, BC, from July 2018 to February 2020. The study holds ethical approval through the Simon Fraser University (SFU) and Providence Health Care/University of British Columbia (UBC) harmonized ethics review boards. All procedures were conducted in accordance with ethical standards outlined in the Declaration of Helsinki.

4.2.1. Study Setting

Vancouver, British Columbia is the third largest city in Canada, and its Metropolitan area (including Surrey, Burnaby, Richmond) is a top destination for im/migrants.¹¹⁰ The two largest immigrant groups are economic immigrants from India and China; however, im/migrants in BC are highly diverse, and the province remains a key destination for refugee claimants, resettled refugees. BC also employs about a quarter of all Temporary Foreign Workers in Canada.^{81,111}

Primary care in BC is principally provided in community-based fee-for-service offices, following the gatekeeper model, where specialized services are accessed through a referral from a primary care clinician.¹¹² Im/migrants in BC face barriers to accessing both primary care and specialist services due to communication challenges and physician payment models.^{59,60} The regional health authority with the largest im/migrant population funds three im/migrant-specific clinics that provide transitional primary care to a limited number of marginalized im/migrants (primarily refugees), and a few other im/migrant focused fee-for-service clinics operate around the Lower Mainland of Vancouver.⁵⁸ There are some multi-lingual clinicians proficient in languages of larger im/migrant groups (e.g., Punjabi and Chinese),¹¹³ but there is no systematic approach towards managing communication when patient and clinician languages are not concordant.

A pilot program of providing phone interpretation (Provincial Language Service [PLS]) free of charge to community-based family physicians in one region of BC found that uptake was low; however those who used the service found it feasible, acceptable, and improved communication especially for visits on sensitive issues.⁶¹ From that pilot, PLS was extended across the province to community-based family physicians, yet uptake remains low outside of heavy usage at a few particular clinics (*personal communication*). Beyond primary care, PLS both in person and over the phone is available to clinicians who request it in most hospital and health authority settings, including public health, in BC.⁶²

4.2.2. Data Collection

We began with community engagement with local community-based organizations providing direct services to structurally marginalized im/migrant women (Watari, Pacific Immigrant Resources Society, MOSAIC). We held community consultations from July 2018 – October 2018 with im/migrant women and service providers (4 focus groups, N=29) to establish research priorities and guide development of the research process. The focus groups took place in trusted community organization spaces, where the focus groups with service providers included staff with lived migration experience who spoke English as an additional language; and, the focus groups with im/migrant women participants took place in Spanish, Tigrinya, and Dari with interpretation from staff known to the participants. Next, we began hiring and training women with lived experience of migration as research staff, including as multilingual qualitative interviewers. The multilingual, multicultural (“community-based”) research team members underwent training in qualitative interviewing, confidentiality, and data management protocols. From December 2019 – February 2020, this team conducted semi-structured, in-depth, individual interviews with im/migrant women (N=49) and service providers (N=10) across Metro Vancouver.

Recruitment strategy for im/migrant women focused on respectfully engaging perspectives underrepresented in the literature and those experiencing added structural marginalization, including people with precarious status (refugee claimants, undocumented, and temporary foreign workers) and resettled refugees. Study outreach was shaped by the communities served by our partners, as well as the population background of resettled refugees arriving over the past 5 years (e.g., Syria, Eritrea, Democratic Republic of Congo, Iraq, Afghanistan).⁸¹ Though federal statistics do not report granular provincial-level breakdowns, most French-speaking im/migrants (i.e., Democratic Republic of Congo) land in the francophone province of Quebec,⁸⁵ and local agencies include Iran as a top country of origin for resettled refugees in BC.¹¹⁴ Within the Temporary Foreign Worker Program, the top 3 countries of citizenship for permit holders in 2019 were Mexico, India, and Guatemala.⁸²⁻⁸⁴ Recognizing the considerable focus occurring after the federal resettlement of >25,000 Syrian refugees in 2015-2016,^{73,115} we

turned to local community partners and community connections working with precarious migrants (e.g. Spanish-speaking from Latin America) and with other groups of refugees (e.g. from Eritrea speaking Tigrinya, Afghanistan speaking Dari, and Iran speaking Farsi). Recruitment proceeded through community partners, community connections, and study posters that aimed to represent a range of experiences (e.g., younger vs. older women, time in Canada, migration journeys) within a *purposively selected*⁶⁷ sample. Service providers were selected to cover a range of immigration and health service roles, including community-based healthcare providers experienced in working with im/migrants, and community outreach workers, and teachers. Sampling proceeded iteratively, with subsequent sampling for interviews being informed by preliminary findings and data as they emerged.

Eligible im/migrant women were self-identified women (cis and trans) of reproductive age (ages 15-49) who had recently migrated to Canada (approximately the last 5 years), and able to provide informed consent. Our recruitment criteria explicitly excluded questions about immigration status, so that potential participants did not have to disclose their immigration status as a condition of participation in this study. However, our approach of collaborating closely with grassroots direct-service organizations serving this population resulted in a high representation of im/migrants with precarious status, refugees, and/or racialized participants. Similarly, language spoken was not an eligibility criterion, but was shaped by the recruitment strategy and the languages represented by the community-based research team members and recruitment materials (study flyers, community presentation) in Spanish, Farsi, Dari, Tigrinya, and English. *Eligible service providers* were health or community organization staff who worked directly with im/migrant women in Metro Vancouver.

Im/migrant women participants were invited to focus groups by trusted community organization staff or offered interviews by trained interviewers with lived migration experience in their preferred language (Spanish, English, Tigrinya, Dari, Farsi). They were given \$40 honoraria in recognition of their time, expertise, and travel, as well as supported with childcare as needed. Interviewers explained the purpose of the study, the voluntary and confidential nature of participation, its risks and benefits, and obtained

written informed consent prior to participation. Interviews and focus groups were conducted in the participant's preferred language, or with a translator familiar to the participants, audio recorded with consent, and lasted 60-90 minutes. Translators were only used in the focus groups and participants knew them as trusted staff of the organizations where the focus groups took place. The research team developed an active referral resource vetted by community partners to respond to participants' health and social needs as they arose during interviews. The research team also conducted the service providers interviews, along with the first author in her role as a family physician providing care to im/migrant populations.

Interviews followed a semi-structured interview guide eliciting participants' perspectives regarding im/migrant women's SRH service needs; experiences with health and social services in Canada, including barriers and facilitators faced across the arrival and settlement process and for different types of care; im/migration background; structural determinants of im/migrant women's' health care access and experiences, and recommendations for improving access to health services for im/migrant women. Service provider interviews included the above domains in relation to their professional experiences working with im/migrant women. All participants who completed in-depth interviews completed a brief interviewer-administered socio-demographic questionnaire to contextualize the interview sample (e.g., ethnicity, time spent in Canada, comfort speaking English).

4.2.3. Data Analysis

Multilingual transcriptionists simultaneously transcribed interviews verbatim and translated them into English. Transcripts were then cleaned and accuracy checked by a separate community-based research team member. All participants were assigned unique codes upon recruitment and all personal identifiers removed during transcription and cleaning. Analysis of focus group and interview transcripts occurred alongside data collection and employed a team-based approach with academic and community-based research team members contributing to coding, analysis, and development of materials (plain language summaries and short videos) for member checking interviews and to

elicit community feedback on preliminary findings. While undertaking the interpretation of the results, the members of the coding team reflected on their positions as researchers and members of im/migrant communities, as well as the complexity of working with translated text.

Coding and analysis were managed in NVivo v.12 (QSR, AUS). Drawing on intersectional and structural determinants of health frameworks, the coding team used content analysis to generate an initial set of codes and describe key themes based on participants reflections and experiences (e.g. language barriers, health care experiences). The codebook was developed and iteratively refined using a combination of inductive coding to group data and deductive coding using themes that arose out of the initial IRIS consultations (e.g., migration timing, discrimination) and conceptual frameworks (e.g., policies and enforcement, im/migration status, gendered power dynamics). The coding team met regularly to discuss definitions, the boundaries of the codes, and establish inter-coder reliability. As data collection proceeded alongside analysis, the coding team followed a structured, collaborative process with detailed notes on meetings, discussions and coding approaches to allow for rich discussion of alternative explanations for findings, examination of negative or contrary findings, and both addition of new codes and refined definition of existing codes. In this phase of analysis, participant experiences involving language or communication concerns were coded under '*language issues*' using the definition: "Barriers and facilitators related to communication in daily life and in accessing health, social and settlement services (e.g., language barriers with health care professionals, experiences with interpreters/translation services, access to English schools, level of English)."

In the next stage of analysis, I conducted more refined inductive coding and synthesis of data on 'language issues' to shed light on how communicating with limited English proficiency shapes access to and experiences of SRH care in Canada. First, I extracted all of the data coded under *Language Issues* and removed all of the other coding to review the grouped data and inductively coded it again, drawing on the central codebook as relevant (e.g. discrimination, provider competencies), but introducing new codes specific to communication experiences (e.g., interpreter/interpretation

characteristics, barrier/facilitators to English classes). Next, I grouped the codes under related themes (Interpretation Nuances, Learning English). Focused coding and synthesis in this stage drew on the critical approach within constructivist grounded theory^{68,69} where I continually moved between data and possible theoretical explanations while maintaining a critical stance considering power, historical context, and injustice. This process was deeply informed by the frameworks of intersectionality,⁷⁰ to recognize the operation of multiple axes of oppression, and structural determinants of health,⁴⁴ to link this context to health outcomes.

4.2.4. Member-checking process

To ensure that the interpretation and findings resonated with the community and participants, and following ethical community-based approaches to research with im/migrants,^{43,63–65} we undertook three overlapping feedback and engagement mechanisms: 1) ongoing discussions with community partners, 2) sharing findings directly with participants, and 3) purposive member-checking interviews.⁶⁶ As preliminary findings emerged, we shared them with partner organizations and elicited their feedback. The research team also developed a process to produce accessible, short videos that reviewed high-level findings in plain language with graphics aiming to visually represent the community and research process.

For the first wave of preliminary findings (including some from this analysis), we reviewed the video with community partners, then translated them with text and voice-over in the languages of the participants. Starting in small batches, community-based interviewers then began progressively sending the private video link to all participants who had consented to follow up. The video invites participants to text, email or call to share feedback on the findings or the video, and then offers any of those interested the opportunity to do a follow up ‘member-checking’ interview. Additionally, the community-based interview team purposively invited follow up interviews from participants whose perspectives might expand the analysis either through a unique viewpoint, unexpected experience with migration or SRH care, or might be experiencing a change in im/migration status or health status (i.e. before and after a pregnancy). These

mechanisms served to validate and inform findings as they emerged, and to elicit suggestions for pragmatic, local intervention.

4.3. Results

4.3.1. Socio-demographic characteristics

This sample was composed of 49 im/migrant women and 10 service providers. The mean age of im/migrant women participants was 30.6 years (range 18-41) and a mean time in Canada of 2.8 years (range 0.25 – 12) [Table 4.1]. A majority of the im/migrant participants (73%) spoke Spanish as a primary language. Most of the participants identified as Latina (65%), with 8% identifying as Afrolatina or Negra. The service providers interviewed spanned a diversity of professions including clinicians (nurses and nurse practitioners) with experience working in im/migrant-specific settings that provided interpretation and community organization staff.

4.3.2. Thematic Results

Despite communication being a core competency for Canadian clinicians, the onus of responsibility for addressing communication needs often rested on im/migrant women, typically via ad-hoc interpreters (e.g. friends, family, apps), resulting in compromised care. Institutional funding for interpretation and provider expertise influenced interpretation provision at varied sites of care. Where provided, interpretation was shaped by gender and dialect of the interpreter, mode (e.g. phone, in person), and provider skill, which impacted trust and safety. Gender, xenophobia, and poverty converged with language to structure im/migrant women's health care experiences, particularly SRH. Where usual care provision fell short, clinicians experienced in im/migrant health took responsibility for navigating communication and mitigating structural violence, in the absence of fitting health and social supports.

4.3.3. “I used to tell them by pointing and acting”: Determining responsibility for communication

Counter to the fundamental principle of communication outlined as a core component of health provision in Canada, few participants had experiences of being offered any type of interpretation, and fewer still found a language-concordant provider.

The costs of making do with what you have

In this constrained context, im/migrant women understood that the onus then rested on them to facilitate communication in health care settings, and reached into their personal networks of friends, family, and community workers to find people to interpret for them (Table 4.2). At the very least, this meant every new health need required asking another person for help, and often meant navigating the nuances of confidentiality or consent by bringing in a friend, child or spouse to a visit discussing sensitive SRH concerns. For example, an essential reproductive health procedure such as a Caesarean-section or surgical management of miscarriage requires informed consent – a process where the provider explains the risks and benefits of the procedure, capacity to consent is assured, and reasonable efforts are made to ensure the patient understands the nature of the procedure before providing voluntary consent.²¹ Despite the fact that obtaining informed consent is a fundamental responsibility of clinicians, participants and providers found that the informed consent conversation took place in a range of scenarios – where at times it might appropriately be done through professional medical interpreters, it also occurred through spouses, unrelated hospital workers, or in English that the patient did not comprehend (Table 4.2). In the absence of clinician-supported interpretation, obtaining even this attenuated level of communication meant resorting to taking children out of school or asking extended family or spouses to leave work to accompany them. This Farsi-speaking woman described her perspectives on the interaction of interpretation provision and economic considerations for both herself and the clinicians:

So, it's hard to find someone who isn't at work who can help you with translations, it's almost impossible. If someone is here long enough to know the language well, then they are probably working during working hours, so it's hard to find someone. If the private doctor used the phone translation service, then it

would solve the issue. But I know there is a cost for this, so that's probably why they won't use it.

These situations required complex navigation of family dynamics and days of lost income or education, so im/migrant women struggled with balancing these consequences against clinicians who refused to see them without an English-speaking person present or omitting sensitive clinical information during visits (Table 4.2). In some cases, they might find a sympathetic and available community organization staff who was willing to go above and beyond to provide accompaniment or support translation over the phone. Other times, they simply pulled up a phone app like Google Translate. In instances where they had care at a site that provided interpretation, they appreciated the relief of this burden, noting that in these places, language needs were established during routine intake processes (Table 4.2).

Determinants of medical interpretation provision

At the provider level, taking responsibility to accommodate communication needs was highly contextual. Clinicians in this sample were experienced with the im/migrant context and assumed provision of professional medical interpretation was their responsibility; however, this was influenced by factors at the site of care, such as cost of interpretation and workplace norms. One clinician who started a job at a large provincial agency found that despite having funding for interpretation, it was poorly implemented, so she amended workplace policies to encourage its routine use:

I've updated our policies around that to let people know that clients have the right to making an informed decision in their language, and discouraging people from using family members, cause that's what we used to see a lot, or other staff, so you know, pulling a nurse from another department to come and interpret, or pulling somebody who is not even a nurse, an outreach worker or something.

Both im/migrant women and provider participants observed that differing sites of care, such as hospitals, specialist clinics and emergency rooms sometimes provided interpretation, but it was unpredictable (Table 4.2). They offered opinions as to why other sites might elide responsibility for accommodating communication needs for people with limited English proficiency, citing potential cost concerns for the health care system and prolonged appointment times. The context of interpretation provision evolved out of

interactions between the site-level determinants (e.g., workplace norms), provider competencies (e.g., knowledge of interpretation systems and how to use them), and system level supports (e.g. funding for professional interpreters at the site of care). Primary care clinics with experienced im/migrant-health providers that had funding support for interpretation routinely took responsibility for ensuring appropriate communication, while other community-based offices pushed the onus back onto patients (Table 4.2). In hospitals or health authority sites with funding for professional interpretation, utilization of the service relied on individual provider choices (Table 4.2).

4.3.4. Beyond Language Concordance: Influences of gender, culture, and mode of interpretation

Where professional interpretation was provided, there were important nuances to how it was provided that contoured experiences of health care for im/migrant women.

Modes of interpretation

Modes of interpretation ranged between phone, in person, video, or language concordant clinicians or staff. Im/migrant women found that the quality of each experience varied, where sometimes the phone interpreter was adequate – particularly for simple issues – and other times there would be connection issues or missed complexities (Table 4.3). Generally, they preferred having an in-person interpreter for the ability to discuss sensitive SRH issues (Table 4.3), but this was complicated by interpreter competencies, where they might be inattentive or interpret incorrectly:

I had access to an interpreter at the hospital, I had my interpreter, but I think that that affects too, the fact that the interpreters rotate because I felt comfortable with some of them, but with others no, because they didn't listen to me. I don't speak English because I don't feel comfortable, but I understand a lot of things, and I was telling them some questions that I had, and the interpreter cut my words. [...] So I think that that affects too, as there is a third person, they cut my words. (Woman speaking Spanish)

Clinicians had similarly diverse experiences, where having the phone interpreter was helpful for rapid assessment of walk in visits, but having a good in person interpreter was crucial for addressing sensitive issues of sexual or mental health. For these issues,

they balanced better communication and informed consent with confidentiality concerns, for example, where patients and interpreters were from the same small ethnocultural communities. They emphasized the importance of interpreter competencies, and detailed cases where in-person professional interpreters had been judgemental or offered their own opinion rather than the provider's words, and in some cases, were asked to leave. This clinician working at an im/migrant-focused primary care clinic with embedded interpretation described how they were often navigating all of these factors:

So people are known by their community and that affects privacy and what they want to talk about, and then also, depending on the person interpreting, like I mentioned before, a number of interpreters throw their two cents in and that could make things worse than more helpful.

Gender, cultural context and trust

Both im/migrant women and service providers detailed the complex ways in which the gender and cultural background of interpreters shaped their health communication and consequently, outcomes for the patients. For most participants, an interpreter's gender was important in the context of SRH care, with many noting that it was culturally inappropriate or uncomfortable for them to disclose sexual health needs with a male interpreter or physician, even if he spoke their language (Table 4.3).

Further, while people trained as professional interpreters often mirror the dominant im/migrant groups who have landed in BC, there is significant diversity and cultural variation within im/migrant groups, even if they come from the same region. Im/migrant women recounted misunderstandings due to differing dialects that ranged from small inconsistencies (e.g., a humorous confusion over “hule” vs. “goma” to mean condom for one woman speaking Spanish) to extreme frustration at not having their words fully relayed to their health care provider. Some women whose first language was not the official language of their country of origin (e.g., an indigenous or ethnic minority language) faced additional challenges, as described by this woman from Latin America:

I can say: “I have an appointment,” but I can't express what I really feel because there is no one who speaks my language. Spanish is only a second language, so a person like that can't really express what you want to say, or you go to a clinic and there's no one, there's no one.

Given the essential context of communication that reaches beyond language concordance, trust in the interpreter and mode of interpretation was critical and significantly shaped the overall health care interaction for im/migrant women. When the responsibility for faithful interpretation was broken or cultural contexts unheeded, trust quickly eroded and im/migrant women felt angry or betrayed and sometimes left with unmet health care needs (Table 3). Through a combination of provider competency and contextual appropriateness, however, trusted in person interpreters were highly valued. For a Spanish-speaking participant who was uninsured and had experienced questioning of her immigration status (i.e., status-checking) and subsequent health care rejection, finally finding trusted communication was vital:

It was an interpreter, so when I knew that there was an interpreter, because I was afraid of arriving at the hospital and say: it is me, accept me, because I did not even know how to say that. So, when they gave me an interpreter, well, wow, it is... very beautiful.

4.3.5. Language at the intersections: reproducing or mitigating harm

Language at the intersections

Im/migrant women struggled to meet their health and daily needs at the intersections of racialization, im/migration precarity, poverty, and gender, and these struggles were reproduced with limited English proficiency in the absence of appropriate communication support. Community organization staff in a focus group described instances where their clients had experienced threats by clinicians to call the Ministry of Children and Family Development (the provincial child protection agency) when their fear of answering the phone in English or inability to explain a child's illness without an interpreter was misconstrued as neglect. When the responsibility for health communication was shifted onto the participants, these struggles were amplified and reproduced in health outcomes including delayed care, neglected health needs, and compromised confidentiality and consent. Conversely, when responsibility for communication was assumed by clinicians experienced with im/migrant patients, women's specific health needs were met in the face of structural harms and provided insight into effective opportunities for intervention (Table 4.4).

These intersectional communication processes were apparent in experiences of sexual and reproductive health and interpersonal violence; and, women with precarious status experienced deeply intersectional struggles, where needing urgent reproductive health care with limited English proficiency magnified fears of status-checking or reporting to immigration authorities (Table 4.4). One Spanish-speaking participant described the interactions of precarious im/migration status and poverty after experiencing discrimination while receiving pregnancy care (Table 4.4), which was intensified by communication struggles, and how this damaged her trust in health services going forward:

Yes, even now...that's the reason for the little trust... [She double checked with a trusted organization before she came to the interview] Yes, it's that...to feel more trust...Ay... if I go...then they are going to ask about my status.... if I go how much am I going to pay?...or if I go...I do not know...the language, the cost, what they ask...because sometimes they ask about things that I do not feel are related to the disease or the person.

Several clinicians described unique considerations with abortion care, where rigid requirements that only the person requesting the abortion complete the intake phone screening meant they struggled to even make an appointment. They noted complexities of language, im/migration and gender in the context of abortion, where structural forces (e.g. income inequality) that shape abortion-seeking are complicated by abortion stigma, and a breach of confidentiality through an ad hoc interpreter or intra-community interpreter could mean the loss of vital community relationships (Table 4.4). Further illustrating the intersections of gender and im/migration, clinicians and community-organization staff described complex situations where im/migrant women experiencing spousal abuse struggled to be connected to available Gender-Based Violence support services because they did not all provide interpretation support.

Service and provider adaptations

Concomitantly, the providers experienced in supporting im/migrants that were interviewed here gave accounts of attempts to circumvent these obstacles, in order to ensure the safety of the people in their care or secure a needed reproductive health procedure. Often this required multiple steps, where they negotiated with services,

arranged for an interpreter to or themselves accompanied people to services, or adapted their own services to accommodate (Table 4.4). Beyond specific instances of reproductive health or gender-based violence, providers who regularly worked with marginalized im/migrants routinely adapted their services to operate with nuanced understandings of the unique context of communication for im/migrant women. They balanced cultural considerations with reproductive health needs and privacy, were alert to potential alterations in translation, and quick to address translation errors by changing modes (i.e. from in person to phone) or providing immediate feedback to the interpreter. Conversely, they recognized that these approaches were not the norm throughout the system, and some of their adaptations were required in the absence of systemic provision of competent interpretation or other social supports (Table 4.4). Identifying the influence of language on gender, im/migration, poverty, and safety, a community organization staff teaching English for im/migrant women explained:

“I want them to be able to say no to unsafe work, or to be able to identify a danger, that’s my goal instead of being able to write perfectly...”

4.4. Discussion

In our findings, the onus of responsibility for communication in health care settings often rested on im/migrant women, highlighting a serious failure of the Canadian healthcare system to appropriately accommodate communication needs for women with limited English proficiency. This neglect resulted in concerning health outcomes including delayed care, neglected health needs, and compromised confidentiality and consent, especially when requiring women to provide their own ad hoc interpretation for sexual and reproductive health care. In the absence of a systematic approach, individual clinicians’ decisions to accept responsibility for communication relied on institutional funding, experience with im/migrant care, and workplace norms, all of which interacted to shape healthcare for im/migrant women. Further, health inequities were intensified by this systemic neglect for im/migrant women living at the intersection of other axes of oppression such as racialization, poverty, and precarious im/migration status. Ultimately, the system-wide failure to reliably accept responsibility for communication with im/migrant patients engendered a form of structural violence¹²⁶ in providing a lower

quality of care to a marginalized population based on their language ability. These findings bridge the large body of literature documenting the harms of “language barriers” with the persistent failure of the health care system to routinely accommodate communication needs for im/migrant women, by uniquely highlighting that addressing im/migrant women’s healthcare needs goes beyond simply available language interpretation towards models of health provision that address intersecting needs of language, migration, and gender.

While appropriate professional interpretation is an essential foundation, bridging the gap in meaningful communication for im/migrant women requires an intersectional approach. In Crenshaw’s framework in “Mapping the Margins”, she describes interacting systems of race, gender, and class, but goes on to cite language and immigration status as structures that uniquely shape the access of im/migrant women to domestic violence services.⁷⁰ Our findings echo hers, and others, in demonstrating that meaningful health care provision for im/migrant women relies on an understanding of the structures uniquely shaping their experience (e.g., poverty, im/migration status, gender) and then finding an approach to communication that encompasses that understanding. To ensure our health care interventions for im/migrant women are effective and equitable, that communication approach then needs institutional support and system-wide implementation.

Our findings are thus situated amongst other work describing approaches to care that consider patient context in health care, specifically trauma-informed care¹²⁷ and patient-centered care.¹²⁸ Rather than a checklist of proscribed practices, these approaches optimally arise from commitment and competency at every level of the system from the front desk to the providers to the administration and, ideally, the health system funders. Trauma-informed care is a framework that rests on an understanding of context that leads to action organized by six principles^{††} which can be adapted and applied across multiple settings and interactions, in order to improve health care and reduce iatrogenic harm for

††Principles of TIC: (1) Safety, (2) Trustworthiness and Transparency, (3) Peer Support, (4) Collaboration and Mutuality, (5) Empowerment, Voice and Choice, (6) Cultural, Historical, and Gender Issues (SAMHSA, 2014)

trauma survivors.¹²⁷ Similarly, patient-centered care was defined by the Institute of Medicine as a key quality indicator in health care, and is based on a set of principles^{‡‡} that must be adapted with the patient at the center of decision-making.¹²⁸ Both of these approaches incorporate aspects of the other, and when applied with an intersectional framework, offer a path forward to safely, ethically, and appropriately attending to the communication needs of im/migrant women so they can meet their health needs.

Our findings confirm that implementation of these approaches requires appropriate systemic supports, which start from system-wide provision of professional medical interpretation⁶¹, and workplace norms endorsing its routine use. Further, it requires building competency in the full spectrum of health care workers in using an intersectional approach considering gender, im/migration status, and poverty to inform how, when and why to use different modes of interpretation. This reassignment of communication responsibility to the health care system addresses the omission of people with limited English proficiency in existing physician competency frameworks. To support this competency, health professional training can include teaching on routine use of appropriate medical interpretation with attention to identifying converging social structures and adapting to patient context.¹²⁹ This recommendation joins other work invested in utilizing an understanding of structural determinants of health to develop and implement effective health interventions to mitigate harms experienced by marginalized people.^{44,121,130}

Along with current health system implementation of trauma-informed care and patient-centered approaches,¹³⁰ an intersectional framework that considers language, migration, gender, and race can be incorporated into novel health intervention design. An example of this type of intervention could be the training and funding of a multi-lingual, multi-cultural doula program to support prenatal care and births for women speaking with limited English proficiency. The doula would support culturally appropriate communication needs during the dynamic birth process, and act as an advocate and

^{‡‡}Principles of PCC: (1) respect for patients' values, preferences, and expressed needs; (2) coordination and integration of care; (3) information, communication, and education; (4) physical comfort; (5) emotional support—relieving fear and anxiety; and (6) involvement of family and friends. (IOM, 2001)

system navigator as the birth parent moves through different care providers and settings. Similarly, grassroots and peer-led organizations that originate from im/migrant communities could be funded and scaled to work within the health care system. Local examples include a cross-cultural health broker model¹³¹ or a peer-support program for African im/migrants living with HIV.¹³²

4.4.1. Strengths and Limitations

This research analyzes qualitative data that are by design not generalizable, but rather intended to generate a rich description of participants' narratives through open-ended interviewing and focus groups. A strength of this qualitative study was a rigorous team-based analytic approach, allowing for diverse perspectives on definitions of codes, in depth discussion and consensus-building to develop clear and thoughtful boundaries of codes, and richer consideration of alternative explanations for findings as they emerged. Limited sample diversity might be a limitation, but we elected to prioritize underrepresented perspectives of marginalized im/migrant women above a commitment to maximum diversity. Our sample was not designed to represent the full spectrum of im/migrants in our region, and reflects oversampling of precarious migrants in our region, the majority of whom are in the Latin American community. This study was grounded in community collaboration which supported rapport and sensitive engagement with structurally marginalized im/migrant women, who were purposively sampled in view of previous underrepresentation in research;⁴² a strength, given high levels of unmet need and the ethical imperative to ensure that those most impacted are engaged within research.¹²⁰ Further, we sampled smaller proportion of service providers, to add context but not overshadow participant voices; a weakness may be the lack of provider diversity, where we sampled only people with either lived experience or extensive experience working with im/migrants in supported settings. The first author is a physician working with im/migrant communities and recognizing her positionality and to mitigate role confusion or risk confidentiality breaches with patients, she avoided direct involvement with recruitment or interviews, and only viewed de-identified transcripts.

Grounded in inclusive and critical frameworks of intersectionality and structural determinants of health, the overall findings are relevant to the development of theoretically informed policy and practice changes in other settings where im/migrant women facing structural marginalization encounter challenges accessing and using health services. Further, policy recommendations developed from this research aimed at addressing barriers for those with immense structural risk would still likely benefit other people who immigrate to Canada.

4.4.2. Conclusions

These findings highlight a serious failure of the Canadian healthcare system to appropriately accommodate communication needs for im/migrant women, resulting in compromised SRH care, which manifests a form of structural violence (i.e., the “social arrangements that put individuals and populations in harm’s way.”)¹²⁶ They also uniquely highlight that addressing im/migrant women’s healthcare needs requires a holistic approach that goes beyond mere availability of language-concordant options (e.g., phone translation) towards models of im/migrant healthcare that address converging needs related to language, migration, and gender. Further research on health system funding models, interpreter training, novel im/migrant-sensitive health programs (e.g. multilingual doulas), and health professional training on structural determinants of health would support these aims.

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Tables and Figures

Table 4.1. Participant Characteristics

Participant Characteristics [±]	N=49
Age in years, mean (range)	30.6 (18-49)
Primary Language, n (%)	
Spanish	36 (73)
Dari/Farsi	12 (24)
Other (English, Tigrinya)	1 (2)
English Language Comfort [§]	
Uncomfortable*	27 (55)
Comfortable**	22 (45)
Years in Canada, mean (range)	2.8 (0.25-12)
Ethnicity ⁺⁺	
Afghan/i	6 (12)
Latina ^{§§}	32 (65)
Afrolatina/Negra	4 (8)
Iranian	4 (8)
Other (African, Mediterranean, Caribena, Mixed)	4 (8)
Provider Characteristics	N=10
Clinicians (Nurses, Nurse Practitioners)	4
Community Organization Staff	6

[±]excludes focus group participants who spoke a variety of languages including, but not limited to, English, Spanish, Dari, Farsi, and Tigrinya.

[§]Self-assessed responses on a 5-point scale from Very Comfortable to Very Uncomfortable to the question: 'How comfortable do you currently feel with [speaking, reading, writing] English?'

*includes responses: Very Uncomfortable, Uncomfortable, Not Very Comfortable

**includes responses: Very Comfortable, Comfortable

⁺⁺includes responses to the question: "What ethnicity(s) do you identify with? Please check all that apply."

^{§§}Latina: in this sample included Mexican, Colombian, Guatemalan, Honduran, Venezuela

Table 4.2. Determining responsibility for communication

<p>The costs of making do with what you have</p>
<p><i>To find a translator... more then 80% I used to try by myself or took a friend of mine, or someone from our relatives. If they were not there, I used to tell them by pointing and acting. If it became more difficult, they used to find a translator over the phone. (Woman speaking Dari)</i></p>
<p><i>One that I will never forget was a woman who was actually having a miscarriage and she was in the ER and she called me via the interpreter at our clinic because she couldn't communicate with the on call doc and they couldn't find an interpreter and she didn't know what else to do, so she was calling our interpreter and trying to get a hold of me or the interpreter just so that she could actually communicate and she was so scared and she didn't know what they were doing, and she didn't know if she should say yes or no to whatever treatment she was given. (Nurse Practitioner)</i></p>
<p><i>My sister-in-law she was pregnant, and there was always, there should be one person to go with her. And, mostly she was like talking to me, because I was working and I was not able to go with her and she's so close to me. And she was like, discussing with me and she was telling me that I have a lot of problem that I can not share that in front of someone else. [...] I think there is a lot of women that they have a lot of problem with the language. Actually, the language is the main problem to every other problem. (Multilingual woman speaking Dari and English)</i></p>
<p><i>I brought the document and I said that I needed to have a doctor. And they gave me a form to fill in, and told me to bring it back, and that they will call me. The form asked how long have we been in Canada, which illness do we have, like if we had any health condition, and if we needed a translator, and I wrote that yes. (Woman speaking Spanish)</i></p>
<p>Determinants of medical interpretation provision</p>
<p><i>In [maternity care clinic], I have had the support of, of a translator, so, in that matter I haven't had any problem. In some places, eh, such as walk-in clinics and such, well, no, they don't offer it. Nor in hospitals. (Woman speaking Spanish)</i></p>
<p><i>Yeah he [the family doctor] was English-speaking, and we were doing translations via phone. But the specialist that I want to see, they told me that they don't have a translator and that I need to bring my own or cancel it. (Woman speaking Farsi)</i></p>
<p><i>It's been hard because when I needed to go to check-ups for my baby, the clinic where they referred me to...the doctor asked me if I needed a translator and I said yes, and we had a translator twice and then the doctor said: "We understand each other well", so we don't... But, yes, when I wanted to explain more things about the baby to her, it was hard, but in the end I end up explaining. But it is hard to find a doctor who speaks</i></p>

Spanish, and...when I take her to check-ups everyone speaks English and it's hard for me, it is hard. (Woman speaking Spanish)

Table 4.3. Beyond Language Concordance: Influences of gender, culture, and mode of interpretation

Mode of interpretation
<p><i>Because they [phone translation] listen just some parts of what you are saying, or does not listen to everything, or they reply or they tell you just a little part of everything that the doctor is saying. It's better to have an in-person translator. Well, they do not do a bad job, through the phone, but you feel better with an in-person translator. (Woman speaking Spanish)</i></p> <p><i>When I go to my appointments with, with the gynecologist, the translator comes in... So, it's not like I speak English 100% or I understand it perfectly, so I say, if I miss any word or there is something that I don't understand or that I don't know how to express myself, she will be able to help me, and it is better not to have any doubts because it is not a game, it is my child's health and mine. In contrast to the diabetes clinic, well I mean, I... it is like... it is like a monthly appointment and... and I understand more, because those are not very complicated things, we are talking about... that they are teaching me about what to eat, just to maintain my, my sugar well, maintain my blood pressure well, and all that. But I did ask for a translator... with the gynecologist. (Woman speaking Spanish)</i></p>
Gender, cultural context and trust
<p><i>One of the obstacles was the male interpreter, every time we used to go to talk about sexual and reproductive problems to the doctor, we had a male translator and couldn't tell our problem because of shame, and our problem will be left like that, and that was very hard for us. (Woman speaking Dari)</i></p> <p><i>I had faced such a problem, that when I was telling something to Iranian woman who was my translator, she was telling something else to the doctor. Later when I knew little English but could not talk, I found out. I said it has no benefit, Allah knows those days that I came to see the doctor, what I said and what she translated to the doctor I did not know. Sooner than a year I did not need a translator, I was going by myself. (Woman speaking Dari)</i></p>

Table 4.4. Language at the intersections: reproducing or mitigating harm

Language at the intersections
<p><i>No, well, with [baby's name] I have no problems. When she wants to go to the doctor, they accept her anywhere. The problem is us. For us, they don't accept us anywhere. The only place that I know is the one I have mentioned for a while now, and there I think they attend to you so well. They schedule an interpreter and I think that is where I would go. For me, that is the place where I would go and the perfect place where they help a lot. (Woman speaking Spanish)</i></p>
<p><i>Obviously there was a moment in the appointment that she knew I didn't have a status. I was afraid a legal letter could come and send us back! So I asked the interpreter, what is she telling me? And she said "Just wait, we'll find out soon what they say." And I saw that she was calling and calling, she called [another agency], and what bothered me was her calling. I came to a medical consult I didn't come somewhere for someone to call migration because I didn't have status. (focus group participant, speaking Spanish)</i></p>
<p><i>The language thing was very difficult...I was at the hospital for about 20 days before she was born....it was very difficult because sometimes the nurses were like "she is a tourist, just leave her" "she does not speak English, just leave her" (Woman speaking Spanish)</i></p>
<p><i>I felt so badly for that patient and I will always remember that one because I could see that she was just torn because she knew that if it is going to get out into her relatively small community, that she would probably, you know, potentially, there could be some serious backlash with regards to husband, friends, community, that she could really be kicked out almost of that community. So I think she was very fearful and um, you know really didn't know what to do, but at the same time she didn't want to keep this baby, or go along with the pregnancy. (Nurse Practitioner)</i></p>
Service and provider adaptations
<p><i>I spend hours calling...to connect women to their resource because many clinics are like, we provide the resources, this is out there for you, but they're [women] not ready. But the women who are ready to actually leave their partner and need a place to go, it's many, many hours to actually access that. I actually book interpreters from our clinic, to go to help me and help set up these appointments so that the woman can make it there, and then navigate, and depending on the crisis, we're lucky we have some taxi services, so go with the taxi, book the interpreter, and then we go, because [that needs to be done] in the moment, it's not like: Oh, let's plan it for an appointment later. (Nurse Practitioner)</i></p>
<p><i>You don't have an option obviously [of not sending them to Emergency], so the biggest thing I always, I really advice and urge, is no matter what, you tell them PLS [Provincial Language Service] and I give them even, sometimes I even write down, like: "this is what you need to say or do" on a card. And we would have a card that enforce that, that has our names on it too, if there is, you know, any reason to, you need more information or whatever, please contact this clinic, or this person, which I think is at least something, if they can find that card when... [laughs] (Nurse Practitioner)</i></p>

Chapter 5.

Discussion

5.1. Summary of key thesis findings

Decades of research documents negative health outcomes of ‘language barriers’ and effectiveness of medical interpretation, yet a systemic failure to accommodate communication needs for people speaking non-official languages persists in Canada, with particular impact on the sexual and reproductive health of im/migrant women. This systemic neglect reproduces and amplifies health inequities experienced by im/migrants living at the intersection of multiple axes of oppression including gender, racialization, poverty, and precarious im/migration status. To overcome this persistent inequity, this thesis sought to inform a more nuanced and robust understanding of how speaking a non-official language shapes health service provision for im/migrant women.

Drawing on the Evaluating *Inequities in Refugee and Immigrant Women’s Sexual Health Access* (IRIS) study – a community-based, mixed-methods project examining im/migrant women’s health access in BC – this thesis drew on frameworks of intersectionality⁷⁰ and structural determinants of health⁴⁴ to understand and inform implementation of evidence-based, population-tailored communication supports in health services for im/migrant women. The specific objectives were (1) to characterize the structural context of how limited English proficiency operates to contour access to and experiences of SRH care for im/migrant women (Objective 1), and (2) To evaluate how communication and experiences with interpretation services interact with other converging structural determinants (e.g., im/migration status, gender, racialization) to shape im/migrant women’s health and health care in BC (Objective 2). Unlike much im/migrant health research which has focused primarily on individual and cultural explanations for health inequities and gaps in healthcare access, this thesis explicitly aimed to mobilize community-based knowledge to address effects of intersecting axes of oppression (e.g., racialization, gender) and structural determinants of health (e.g.

immigration status) as they interact with language and interpretation needs of im/migrant women.

Chapter 3 describes how language operated as a form of systemic discrimination in im/migrant women's lives, posing challenges at every turn as they tried to meet basic needs and navigate healthcare and social systems (e.g., education, employment, immigration) in Canada, in the widespread absence of communication support. By constraining im/migrant women's decision making about when and how to seek care, this discriminatory neglect resulted in deferred, delayed and ultimately compromised care – particularly sexual and reproductive health care. This pervasive refusal to accommodate communication needs within the Canadian health care system placed an enormous burden on im/migrant women and their families, limiting their access to care and social support. Rather than seeing communication in a non-official language as an individual-level “barrier” within clinical practice, these empirical findings suggest that limited English proficiency operates as a structural determinant of im/migrant women's health, where multiple axes of oppression (racialization, gender) interact with social structures (immigration policy, poverty) to reproduce health inequities for im/migrant women. These contexts combined with the lack of systemic measures to support equitable communication for im/migrants articulate the profound institutional discrimination built into our health care systems. Moving beyond the concept of speaking a non-official language as an individual-level ‘barrier’ to healthcare, these findings show that pervasive neglect of communication needs in fact represents a form of systemic discrimination that routinely consigns im/migrants to a second tier of health care within an aspiring universal system.

Chapter 4 found that the onus of responsibility for communication in health care settings often rested on im/migrant women, who turned to their networks of ad hoc interpreters (e.g. family, friends, phone applications) for interpretation support in the context of healthcare. Communication is articulated as a core competency for licensing physicians in Canada, yet these findings underlined a serious failure of the Canadian healthcare system to appropriately accommodate communication needs for im/migrant women. This neglect resulted in compromised SRH care, in a context where gender,

xenophobia, and poverty also converged with limited English proficiency to structure im/migrant women's health care experiences. Beyond language concordance, where professional interpretation was provided, experiences were shaped by gender of the interpreter or clinician, dialects spoken, mode of interpretation (e.g., phone vs. in person), and clinician skill in working with interpretation. Although provision of interpretation varied by site of care, clinicians and community organization staff with experience and training working with im/migrants took responsibility for navigating communication and addressing structural determinants, in the absence of available health and social supports. Building on previous literature and findings of chapter 3, these findings illustrate how the Canadian healthcare system neglects its professional responsibility of communication for im/migrants with limited English proficiency. Ultimately, this analysis found that addressing im/migrant women's healthcare needs requires a holistic approach going beyond mere availability of language-concordant options (e.g., phone translation) towards models that respond to intersecting effects of language, migration, and gender.

5.2. Strengths and Limitations

Qualitative research by design does not seek to generalize specific experiences, but to generate rich description of participants' lived experiences. A strength of this qualitative study was a rigorous team-based analytic approach drawing on robust conceptual frameworks, which allowed for diverse perspectives on definitions of codes, in depth discussion and consensus-building to develop clear and thoughtful boundaries of codes, and richer consideration of alternative explanations for findings as they emerged. As a result, this study provides a nuanced description of the experiences and perspectives of marginalized im/migrant women in BC, including undocumented, refugee, and racialized participants, and service providers, which may not be generalizable to the full population of all im/migrant women in BC or elsewhere. The overall findings, however, grounded in inclusive and critical frameworks of intersectionality and structural determinants of health, are relevant to the development of theoretically informed policy and practice changes in other settings where im/migrant women facing multiple forms of marginalization encounter challenges accessing and using health services

Sampling was designed to prioritize underrepresented perspectives of marginalized im/migrant women above a commitment to maximum diversity, which would have allowed for less opportunity to hear those perspectives. Consequently, the results reflect the oversampling of precarious migrants in our region, the majority of whom are in the Latin American community; a strength, in addressing a research gap with a frequently excluded community. This sampling approach required thoughtful consideration, and as such, we purposively recruited im/migrant women facing structural inequities (those with precarious status, refugee claimants, racialized) who are underrepresented in larger, population-based quantitative studies. We chose to sample a much smaller proportion of service providers, to add context but not overshadow participant voices; as such, we sampled only service provider participants with either lived experience or extensive experience working with im/migrants in supportive settings. As a result, our findings may overrepresent the perspectives of providers with more skills and experience in addressing the communication and social needs of im/migrants than average clinician or community organization services.

Given historical underrepresentation in research⁴² and high levels of unmet need for these populations, there is an ethical imperative to ensure that those most impacted are engaged within research.^{63,120} To this end, a strength of this study was deep community collaboration which supported sensitive engagement with marginalized im/migrant women along the research process.

5.3. Reflexivity

As a community-based family physician with practices in both family planning and im/migrant health, my prior research and clinical experiences fostered a profound awareness of the inequities experienced by im/migrant women in Canada in accessing SRH care. In my offices in Metro Vancouver, I heard from women who were denied care by lack of coverage or judgmental providers; through my research, I have identified gaps in contraceptive screening, higher induced abortion rates, and mental health access for im/migrants;¹³³⁻¹³⁶ and, in chairing a working group for the Standing Committee on Population Health and Health Services to develop a provincial

refugee health program proposal,⁵⁸ I heard that access to timely, culturally appropriate health care is an issue for im/migrants province-wide. From a personal perspective – as a privileged immigrant to Canada, the daughter of a Chinese immigrant parent, and with diverse and multi-racialized extended family members – I have a deep commitment to undoing injustice, while recognizing and struggling with the ways in which I personally have benefited from current unjust structures. With a desire to bridge policy and practice in a real and meaningful way that acknowledges historical inequities and ongoing oppression for individual im/migrant women and the larger community, I hoped to contribute to the development of an evidence base to support this bridge by collaborating with CGSHE and entering the MSc program in the Faculty of Health Sciences at SFU.

As a knowledge user, co-investigator, and new PI within the larger IRIS project at CGSHE, I have built upon my longstanding clinical experience and collaborations in im/migrant health and family planning to foster research collaborations with community partners (Pacific Immigrant Resources Society, MOSAIC, Watari/Sanctuary Health). Through these partnerships, we initiated community consultations which guided the development of our recruitment approach and interview guide, and which I have helped to oversee as the project develops. In this role, I supported hiring and training of experiential community-based interviewers, translators/transcriptionists, and am deeply involved in the coding and analysis process. As a local physician working with im/migrants, I avoided any contact with im/migrant women participants in the research context, to preclude encountering patients known to me and protect their confidentiality within the research project. This was also meant to ensure voluntary participation, where being aware of my involvement in the study might cause concern about their responses impacting their clinical care and imply coercion. Moreover, this aligned with our intentional strategy of prioritizing community-based interviewers to address power imbalances, build rapport and a supportive interview process, and ensure that lived experience was represented across the research process.

To that end, I encountered participant data only at the level of analysis, via analysis and coding of de-identified transcripts; however, reading some of the stories was distressing from a clinician perspective where I might have had some ability to impact

individual-level service delivery. Direct knowledge of harmful systemic interactions experienced by participants created an internal conflict, where I might have knowledge that could address a clinical need and failing to do so felt like abandonment of my oath to ‘Do No Harm.’ However, the research setting has different boundaries than the clinical one, and there are ethical hazards to offering episodic clinical care in a non-clinical research setting, and in the absence of long-term structures to support ongoing clinical care. To work through these, I debriefed regularly with the coding team and with my thesis supervisors regarding preliminary findings which could impact my day to day clinical practices, and I continued to openly reflect on my position throughout the process. At the same time, I worked closely with the community-based research team to develop and update referral resources vetted by our community partners to best equip staff to offer support and active referral for clinical or social issues that arise for participants during the research process. For specific questions and challenging cases, I made myself available to interviewers to assist with problem-solving and coordinated referrals, which has been successful in connecting participants to needed services. Finally, I limited my role in data collection to interviewing peers (the clinicians) but discussed decisions about which types of providers to recruit with the research team, to avoid privileging my own colleagues or field of practice. Ultimately, this balance was imperfect, as I did not include any peer physicians in the sample.

A critical aspect of this methodology and analysis was a process of ongoing self-location and reflection on my identity and social location as a physician and researcher working with im/migrant women who may have experienced discrimination from health care providers, or are either excluded from health research or included via quantitative variables or through the perspective of a health care provider.^{42,137} While these types of research make up the majority of the literature on im/migrant women’s SRH care, they obscure the voices and lived experiences of this group, and may perpetuate power imbalances throughout the research process.¹³⁸ In response, as a part of the research team, I regularly reflected on how our identities and social positions can create unequal power dynamics both within the research team and between the team and participants – which may influence the research process, especially in development of research questions, data

collection, analysis, and knowledge translation strategies – and considered ways to mitigate these.

As a research team, we acknowledge and work to address the impacts of unequal power dynamics by grounding our research in community-based methods, which involve community members (both individuals and grassroots community-based organizations) at each stage of the research process. Beginning with our early collaboration with deeply trusted organizations serving im/migrant women, we sought input from providers and im/migrant women on their experiences and SRH priorities in designing our research questions, and have hired and trained im/migrant women with lived experience to be members of our research team as experiential community-based interviewers and project coordinators. We will continue to engage and recognize the expertise of im/migrant women themselves through development of advisory groups and creative member-checking and feedback mechanisms to deepen our analysis and propose community-developed recommendations for policy and programs to improve SRH access. Through my longstanding engagement as a clinician in the im/migrant health community, I have developed trusting relationships with community-based organizations, as well as recognized expertise in policy development and teaching around immigrant and refugee health. I hope to humbly leverage this unique position bridging research, policy and practice to support implementation and ongoing evaluation of recommendations developed from this community-based research to resist ongoing systemic medical violence experienced by im/migrant women in Canada.

5.4. Key implications and directions for future work

5.4.1. Implications and theoretical contributions

The results of this project build upon and contextualize the extensive body of work examining unmet communication needs (‘language barriers’) linked to health inequities for im/migrants in Canada and similar destination settings. Whereas prior studies point out the persistence of ‘language barriers’, even in settings where it is mandated by law, this thesis reveals this inequity as the outcome of discrimination based

on converging structural inequities (racism, gender, income inequity, immigration status) rooted in xenophobia. Amongst studies that investigate the implementation of interpretation services, this research affirms findings of the hazards of ad hoc interpreters, especially for communication around sexual and reproductive health or gender-based violence. It further identifies this abrogation of the professional responsibility of communication, which specifically excludes people speaking non-official languages, as a form of structural violence. By utilizing frameworks of intersectionality and structural determinants, this project builds on previous studies that examine low uptake of available interpretation,^{61,139,140} variability between and within modes of interpretation,^{28,30,99} and provider education interventions^{47,129,141} to propose a basis for responsive and effective health services design that accepts the responsibility of communication to include im/migrant women. This design requires consideration of holistic models of care that go beyond simply language-concordance towards im/migrant-sensitive models that address the converging impacts of speaking non-official languages, systemic racism, im/migration status, and gender inequity.

5.4.2. Recommendations for socially accountable interventions

By applying these understandings, novel opportunities for intervention arise. Buchman et al., designed a *Social Accountability framework* for physician intervention in social and structural determinants of health which considers three levels of intervention: 1) micro¹⁴² (the clinical environment); 2) meso¹⁴³ (the local community and context, including education and training); and 3) macro¹⁴⁴ (broader realm of policies and their impact on population health).¹⁴⁵ The utility of the frameworks of intersectionality and structural determinants of health in this context is that im/migrant communication interventions can be adapted along the spectrum from individual care to system-level services design (Figure 1). Additionally, these frameworks neatly imbricate with established frameworks of Trauma and Violence Informed Care^{127,130} and Patient Centered Care¹²⁸ to ensure that applications of those instruments do not marginalize and exclude im/migrant women. These approaches offer a path forward to safely, ethically, and appropriately attending to the unique communication needs of im/migrant women in any program setting so they can meet their health needs.

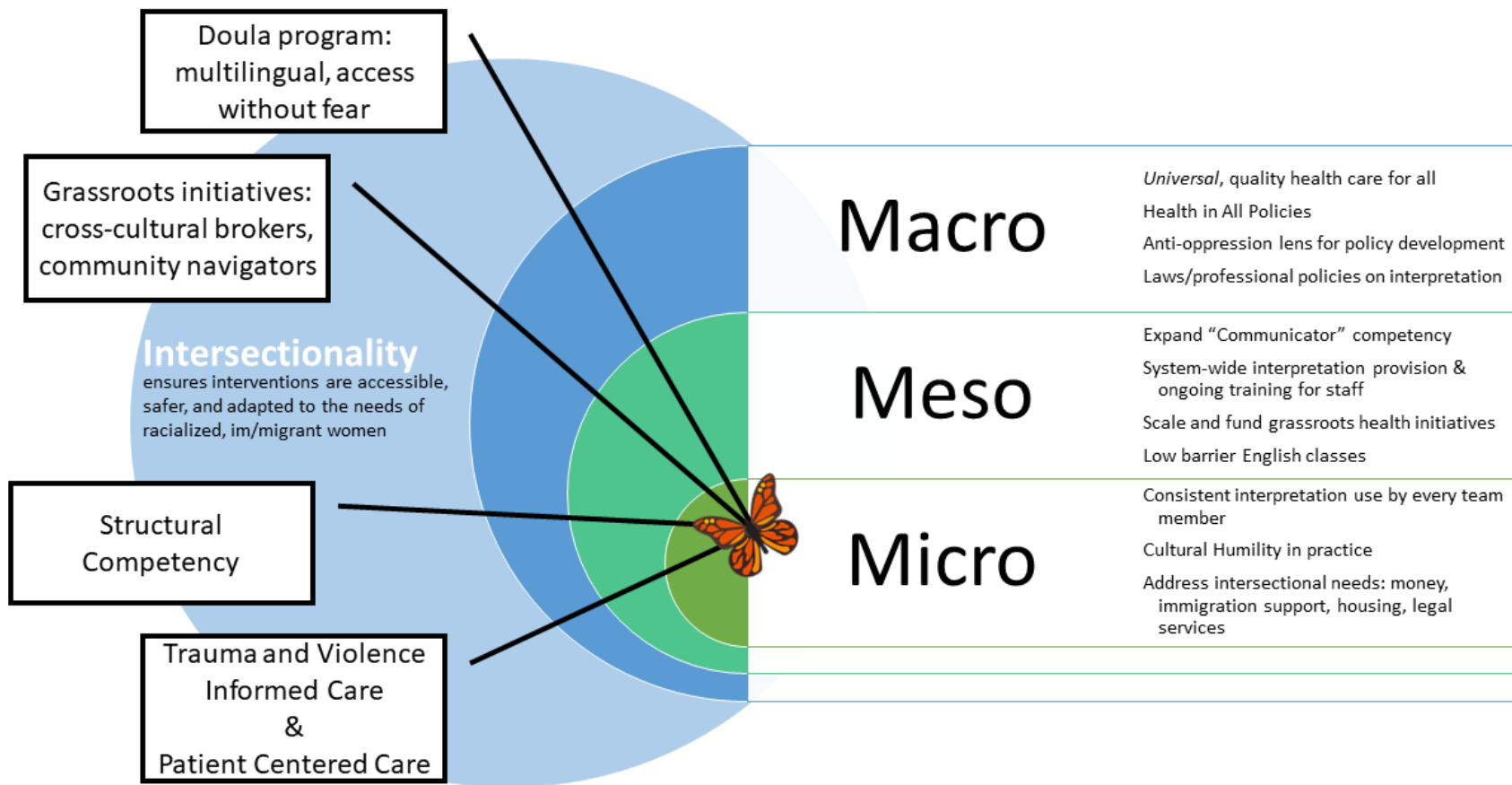


Figure 5.1. Recommendations for interventions to address intersectional and structural inequities shaping healthcare for im/migrant women speaking non-official languages in Canada

Adapted from Buchman S, Woollard R, Meili R, Goel R. Practising social accountability. Can Fam Physician 2016.

Recommendations at the micro level

The basis for every clinical interaction is communication, and for people speaking non-official languages in Canada, this requires consistent and context-appropriate interpretation use across the spectrum of team members (e.g., front desk staff, administrative staff, clinicians) and range of health-related services (e.g., imaging, laboratory). Recognizing communication encompasses nuance beyond language concordance, employing interpretation with a culturally humble approach is critical.¹⁴⁶ Applying an intersectional lens at this level considers the particular set of challenges faced by im/migrant women sitting at the convergence of precarious immigration, poverty, and gender inequity. This requires offering clinical services that support communication in combination with addressing social needs. For example, while providing medical care with skilled interpretation support, clinicians can include social prescribing¹⁴⁷ – or addressing social needs through direct clinical connection to services, such as legal,¹⁴⁸ immigration,^{149,150} income support,¹⁵¹ and housing.¹⁵²

Recommendations for interventions at the meso level

Given the existing baseline of communication as a core competency for physicians in the U.S. and Canada, accreditation bodies can correct their discriminatory omission to include communication with people who speak non-official languages in their training and evaluation of trainees. Learning about the minimum standards for communication and risk mitigation without including teaching on routine use of appropriate medical interpretation – with attention to structural competency (identifying and adapting to converging social structures)⁴⁷ – both engenders and reinforces systemic acceptance of a second tier of care for people speaking languages that are not concordant with their clinicians. This inequity, and related medicolegal risk, is avoidable by expanding the communication competency to encompass an understanding of the realities of im/migrant patients, and adopting a culturally humble approach to reclaiming the responsibility of communication.^{129,146,153–155}

Alongside clinical interventions, our findings confirm that implementation of these approaches requires appropriate systemic supports, which start from system-wide

provision of professional medical interpretation,⁶¹ and workplace norms endorsing its routine use.¹⁰² Further, it requires building competency within the full spectrum of health care workers in using an intersectional approach to inform how, when and why to use different modes of interpretation. With an understanding of how converging structures such as gender, im/migration status, and class create a unique set of challenges, they can support communication to mitigate these effects. Corresponding training for interpreters or other language-concordant providers beyond medical terminology that includes components of Trauma Informed Care and cultural humility would reach essential contextual factors beyond language concordance. This recommendation joins other work invested in utilizing an understanding of structural determinants of health to develop and implement effective health interventions to mitigate harms experienced by marginalized people.^{121,145,148,156}

Participants themselves advocated for universal language and communication support at baseline, but also linked this to social participation (e.g., volunteer conversation programs) and opportunities for mutual support within their communities. Given that programs of this type have existed in piecemeal and pilot form for decades in Canada, we recommend that health providers and policy makers support systematic implementation of low-barrier, community-responsive language classes with stable funding, for all im/migrants regardless of immigration status, wherever im/migrants reside.

Recommendations for interventions at the macro level

Implementing these micro and meso level interventions both lays the groundwork for and benefits from a structural environment that incorporates im/migrant realities. While policies and legal frameworks often fail to correct inequities without broader structural change,^{50,157} developing health professional standards or policies may provide a helpful standard by which to guide system-wide adoption of im/migrant communication norms.¹⁵⁸ Further, strengthening policy development to attend to structural determinants of health through a Health in All Policies approach may be one avenue to improving government initiatives across sectors and reducing linked health and social inequities,^{159,160} such as those described in this research. Likewise, current and new health

policy and health services research can be reviewed with an anti-oppression lens to avoid reproducing structural and health inequities.¹⁶¹ Enacting these health policy developments might move Canada towards a meaningfully universal system,^{162,163} one that operates with an ethic of care extending to all who reside here.¹⁶⁴

Recognizing that policy development and implementation can be lengthy processes and limited by silos and institutional dynamics,¹⁵⁷ immediate consideration of community-based initiatives that cut across multiple levels of intervention is warranted. For example, a program grounded in understanding the convergence of limited English proficiency, migration, gender, and racism could look like training and funding of multi-lingual, multi-cultural doulas to support prenatal care and births for women speaking non-official languages, with no im/migration status requirement for entry. This type of program uniquely provides both an opportunity to offer flexible and competent language support as well as challenge racism and discrimination within birthing experiences.¹⁶⁵ Similarly, grassroots and community-led organizations that originate from im/migrant communities could be funded and scaled to work within the health care system. Examples of locally implemented culturally responsive¹⁶⁶ and community-engaged¹⁶⁷ models include a health cooperative with cross-cultural health brokers¹³¹ and a peer-support program for African im/migrants living with HIV.¹³² Expanding community-led models would directly develop services that already respond to im/migrant women's converging communication and social realities, as well as increase the capacity of the system to train clinicians in settings providing equity-oriented care, including structurally competent and trauma and violence informed care.¹³⁰

5.4.3. Directions for future research

These recommendations provide a basis for further research evaluating novel forms of interpretation provision, or outcomes of incorporating communication in non-official languages as a structural determinant of health into new or existing models of care. While evaluation research can guide effective implementation efforts, scale up of existing effective programs (e.g., grassroots programs developed by im/migrant communities) and system-wide funding and support for accepting responsibility for

communication in health care settings is currently appropriate and urgently needed for people speaking non-official languages. Further, the approach integrating intersectionality linked with structural determinants of health in health services design is widely applicable, and relevant for any im/migrant with communication needs. In the context of increasing resettlement of refugees experiencing persecution based on sexual orientation or gender identity, these same approaches are critically needed.^{168,169}

5.5. Conclusion

While considerable research has documented negative health outcomes of ‘language barriers’ for im/migrants in destination countries, this thesis addresses a crucial gap in the literature by examining communication with limited English proficiency and experiences with interpretation services through a unique structural and intersectional lens. This research, grounded in im/migrant women’s voices and priorities, provides evidence-based recommendations for health interventions that move beyond the individual-level towards systemic, equity-oriented change.

Using qualitative data illustrating the lived experiences of marginalized im/migrant women and service providers in Metro Vancouver, BC, this thesis revealed how unmet communication needs for im/migrant women operated as a form of systemic discrimination. Responsibility for communication often rested on im/migrant women, relegating them to a second tier of care; jeopardizing their privacy by requiring them to provide their own interpreter, which was particularly problematic in the context of sexual and reproductive health care.

Ultimately, this project found that beyond language as a ‘barrier,’ the Canadian health system’s failure to adequately address the communication needs of im/migrant women interacted with poverty, im/migration status, and gender in ways that constrained their health access and subsequently health outcomes. This further entrenched their income inequality, and suffused their daily lives with discrimination, all worsening the injustices they faced – and which they resisted with great effort. To address inequities faced by im/migrant women speaking non-official languages within the healthcare

system, holistic models of care that go beyond availability of language-concordant options towards im/migrant-sensitive models that address uniquely converging effects of speaking a non-official language, im/migration status, systemic racism, income inequity and gender are needed.

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