

**Im/migration experiences, healthcare access, and
impacts of the COVID-19 pandemic: Findings of
community-based qualitative research with
im/migrant women in British Columbia, Canada**

by
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Abstract

This dissertation uses qualitative and community-based research to explore women's im/migration and healthcare experiences during and beyond the COVID-19 pandemic in the lower mainland of British Columbia, Canada. The research specifically focuses on the experiences of two populations that have been underrepresented in im/migrant health research: women with precarious im/migration status, and younger im/migrant women. More specifically, this dissertation interrogates the role of structures and processes of marginalization through three distinct studies of im/migrant women's lives. I do this by 1) examining how migration experiences shape women's access to healthcare; 2) exploring how im/migration shapes young women's experiences of pregnancy, motherhood, and marriage; and 3) investigating the impacts of shifts in health service delivery made early during the COVID-19 pandemic on young im/migrant women's access to sexual and reproductive healthcare. The research in this dissertation is conceptually underpinned by a framework that brings together intersectionality theory, a migration process framework, the structural determinants of health, and a framework for patient-centered healthcare access. I emphasize personal experience, interpretation, and knowledge shaped by im/migrant women who led, participated in, and collaborated on all stages of the research. Im/migrant women's descriptions of healthcare needs and experiences of seeking and using care for sexual and reproductive health, mental health, and chronic conditions illustrate how healthcare access is shaped by multiple experiences. These include experiences at origin, during travel, and in transit settings; experiences of unplanned pregnancies and unequal gendered power dynamics; and the transition to virtual health services and restricted in-person care early during the COVID-19 pandemic. Together, these findings present important understandings of im/migrant women's experiences and critical areas for action within Canada's im/migration, health, and employment systems. The research highlights the dynamic nature of im/migrant lives and the need for efforts that are context specific. Ultimately, this dissertation demonstrates that all people, including im/migrant women, deserve to live full lives, have their needs met, and thrive with optimal health and well-being.

Keywords: im/migration; healthcare access; women's health; COVID-19; community-based research; qualitative research

*For all im/migrant women who continually pave the way for our
communities and families to thrive*

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List of Acronyms

BC	British Columbia
GCM	Global Compact for Migration
IRIS	Evaluating Inequities in Refugee and Immigrants' Health Service Access
MSP	Medical Services Plan
PIRS	Pacific Immigrant Resources Society
SFU	Simon Fraser University
SRH	Sexual and Reproductive Health
TA	Thematic Analysis
TFW	Temporary Foreign Worker
UBC	University of British Columbia
WHO	World Health Organization

Prologue

I am a cisgender, heterosexual woman of Indian origin, and an immigrant and settler in what is now known as Canada. I live and spend time on the traditional, unsundered and stolen lands of the Sk̓wx̓wú7mesh Úxwumixw (Squamish), Səlilwətaʔt (Tseil-Waututh), Qiqéyt (Qayqayt), S'ólh Téméxw (Stó:lō), Stz'uminus (Chemainus), and X̣wməθkʷəy̓əm (Musqueam) Nations. I have deep respect for the teachings of these lands and its owners and understand that my migration is an impact of settler-colonial practices, including division imposed by borders that has displaced Indigenous communities. At the age of 18, I arrived in Canada as an undergraduate student and permanent resident with English fluency and no sexual health education. I know the experience of controlled movement as a young woman who was born and raised as an immigrant in Abu Dhabi, United Arab Emirates, where my temporary immigration status was tied to my father's work permit. I also know economic, immigration, language, and educational privilege. My first language is English, and for most of my life, I was financially supported by two working immigrant parents. Their employment allowed our family to stay in the United Arab Emirates and provided me with the means to pursue higher education and a more secure life in Canada.

Despite being unable to obtain citizenship in the United Arab Emirates, my family and I lived a privileged life. Our access to healthcare was supported by my parents' employment and accompanied by out-of-pocket payments possible because of salaries that remained consistent for most of our time there. In my teens, however, some of our experiences raised questions for me. Would we all have to leave the country if my father lost his job? Why did my parents encourage me to let children with citizenship have their way when they were being mean? Why was I told not to speak ill of the government, especially in public? These were questions directly linked to unequal power and precarious immigration status, although I didn't know it at the time. I also had questions around the stigmatization of sex and sexual health, including "why did we skip over the reproductive system in biology class?". When I lived in Abu Dhabi, sexual health education was not permitted, pre-marital sex was illegal, and identifying as a member of the LGBTQ community was criminal. Despite these injustices, I was able to comfortably complete high school in 2013 and moved to Nova Scotia soon after to pursue higher education. My arrival experience involved navigating isolation, discrimination, and

barriers to healthcare with privilege in language, immigration status, and class – intersecting identities that continue to give me security and safety in British Columbia today. This means that in most circumstances, I receive healthcare when needed; however, I have also been refused care because of my assumed cultural background, faced judgment based on my age and gender identity, experienced harassment in healthcare and other settings, and often felt neglected by the health system.

The lens through which I study, work, and see the world today is shaped by my experiences, identity, and the strongest aspects of my culture and upbringing. Over the years, I have strengthened this lens with the wisdom of Indigenous communities to believe that knowledge is co-created. My most critical learning is their creation of principles for respectful engagement in research with communities - Respect, Reciprocity, Relevance, Responsibility. While these principles inform my PhD research, they were not always centered in my public health background and have been challenging to attend to within colonial academic institutions. While I reflect on the ways in which my personal and community experiences conflict with my academic experience, the values of Respect, Reciprocity, Relevance, and Responsibility are central in the lens through which I learn, think, and act in community-engaged research with immigrants.

Chapter 1. Introduction

In this dissertation, I use a community-based research (CBR) approach to explore immigrant women's health and healthcare access. I describe women's migration journeys, the health experiences of young immigrant women and women with precarious immigration status, as well as their experiences of healthcare access early during the COVID-19 pandemic. Using principles of CBR, each analysis is built upon respectful relationships, honest conversations, and collaboration with immigrant communities to support nuanced understandings of immigration, health, and healthcare access. In this dissertation, I attend to personal experience, interpretation, and knowledge shaped by immigrant women through leadership and participation in the development of research materials, data collection, and analyses; the co-creation of clear, accurate dissemination products; and knowledge translation and exchange. An example through which this took place is the use of participant quotes and cases, which helped make lived experiences of injustice and inequities in immigrant women's health and healthcare access more visible.¹ Participant cases play an important role in creating empathy and compassion, which is necessary in attending to issues of power, social justice, and equity,^{2,3} as well as spurring action by way of human connection.⁴ The lead authors of each analysis, including myself, are self-identified immigrant women with research lenses informed by migration, health, and healthcare experiences both similar to and different from those shared by participants. I recognize my privilege and power as a researcher *and* immigrant woman and chose to work closely on this dissertation with other immigrant women both within and outside of academia to co-create findings that center participant experiences and incorporate critical, yet underrepresented, immigrant perspectives.

1.1. Situating the research: Im/migration in Canada

In this dissertation, I use the term 'im/migrants' to include immigrants and migrants who have lived in destination settings for short and long periods of time, who arrived through different migration pathways, and who have permanent and precarious im/migration status, the latter of which includes people with temporary and without immigration status.⁵

I cannot write about im/migration in Canada without speaking to the country's colonial history, especially given its ongoing impacts. Borders that now define Canada and run through Indigenous nations were created through colonization by European settlers. Despite resistance, this division by borders displaced, dispossessed, and marginalized Indigenous communities, and led to inequities that continue to impact their health, housing, food security, and more.^{6,7} Today, international borders continue to be used to regulate entry and exit through travel documents and screening, where people moving across borders permanently or temporarily, many of whom may have been Indigenous to their own lands, are known as immigrants and migrants in Canada.⁸ This movement, although controlled, benefits and reinforces settler-colonial structures and practices in Canada that can contribute to both opportunities and challenges related to safety, financial circumstances, housing, and more.^{9,10} However, it is also related to global colonial processes that have displaced communities in other countries, including resource extraction, political tensions, and financial dominance by imperial countries¹¹ that have, in turn, contributed to climate-¹², war-¹³, and economic-related migration.¹⁴

Given Canada's colonial history, the country's im/migration patterns are heavily marked by systemic racism and xenophobia. Early trends in Canada reflect strategies that involved the colonial government attracting white im/migrants from Europe and America by providing them with stolen Indigenous lands to settle in and advance the economy through farming.⁶ In the 1800s, as white settlers arrived in Canada, Indigenous communities were displaced and confined to reserves.⁶ The 1800s were also marked by the construction of the transcontinental railroad, where im/migrants from China endured precarious and exploitative labour, as well as the head tax that required each im/migrant of Chinese origin to pay a fee.¹⁵ After profiting from a policy that aimed to discourage Chinese im/migrants from entering Canada, the government prohibited their im/migration for 10 years.^{15,16} Similarly, as soon as im/migration from South Asia to Canada began to increase in the late 1800s, their entry was banned.¹⁷ Overt discrimination continued to dominate the mid-1900s, when the government encouraged European im/migration while deporting Japanese Canadians.^{16,18} Im/migration from Japan was only allowed 20 years later after the points-based system was established – an effort to restrict im/migration while assessing people's entry based on age, English language fluency, and qualifications.^{16,19}

While 1962 marked the end of *explicit* racism in Canada's im/migration system, where im/migrants were chosen based on race, ethnicity, or place of origin, structural racism continued to be covertly embedded in programs and policies that still exist today. The Temporary Foreign Worker (TFW) program began in 1973 and supports employers in hiring primarily non-white people living in other countries to temporarily im/migrate to Canada to work in positions unoccupied by Canadian citizens.²⁰ As the TFW program was established only six years after the points-based system, it is no coincidence that the 1970s saw the largest number of non-European im/migrants for the first time in Canada's history.¹⁶ By the mid 1980s, more im/migrants were temporary residents than permanent residents.²¹ Despite this, the TFW program continues to be used to boost the country's economy while restricting im/migration and exploiting people to provide cheap temporary labour. The points-based system continues to be weighted towards privilege, providing permanent residency through ableist practices that are designed to benefit the im/migration system over im/migrants themselves. Both programs continue to neglect im/migrants' rights, health, and well-being.^{22,23} Temporary im/migration programs have become a central feature of Canada's immigration system and continue to expand.²⁴ Decades of advocacy to uphold health and human rights of people with precarious im/migration status have led to important promises and potential for change,^{25,26} including the Canadian government's recent commitment to develop a pathway to permanent residency for workers without official im/migration status.²⁷ However, this is taking place after years of exclusion of people without official im/migration status, who have experienced no entitlements to workplace protection, mobility rights, or access to health services.^{28,29}

Today, international im/migrants make up over 272 million of the world's population, almost half of whom self-identify as women (48%).³⁰ Canada remains a top destination country for im/migrants globally, where one in five women is an im/migrant.³¹ Recent im/migrants aged 15-34 make up the highest proportion of im/migrants in the country (20%)³². British Columbia (BC) is also a top destination province for im/migrants, where im/migrant women comprise over 25% of residents^{33,34} and over half of people aged 15-24 in Vancouver are racialized (53.6%).³⁵ Federal immigration targets in Canada continue to increase; in fact, the government's plans for the years 2022-2024 include the country's highest targets in im/migration history – an expected 430,000-450,000 permanent residents are to arrive annually.³⁶ However, people will also arrive

with other, more precarious im/migration statuses and live as temporary foreign workers, visitors, international students, without official im/migration status, and without the healthcare, mobility and employment rights associated with permanent residency and citizenship.^{5,37,38}

Given the ways in which systemic racism and colonial practices form the basis of im/migration and health policies, programs, and trends in Canada, the expected increase in the country's im/migrant population may also be accompanied by heightened precarity and oppression related to health and healthcare access. Understanding Canada's colonial and im/migration history is important as many of these processes and practices continue to exist and underpin im/migrant health and healthcare access experiences. In this dissertation, when thinking about why and how people experience opportunities and inequities in health and healthcare access today, I find it helpful to draw on this history to understand im/migrant experiences, health equity, and social justice.

1.2. Im/migrant health equity: A matter of social justice

During my MPH, I read a study on Canadian health workers' perceptions on whether people with precarious im/migration status deserved universal healthcare. The findings stood out to me as they included two opposing arguments built on very different values. Participants who were against universal access to healthcare drew on ideas of insecurity, exclusion, and individualism to explain that people without official im/migration status did not respect Canada's im/migration policies and processes, and that their lack of tax contributions would strain health resources.³⁹ On the other hand, participants who supported universal access to healthcare drew on principles of public health, social justice, compassion, and human rights to explain that Canada had a moral obligation to provide healthcare to every person that needed it. They also explained that restricting access to healthcare would contribute to a greater financial burden on the health system than adopting preventative approaches like universal healthcare.³⁹ Ultimately, these arguments were based on what different health providers considered to be fair.

This dissertation is based on the idea that all people, including im/migrants, deserve to live full lives, have their needs met, and thrive with optimal health and well-being, which aligns with sustainable development discussions of health as a legal right and matter of social justice.⁴⁰ However, this community-based research – rooted in the

lived experiences of im/migrant women – demonstrates how inequitable access to healthcare among im/migrants is aligned with the injustice embedded in Canada's colonial and im/migration history and ongoing operations. To achieve im/migrant health equity means that im/migrant communities must experience no unfair differences in opportunities to achieve optimal health, including accessing healthcare – that is, they must experience no preventable health disparities.⁴¹ This, however, is far from our reality. Previous research suggests that im/migrant communities face severe inequities in health and healthcare access that stem from exclusionary and discriminatory structures related to health, im/migration, labour, and more. This includes Canadian im/migration policies and practices including visa restrictions, deportation and detention, and border policing¹¹, implemented to serve the economy at the expense of im/migrant health and well-being. Despite this, however, the links between im/migration policy and health have not been explained in detail. In this dissertation, and particularly in Chapter 2, I discuss *how* im/migration control has contributed to unsafe migration^{42–44} and resulted in poor physical and emotional outcomes related to health and healthcare access.^{45–48} Health and healthcare access inequities among im/migrants are specific and preventable, yet still impede the fight for social justice – a core value of public health.

The argument that universal healthcare access would strain healthcare funds is not new, yet deeply flawed and neglects basic human rights. Years of evidence demonstrate the ways in which re-allocating healthcare spending to the social determinants of health would support both health system efficiency and health equity.^{49–51} Moreover, an increase in healthcare spending and resources by way of additional tax contributions will not contribute to better health outcomes and access if it is not allocated in equitable ways, as is the case with education^{52,53} and childcare^{54–56} as well. Despite the popularity of economic arguments, however, the issue of universal healthcare access is fundamentally an issue of justice. Social justice demands action to protect the human rights of those most marginalized, including within im/migrant communities, and the Canadian government's historical inaction in this area has sent a public message that im/migrant needs and rights do not matter as much as those of people born in Canada. Health is a human right, and health equity requires a commitment to improving the health and healthcare access of those most marginalized and with the greatest needs. We have recently seen this commitment at a systemic level in Canada, where the federal government plans to develop a new program to help undocumented workers

obtain permanent residency in Canada;²⁷ however it is unclear when this program will be developed or how many workers will receive permanent residency. Concrete action is needed to support all im/migrants.

1.3. Im/migrant health, healthcare access, and gendered inequities among women with precarious im/migration status

In this dissertation, I focus on the experiences of health and healthcare access among self-identifying im/migrant women. Experiences of health and healthcare access are multilayered, heterogeneous, and complicated by the converging impacts of im/migration status, gender identity, sex, socioeconomic status, health policies, and other social and structural determinants. However, im/migrant health research in Canada has often overlooked this heterogeneity. For example, studies have emphasized culture and behaviour to explain better health outcomes among economic immigrants upon arrival compared to the Canadian-born population, also known as the *Healthy Immigrant Effect*, followed by poorer health outcomes over time.⁵⁷ This line of research ignores and misrepresents the diversity in im/migrant health experiences in its focus on economic immigrants. It focuses primarily on non-communicable health outcomes. Most importantly, it provides little attention to the role of structure in informing im/migrants' health outcomes and experiences, focusing instead on explanations tied to culture and behaviour. For example, the *Healthy Immigrant Effect* in Canada is shaped by an im/migration policy that requires economic immigrants to undergo medical examinations to prove themselves sufficiently healthy to work without posing a "strain" on health services.^{58,59} This, however, is not the case for all im/migrants. The im/migration of refugees and asylum seekers, for example, is prioritized based on an urgent need for protection.^{60,61} Therefore, many arrive with serious healthcare needs that are further complicated by low socioeconomic status and, for people with precarious or no im/migration status, exclusion from health services.^{62,63} Despite this, recent studies of im/migrant women's health and healthcare access in Canada continue to focus on economic im/migrants⁶⁴ or provide little attention to the role of im/migration status and experiences in shaping health outcomes⁶⁵. By not attending to the experiences of people with precarious im/migration status, we miss opportunities to understand the intentional

ways in which factors like im/migration and socioeconomic status are systemically linked to shape opportunities and inequities in health and healthcare access.

In this dissertation I explore how different factors may be linked to exacerbate barriers or enhance opportunities in healthcare access for different im/migrant communities. For example, as im/migration policies and processes are inherently gendered, we must consider gender identity in attending to precarity in health and healthcare access among im/migrant women. Previous im/migrant health research has demonstrated the ways in which gender identity, roles, and power dynamics; im/migration status; and employment are systemically linked to shape precarity and security in im/migrant lives and well-being. This is visible in the experiences of im/migrant men and women farmworkers,^{66,67} im/migrant women caregivers,^{68,69} and transgender im/migrant sex workers,^{70,71} for example, all of whom hold gendered, precarious occupations that contribute to gendered inequities in health and healthcare access. It is also visible in the experiences of women whose im/migration and financial status is tied to their spouse through im/migration sponsorship programs, further shaping precarity and security in well-being.⁷²⁻⁷⁵

The World Health Organization (WHO) defines gender identity as the socially constructed characteristics of women and men;⁷⁶ however, this dichotomous representation fails to recognize the different and fluid ways in which people identify and express their gender. Social sciences research has often similarly treated gender identity as a binary, leading to potential misrepresentation and inaccuracy in people's experiences, as well as the neglect of experiences of people who identify as Two-Spirit, transgender or non-binary.⁷⁷ The concept of gender identity, however, was not always dichotomous; within countries in Africa, Asia, and North and South America, fluid understandings of gender were and continue to be embraced by Black and Indigenous communities and people of colour.⁷⁸ The binary, which erased and invalidated gender identities beyond man and woman, is rooted in European colonization and Christian views.^{79,80} Since then, however, this division has resulted in an additional, gender-based form of oppression, particularly towards people of colour. Cisgender white men hold the most power, followed by cisgender white women, leaving women of colour and transgender and non-binary communities at the bottom of the social hierarchy. Patriarchy, misogyny, and discrimination against transgender and non-binary

communities continue to exist in roles, practices, and policies related to labour, health, and more.⁷⁸

Just as there are many reasons to understand the experiences of im/migrant men or non-binary persons, there are several reasons to focus on the experiences of im/migrant women. In this dissertation, I do not compare health and healthcare access across gender identities, but I consider how self-identifying as a woman shapes these experiences through gendered roles and power dynamics. This was a decision I made based on the data that was available to me, which solely included the health and healthcare access experiences of self-identified women. In this dissertation, therefore, the aspects of gender most important to the research are self-identified gender identity and social gender. I operationalized self-identified gender identity as fluid,⁷⁷ but understand that all participants self-identified as women during the time they were interviewed, as this was an eligibility requirement for participation. Social gender depicts how gender identity shapes norms, opportunities, and power, which vary across time and context.⁷⁷ In this dissertation, I operationalized social gender by exploring how identifying as a woman shaped participants' experience of migration (Chapter 2); experiences of pregnancy, parenthood, and marriage (Chapter 3); and experiences accessing sexual and reproductive health (SRH) care during the COVID-19 pandemic (Chapter 4). Assigned sex is also an important concept in this research, which I recognize and understand is a label determined at birth by medical factors including genitals, chromosomes, and hormones, and is distinct, yet related, to gender identity.⁸¹ It is related in that both assigned sex and gender identity have implications on the types of services that people need and desire. Understanding how these concepts are distinct shapes the accuracy of research and effectiveness of proposed interventions, particularly for marginalized communities including women, trans, and non-binary im/migrants.

During my MPH, I worked with several people to conduct a review of inequities in and determinants of im/migrant women's access to SRH care in Canada.⁸² The review shed light on serious processes of marginalization related to experiences of gender and race-based discrimination, few rights associated with precarious im/migration status, and insufficient consideration of cultural and linguistic needs across health services. Importantly, this review was the first to our knowledge to highlight heterogeneity in SRH care experiences among im/migrant women with different im/migration statuses and

experiences; for example, while asylum seekers had temporary health insurance coverage upon arrival, women without official im/migration status faced severe barriers to healthcare, including fear of deportation, no health insurance coverage, and unaffordable health services. Accompanying the important findings in this review, however, was the underrepresentation of the experiences of women in BC, specifically younger women, women without official im/migration status, and women seeking asylum.⁸² These gaps in research informed and continue to be addressed by the Evaluating Inequities in Refugee and Immigrant Health Service Access (IRIS) project – a longitudinal, community-based, mixed-methods study of im/migrants’ access to health services in BC, within which this dissertation research is nested. Using IRIS data, this dissertation, therefore, aims to understand in more detail the health and healthcare access experiences of im/migrant women in BC, particularly younger im/migrant women (Chapters 3 and 4) and women with precarious im/migrations status (Chapters 2, 3, and 4). This is done to support the inclusion and understanding of im/migrant experiences and voices in research, as well as to inform responsive interventions.

1.4. Research early during COVID-19 pandemic

As was the case with most marginalized communities globally, the beginning of the COVID-19 pandemic in Canada came with serious concerns of exacerbated health inequities among im/migrants,^{83–85} however, in the early stages, there was little research on how im/migrant women’s access to healthcare was impacted. Im/migrants’ overrepresentation in frontline jobs and precarious occupational and housing environments⁸⁶ placed them at increased risk of contracting COVID-19, experiencing exploitation and violence, and facing barriers to healthcare. Im/migrant women also represent a large proportion of healthcare workers, caregivers, and domestic workers, who play essential roles during and outside of the COVID-19 pandemic and are disproportionately impacted by these risks. Furthermore, increased rates of domestic violence during lockdowns and COVID-19 isolation periods demonstrated that accessing health services may have been particularly difficult for survivors of intimate partner violence whose im/migration status was tied to an abusive partner, creating unique barriers to help-seeking resulting from restrictive im/migration policies and unequal gendered power dynamics.^{72–75}

In the province of BC, several temporary changes to health and immigration policy were implemented during the COVID-19 pandemic, including the elimination of the three-month wait period for provincial health insurance in March 2020 and coverage for COVID-19 related care for some uninsured im/migrants⁸⁷. When these changes were revoked in July 2020, however, there were reports of serious concerns with regards to health service access among im/migrant communities. These included a lack of health insurance and out-of-pocket payments for healthcare, as well as barriers to virtual care related to language, access to technology, and crowded households. Initial impacts of the COVID-19 pandemic have highlighted that im/migration and health policies do not prioritize the needs of im/migrant communities. In fact, urgent needs have often been met by im/migrant-serving community-based organizations as opposed to Canada's im/migration and health systems.^{88,89} However, little is published about how shifts in health service delivery and im/migration processes during the COVID-19 pandemic may have specifically impacted the healthcare access of im/migrant women, particularly younger women and women with precarious im/migration status. As COVID-19 is here to stay and virtual healthcare options increase, Chapter 4 aims to understand how health and healthcare access experiences are different for different groups of im/migrant women, as well as how they are shaped by health policies, the im/migration system, and workplace environments. It is my hope that with this understanding, informed efforts may be made to situate im/migrant women's experiences within the context of im/migration, labour, and health, and appropriately respond to healthcare needs during and beyond the COVID-19 pandemic and within these different domains.

1.5. A framework for im/migrants' healthcare access

A migratory process framework,⁹⁰ the structural determinants of health,⁹¹ and intersectionality theory⁹² have all shown promise for promoting understandings of im/migrant health and healthcare access, but we lack a single conceptual framework that incorporates these approaches. Conceptual understandings of healthcare access have given little attention to how im/migrant experiences, the migration process, and structural factors shape healthcare access⁹³⁻⁹⁶. Understanding experiences across the different stages of migration, how they evolve over time, and how they impact health is important to depict im/migrant lives more accurately, as well as support responsive healthcare experiences.

As part of my PhD comprehensive exam, I developed a conceptual framework of im/migrants' access to healthcare (Figure 1) that informs my dissertation research. The framework was informed by a review of peer-reviewed qualitative and conceptual research from 2010-2020 that used a migratory process framework,⁹⁰ the structural determinants of health,⁹¹ or intersectionality theory⁹² to understand im/migrants' healthcare access. The research in this dissertation was guided by this novel framework to explore im/migrant women's access to healthcare, including the role of migration experiences and the specific experiences of young im/migrant women and women with precarious im/migration status prior to and during the COVID-19 pandemic. The framework builds on prior conceptualizations of healthcare access, which often lacked nuance around im/migration factors and focused on specific health issues. Additionally, few studies have included people with temporary im/migration status and younger im/migrants. For example, Andersen's model of healthcare access has been adopted by many researchers and evolved over the years⁹⁵, but does not account for im/migrant experiences, including those related to migration journeys and im/migration status. Its use in im/migrant health research has primarily focused on individual factors and healthcare needs as opposed to structural factors and their impacts on healthcare access^{97,98}. The conceptual framework that informed this research focuses on how im/migrants' healthcare access is shaped by structural factors related to health, im/migration, and the workplace, as well as intersecting processes of marginalization.

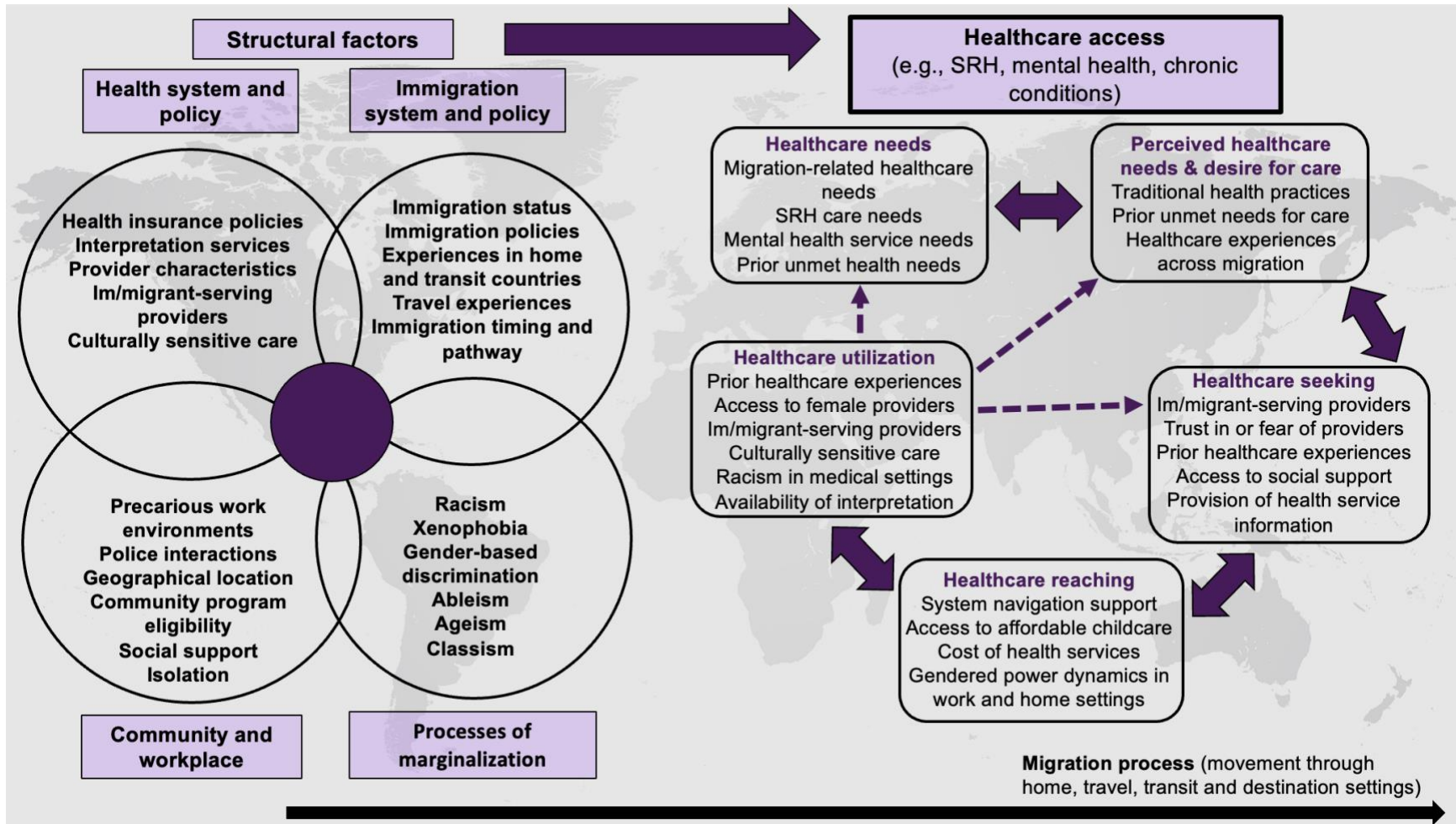


Figure 1. Conceptual framework of im/migrants' healthcare access

This framework is theoretically underpinned by Levesque et al. Patient-centered access to healthcare: IJEH. 2013; Crenshaw. Mapping the margins. Stanford Law Review. 1991; Stonington et al. Case studies in social medicine – Attending to structural forces in clinical practice. Medicine and Society. 2018; International Organization for Migration. Social determinants of migrant health. 2017

Intersectionality and the structural determinants of health

This conceptual framework was informed by the structural determinants of health and intersectionality theory – the combination of which can help explain the ways in which different structures interact with processes of marginalization to shape inequities and opportunities in health and healthcare access. The structural determinants of health build on the social determinants of health, and shift focus towards the structures that shape a person's income level, employment, and access to health services, for example.⁹¹ Coined in 1989, intersectionality theory builds on concepts developed by Black feminists and race and civil rights activists to attend to the cumulative effect of intersecting forms of marginalization in informing people's experiences.⁹² Crenshaw developed this theory to attend to the oppression of Black women who experienced discrimination based on both race *and* sex. As legal courts adopted a narrow view of discrimination that only considered single issues (i.e., race *or* sex), Crenshaw used intersectionality to explain why a combination or *intersection* of the two is needed to identify and address experiences of oppression.

In this dissertation, Figure 1 combines the structural determinants of health and intersectionality theory to explain interactions between health, im/migration, labour structures, and processes of marginalization, and attend to the impacts of these interactions on opportunities and inequities in im/migrant women's healthcare access. Visualizing the interactions between structures and processes of marginalization also helps point to opportunities for interventions that intentionally consider the social locations of persons, and the structures that influence them.^{72–75,99–113} In the research conducted for this dissertation, this conceptual framework helped demonstrate how im/migrant women's experiences were informed by health systems and policies, including eligibility for health insurance, the availability of appropriate interpretation services, and the gender of providers; im/migration systems and policies, including im/migration status and experiences across migration; community and workplace environments, including access to social support and precarious labour contexts; and processes of marginalization, including experiences of racism and gender-based discrimination in health and other settings. An intersectional and structural framing of im/migrant women's healthcare access was essential to support a more comprehensive understanding of im/migrant women's experiences.

Healthcare access

The conceptual framework that informed the research in this dissertation is primarily shaped by Levesque et al.'s framework for patient-centered healthcare access,⁹⁶ which is conceptualized by (i) healthcare needs, (ii) perceived healthcare needs and a desire for care, (iii) healthcare seeking, (iv) healthcare reaching, and (v) healthcare utilization. Levesque et al.'s framework helps break down understandings of healthcare access into intermediate stages, recognizing that having healthcare needs or a desire for care alone is insufficient to utilize appropriate healthcare, for example. However, while the authors portrayed this process as linear, the framework in Figure 1 depicts a more cyclic process, where negative experiences during healthcare utilization, for example, may prevent appropriate healthcare access and create additional barriers to healthcare seeking and a desire for future care. The framework was adapted to attend to intersectionality at intermediate stages, including how healthcare experiences may be different for younger im/migrants and people with precarious im/migration status.

Migration process

Finally, this conceptual framework focuses on how experiences across migration shape im/migrant women's healthcare access^{45,46,48}. The migration process framework, published by the International Organization for Migration, highlights the importance of considering experiences in origin, travel, transit, and destination settings to better understand health outcomes. The framework considers migration as a spatial process with time being largely implicit, consistent with most research; however, we built on this to discuss movement and waiting across time and places¹¹⁴ – processes that are inherent to migration and often controlled by immigration systems. Recent evidence has demonstrated the potential of a temporal focus in highlighting and analyzing the extended nature of inequities in health and healthcare access.⁴⁸ The research in this dissertation, therefore, conceptualized im/migrant women's evolving experiences through origin, travel, transit, and destination stages to understand how these experiences shape health and healthcare access. A focus on the migration process helped clarify how health and healthcare access evolves over time based on various experiences, including the loss of employment or delays in im/migration status processing due to the COVID-19 pandemic.

1.6. The IRIS Project

This research in this dissertation is nested within the Evaluating Inequities in Refugee and Immigrant Health Service Access (IRIS) project – a longitudinal, community-based, mixed-methods study of im/migrants’ access to health services in BC, Canada. IRIS holds ethical approval from the Simon Fraser University (SFU) and Providence Health Care/University of British Columbia (UBC) harmonized ethics review boards. I have been working on the IRIS project in a variety of roles since its inception in 2018, leading and participating in a variety of research activities.

IRIS aims to understand and generate recommendations for policies and programs that improve health, well-being, and access to health services for people who are im/migrants in BC, including (i) SRH services for women and (ii) COVID-19 related testing and care. The quantitative arm of the project involves analyses of confidential, linked health and immigration system data to understand health services use. The qualitative arm involves interviews with im/migrants and service providers with lived experiences, follow-up interviews, and active referrals to health and social supports. Both arms are guided by a community engagement framework (the “backbone”) that involves priority-setting and guidance at all research stages by community partners, collaborators, participants, and community advisory board members. The research in this dissertation focuses on the IRIS project’s qualitative arm and the aim that centers around the health, well-being, and access to health services for im/migrant women in BC, including SRH services, as described below.

1.6.1. Origins

The IRIS project began in 2018 and was informed by a review of literature that demonstrated inequities in im/migrant women’s SRH access in Canada. Following up on these findings, I, along the IRIS team, took time to build relationships and consult with im/migrants and service providers about the health service access of im/migrant women in Metro Vancouver. We did this by conducting five group consultations from September – November 2018; we used a short, semi-structured interview guide with high-level questions regarding priorities around im/migrant women’s healthcare access. These consultations took place in English, Farsi, Spanish, and Tigrinya. Three consultations were audio-recorded, while two involved notetaking by our research team. Building on

what we learned from these focus groups, the findings of our literature review, and in collaboration with community members, we developed the initial focus of IRIS: the SRH access and experiences of im/migrants who self-identified as women. By the end of 2018, the IRIS project was established and built on partnerships with local im/migrant-serving community organizations, including MOSAIC, Pacific Immigrant Resources Society (PIRS), Sanctuary Health, and Watari Counselling and Support Services (Watari), as well as a research team with im/migration experience and expertise in qualitative, quantitative, and health services research.

1.6.2. Team Roles

The IRIS project currently operates with the support of 8 distinct yet overlapping team roles: (i) administrative supports include people who schedule meetings and support budget management; (ii) community researchers include people who help bridge research with im/migrant communities by collaboratively conducting data collection, supporting data analysis, and leading community advisory boards; (iii) principal investigators include people who support project operations, funding, and overall direction; (iv) project coordinators include people who support team functioning; (v) quantitative analysts include people who prepare quantitative data for team analysis; (vi) research assistants and collaborators include people who support the team with research processes; (vii) research associates include people who provide hands-on support for the qualitative and quantitative arms; and (viii) transcriptionists include people who translate and transcribe all written research documents (e.g., interview guides, summaries of findings) and interviews. Most IRIS team members have im/migration experience (through varied pathways), which informs data analysis and interpretation.

1.6.3. Community Relationships

The IRIS project currently has community relations at three levels with: (i) community advisory boards and participants, (ii) partners, and (iii) collaborators. These relationships were built over time and continue to be strengthened through respectful communication and collaboration. Community advisory boards currently function in four different languages (English, Farsi, Spanish, and Tigrinya) that support most of the languages spoken by participants. The communities that we work with are also

represented on the IRIS team - several of the advisory boards are facilitated by team members from the same community. This helps community members feel comfortable with participating in activities and ensures that community perspectives are represented throughout the research project. We also engage with all participants by requesting feedback throughout the stages of research. Participants can engage with the project as much as they choose to and in a number of ways described in detail below. Community partners include im/migrant-serving organizations that we regularly engage with: MOSAIC, Sanctuary Health, and Watari. Community collaborators include im/migrant-serving organizations that we occasionally engage with: Migrant Rights Network, Healthiest Babies Possible, MOSAIC Youth Services, Multi-Agency Partnership, PIRS, SUCCESS, and Umbrella Multicultural Health Co-Operative.

Respectful community engagement with im/migrant communities

“Community” within the IRIS project includes im/migrant participants, im/migrant team members, and community partners. Im/migrant team members and community partners collaborate on the development of research materials, data collection, participatory analyses, and privacy and confidentiality agreements; the co-creation of clear, accurate dissemination products; and knowledge translation and exchange. IRIS uses a CBR design to support cultural humility, transparent and respectful partnerships, and a collaborative process that involves im/migrants leading this research.

Community engagement within IRIS takes place at each research stage and involves a structured process led by a community engagement group. Each person leading a research paper is required to share a community engagement plan with the IRIS team to assess and provide feedback. Once finalized, team members who meet regularly to discuss community engagement within IRIS then provide support in implementing the plan. Community engagement plans generally include a timeline, research focus, community engagement goals, and activities or steps to carry out the plan. Team members also consider how they plan to engage with community members throughout their research to plan for team and community capacity and support. Within the IRIS project, there are three types of research in which we engage community members: (i) ‘new research’, (ii) ‘research in progress’, and (iii) ‘finalized research’. I engaged community members in this dissertation when the analyses were both new and finalized.

'New research' describes projects that are in initial stages, where most of the analysis has not yet been completed. Here, IRIS team members may consider hosting multilingual focus groups or community conversations to discuss the research area and understand community members' thoughts on the relevance of the topic. For example, for Chapters 2, 3, and 4, I invited community members to assist with developing research questions, analyzing data at various stages, and writing the paper.

'Finalized research' describes projects where most of the analysis has been completed. Here, IRIS team members may consider ways to prioritize collaboration with community members when disseminating research findings. For example, I shared the findings of Chapters 2, 3, and 4 with participants through multilingual short written summaries. I also organized discussions with community advisory board members to understand how and with whom they wanted to see the research findings shared. All three research papers included in this dissertation were finalized research projects that went through this community engagement process.

Regardless of the type of research within which I engaged community members, an important activity that is integrated in all community engagement plans within IRIS is the verification of quotes and pseudonyms in final products. This means I shared quotes or pseudonyms included in this research with participants' whose specific experiences were discussed. I then invited each participant to participate in a paid follow-up discussion to refine their contributions should they so wish. This protocol is intended to support a respectful process that prioritizes ongoing consent among participants. All quotes and pseudonyms included in this dissertation were vetted through this process.

The Community Engagement Backbone

Community engagement within the IRIS project involves engaging with community members across research stages with intentional consideration and communication around community capacity and needs. The community engagement backbone (Figure 2) is a diagram that community advisory board members and IRIS team members collaboratively designed to develop a visual representation of the project's commitment to community engagement. The backbone details the key values of the IRIS project, the project's commitment to community engagement at each stage of research, and concrete examples of activities that community members may participate in across the research process. This is aligned with the commitments, values, and

activities in this dissertation. The development of the backbone continues to be a collaborative effort between IRIS team members and community members, and is a living diagram that is subject to change based on evolving community and team needs.

Our Goals & Promises

Stages of Research

This document provides an overview of IRIS research processes and our commitments to community engagement at each stage. With this document, we aim to establish transparency, trust, and effective communication with community.





Figure 2. IRIS Community engagement backbone diagram

The team first introduced this visual representation for community engagement within IRIS in 2021. We proposed the idea of a backbone to demonstrate how community engagement processes are a central component of the qualitative and quantitative activities that take place within IRIS. As a first step to developing the diagram, we began by discussing the values that we felt were important to their work. These values included:

- Community and shared perspectives
- Collaboration
- Care
- Empowerment
- Transparency
- Respect
- Inclusion
- Listen
- Expression and identity
- Learning
- Co-existing power differences

To narrow down this list and identify a set of key values that would form the foundation of community engagement within IRIS, we repeated a similar activity early in 2022 to thematically group the values and choose three that felt most important. We identified three key values: **collaboration**, **respect**, and **relationship building**. Following this meeting, we worked to define the three values, as well as consider how grouped values could be integrated together. Below I discuss the results of these conversations.

Collaboration

The IRIS project is built on collaboration between IRIS team members, community members, and community partners. This means that we work to include community perspectives and advice at each stage of research. We also acknowledge

that power differences between the IRIS team and community members may exist. These power differences may be based on factors like:

- Race and ethnicity
- English fluency
- Im/migration status
- Education and research experience
- Payment from the research project to community members

We are committed to actively reflecting on these power differences and learning from community members to work towards more equal power-sharing.

Respect

We respect the diverse identities and experiences of the community members that we work with. We also respect community members' lived experiences with im/migration and prioritize creating opportunities for community members to share their knowledge throughout the research process. Through research built on community engagement, we aim to provide community members with formalized research findings that reflect their experiences and can inform community advocacy.

Relationship Building

The IRIS team is focused on building meaningful relationships with community members and the community partners we work with throughout the research process. We invite community advisory board members and participants to take on different roles throughout the research process. Some choose to use and develop skills they already have (e.g., sharing findings through social media, creating posters, etc.). However, we also offer training to support new skills so that community members can participate in research activities that are meaningful to them. Part of relationship building is reciprocity or giving back to people and communities we work with both within and beyond the scope of the IRIS project. We prioritize this by offering people and communities support outside the research project when we can (e.g., immigration application support or referrals to legal, health and social services).

Following discussions regarding the values that underpin the community engagement backbone, we defined our commitments and responsibilities to community

members at each stage of research (Figure 2). By engaging in reflective conversations about our responsibilities to community members, we considered how we could provide support beyond the research process and address power dynamics through care and capacity building. Examples of how community members could participate in the project resulted from these meetings, reflections around how community members have previously engaged with research activities, and discussions around new activities.

A draft backbone was first prepared by a small group of IRIS team members before being shared with the full IRIS team for feedback. Once this feedback was discussed and integrated, we shared the diagram with community members at the IRIS project's first multilingual community advisory board meeting in April 2022. Community members shared feedback on the backbone during this meeting, through direct conversations, and in writing via email and WhatsApp. This feedback was incorporated into subsequent versions of the community engagement backbone.

1.6.4. Recruitment

Recruitment in the IRIS project began in December 2018 and operates purposively and on an ongoing basis. This means that recruitment plans are routinely updated to support representation and variety in participant stories and experiences, as well as characteristics such as age, im/migration status, and time spent in Canada. From December 2018 – February 2020, eligible participants of the IRIS project were im/migrants who self-identified as women; moved to Canada from another country; were aged 15-49 (reproductive age); and provided informed consent. Recruitment of purposive samples of im/migrant women, including those with precarious im/migration status, was supported by personal and professional networks of our community-based research team. This was done by creating and sharing study posters with community partners and collaborators, as well as word-of-mouth.

1.6.5. Data Collection

From December 2018 – April 2021, we conducted semi-structured SRH interviews with im/migrant women, and from January 2019 – 2021 with health and social providers. These interviews were one-on-one, in-depth, and explored im/migration background, experiences with health services, and recommendations for service access.

Multilingual and multicultural im/migrant interviewers and team members conducted interviews in private settings within our research offices, in a place of participants' choosing, or virtually. Interviewers explained the purpose of the study, the voluntary and confidential nature of participation, and obtained written informed consent. Interviewers conducted all sessions in participants' preferred language (English, Dari, Farsi, Spanish, Tigrinya). Sessions were audiotaped and lasted 1.5-2 hours. After each interview, participants completed an interviewer-administered socio-demographic questionnaire to contextualize the sample. We gave all participants honoraria of \$40 CAD in recognition of their time, expertise, and travel; referrals to health, social, and legal support; and childminding support as needed. To date, we have conducted 76 SRH interviews with im/migrant women and 11 SRH interviews with service providers (e.g., social workers, physicians, nurse practitioners) in Dari, English, Farsi, Spanish and Tigrinya.

In February 2020, we found that few SRH interviews were conducted with im/migrant women below the age of 30. We met with community partners and collaborators that serve young im/migrants to inquire about their thoughts and suggestions for ways to respectfully engage and converse with younger im/migrant women. These conversations suggested that a combination of specific group and individual sessions may allow for greater comfort and safety among young im/migrants' participation, as well as elicit more in-depth responses. We created and shared a new recruitment poster with community partners and collaborators calling for participants aged 15-30 and recruited 11 additional participants. From August – November 2020, we conducted five one-on-one consultations and one focus group consultation with six participants, exploring young im/migrant women's SRH priorities and needs. Then, as changes in people's healthcare access became apparent early during the COVID-19 pandemic, we conducted follow-up interviews with 18 participants from July – August 2020. These interviews were conducted in English, Farsi, and Spanish with participants who participated in an SRH interview in 2019. Follow-up interviews asked participants how their access to healthcare, im/migration status, and other determinants of health changed since their previous interview.

1.6.6. Data Analysis

Analyzing data within IRIS involves a team-based, step-by-step process drawing on a reflexive thematic analysis (TA) approach,¹¹⁵ which I describe in more detail in this

section. Generally, when interviews and consultations are complete, we transcribe them verbatim; multilingual transcriptionists simultaneously translate and transcribe interviews and consultations conducted in respective languages. A team member who speaks the same language then accuracy-checks each interview transcript. We assign unique codes to participants and remove all personal identifiers from transcripts to ensure anonymity. We then load transcripts into NVivo V12 for analysis. Our NVivo project for IRIS includes a codebook that continues to be adapted based on interview themes and participant characteristics. Our first step in data analysis usually occurs as part of the coding process within the IRIS project. We developed an initial codebook in 2018 using inductive and deductive approaches and based on initial group consultations. Examples of codes included Healthcare Experiences, System Navigation, Pre-migration Experiences, and Economic Considerations. Over the years, we have iteratively adapted the codebook based on evolving participant characteristics and interview data. For each interview and consultation (one-on-one and focus group), we go through an initial round coding using an iterative, team-based process and a combination of inductive and deductive approaches using this codebook.

Once initial coding is complete, lead researchers working on a specific research analysis (e.g., myself working on the research in this dissertation) then draw on our community engagement backbone and Braun & Clarke's six-phase process for a reflexive approach to thematic analysis.¹¹⁵ While thematic analysis is a qualitative method for developing, analyzing and interpreting patterns in data through coding and theme identification, *reflexive TA* recognizes the need for researchers, including myself, to be subjective, situated, aware and questioning.¹¹⁵ While I continue to learn about reflexive TA with IRIS team members, I learned that my dissertation research process was well-aligned with this approach. The six-phase process for reflexive TA within the qualitative arm of IRIS and within this dissertation involves:

1. Familiarizing ourselves with the dataset: Within IRIS, we read through the data several times to get familiar with it and begin to make notes on our thoughts. At this stage, we check in with community members to ensure that research question(s) reflect the needs and priorities of the community. In this dissertation, I familiarized myself with the dataset and was in constant communication with im/migrant team members, friends, and family members. For Chapters 3 and 4, for example, I spoke with other young women about our shared and different

- SRH experiences as im/migrants and during the COVID-19 pandemic, which helped us identify research questions that aligned with relevant needs and priorities.
2. Systematically re-code and re-organize data: Within IRIS, we reflect on coded data and how it relates to our research question. At this stage, we begin to look for emerging themes based on the specific research question at hand. For each research analysis in this dissertation, I worked collaboratively with other team members, participants, and community researchers as co-authors to re-organize and re-code data that had already gone through an initial round of coding through team-based IRIS processes. We did this by focusing more closely on the research question at hand. For Chapter 2, for example, this involved re-organizing and re-coding data under the initial codes “Pre-migration Experiences”, “Travel and Transit Experiences”, “Arrival Experiences”, and “Settlement Experiences” to more specifically understand how migration experiences shape im/migrant women’s access to healthcare.
 3. Generate initial themes: Within IRIS, we summarize key points in the dataset and begin looking for patterns. We share these points with community members and frequently communicate to discuss how the themes resonate with their priorities, concerns, and experiences. In this dissertation, each research analysis involved me, as the lead researcher, regular meeting and communicating with co-authors (im/migrant team members, participants, community researchers) to co-analyze the data and look for patterns.
 4. Develop and review themes: Within IRIS, we review our analysis and the themes we have identified to ensure that they make sense in the context of the data. We also consult community members at this stage to verify themes and explore new ideas and approaches to the data. In this dissertation, to ensure that themes resonate with the priorities, concerns, and experiences of im/migrant women, I worked with co-authors and team members to share summaries of findings at regular IRIS Community Advisory Board meetings, where people of a variety of ages provided feedback in English, Farsi, Spanish, and Tigrinya.
 5. Refine, define, and name themes: Within IRIS, we refine themes by considering what they mean, what they should be called, and the relationships between them. We do this with regular input from community members. Like the previous

stage, in this dissertation this involved me working with co-authors and team members to refine, define, and name themes over a series of meetings and through regular communication. We also shared these themes at relevant IRIS Community Advisory Board meetings.

6. Write up: At this stage, within IRIS, we begin writing the research themes and pulling in relevant background information. The write up is a collaboration between IRIS team members and community members. In this dissertation, the level of collaboration in writing each research analysis varied based on individual capacity and interest. For example, I was the sole writer for Chapters 1 and 2, but had significant, regular, and detailed input from co-authors. Chapter 3 was written collaboratively by me and two participants and community researchers.

1.7. Research Objectives

The research presented in this dissertation explores the lives, im/migration, and healthcare experiences of im/migrant women that have been overlooked in previous studies, ending with an analysis that focuses on young im/migrant women's SRH care access early during the COVID-19 pandemic. This dissertation draws on a CBR approach to demonstrate how respectful relationships, honest conversations, and collaboration across research stages with im/migrant communities can contribute to more nuanced understandings of health and healthcare access.

The overall aim of this dissertation is to use qualitative and CBR methods to describe how im/migration, health and labour structures and intersecting processes of marginalization shape im/migrant women's health and healthcare access. The research also specifically focuses on the experiences of women with precarious im/migration status and younger im/migrant women – two populations that have been underrepresented in im/migrant health research to date. The specific research objectives of this dissertation were to:

1. To use an intersectional and structural framing in examining im/migrant women's access to healthcare;
2. To explore the specific im/migration and health experiences of young im/migrant women;

3. To investigate how young im/migrant women's healthcare access experiences may have changed, if at all, during the COVID-19 pandemic.

Together, the analyses informed by these objectives provide nuanced accounts of women's im/migration, health, and healthcare experiences, and how these experiences inform one another to shape lives.

The goal of the conceptual framework was to demonstrate the ways in which im/migrant women's healthcare access was shaped by interacting structural factors at intermediate stages. While the research in this dissertation was partly focused on SRH access (Chapter 4), im/migrant women described experiences accessing or attempting to access other types of healthcare, including care for mental health (Chapters 2 and 3) and chronic conditions (Chapter 2). Each healthcare access experience was shaped by the interaction of structures and intersecting processes of marginalization. Below is an example of how the conceptual framework informs each of the substantive chapters in this dissertation:

Chapter 2 primarily describes im/migrant women's healthcare needs, desire for care, and healthcare utilization, highlighting how these experiences were shaped by experiences in origin, travel, and transit settings. Here, for example, traumatic experiences in travel and transit settings contributed to a reduced desire for future care.

Chapter 3 primarily describes young im/migrant women's healthcare needs, seeking and reaching for pregnancy services, as well as experiences of motherhood and marriage, highlighting how these experiences were shaped by im/migration. Here, for example, ineligibility for health insurance for those without official im/migration status resulted in unmet healthcare needs and unplanned pregnancies.

Chapter 4 primarily describes young im/migrant women's healthcare reaching and utilization, highlighting how these experiences were shaped by shifts in health service delivery made early during the COVID-19 pandemic. Here, for example, the availability of women health providers prevented young im/migrant women's healthcare use, particularly if they experienced intimate partner violence during the pandemic.

In this dissertation, I adopt an epistemological stance aligned with CBR that prioritizes lived experience, interpretation, and participation. I emphasize a community-

based research approach to shift from analytic decisions often made by researchers in isolation, and support collaboration among im/migrant women in all stages of the research¹¹⁶. I use the term “community” to include im/migrant participants and their communities, im/migrant team members, and community partners. Community-based research has origins in critical theory and intersectionality theory, both of which are concerned with issues of power and social justice¹¹⁷. They pose critical considerations around assumptions that knowledge is based on subjective evidence and is socially constructed¹¹⁸. We collaborated with im/migrant team members, participants, and community partners on the development of research materials, data collection, participatory analyses, and ethical procedures; the co-creation of clear, accurate dissemination products; and knowledge translation and exchange. In each analysis, the lead authors, including myself, were self-identified im/migrant women with research lenses informed by migration, health, and healthcare experiences both similar to and different from those shared by participants. Recognizing privilege and power as both researchers and community members, I worked closely with co-authors to co-create findings while practicing reflexivity and centering the voices of participants.

1.8. Empirical Chapter Overview & Relevance

This dissertation is comprised of three different analyses, Chapters 2, 3 and 4, with some overlap in data sets. Chapters 3 and 4 are under review in academic journals, and Chapter 2 has been published. Below, I provide brief overviews of each analysis. I also discuss the ways in which each chapter’s development connects to my identity and experiences as an im/migrant woman, and how its collaborative process was central to my practice as a community-engaged researcher. As this research is based on an issue of personal importance, engaging in reflexivity was important for me to continually recognize the ways in which my values, biases, experiences, and privilege may have influenced the various stages of this research and my interactions with participants.

Chapter 2: *“It’s not just about being here, but what brought you here”*: A qualitative study of the role of migration experiences in shaping im/migrant women’s access to healthcare

This chapter includes data from all interviews conducted with im/migrant women within the IRIS project from December 2018 to January 2020. The analysis draws on the

context of BC, Canada to explore how experiences during migration shape im/migrant women's needs, desire for, and expectations of healthcare by way of controlled movement, rights, and access. This chapter situates im/migrant women's experiences within a broader im/migration landscape that demonstrates how spatially and temporally manipulative im/migration, health, and labour processes inform lives through experiences related to economic insecurity, intimate partner violence, and movement.

This analysis draws on the experiences of 33 women with complex migration journeys who moved within precarious and secure spaces shaped largely by im/migration status. The analysis highlights traumatic experiences across migration, exclusionary health and im/migration policies, unmet healthcare expectations, and insufficient health system information. The findings of this work point to Canada's health and im/migration system's responsibility to protect people during migration, train health providers in trauma-informed care, and develop health assessments that center migration journeys. Considering im/migrant women's migration experiences and its impacts on healthcare access demonstrated the areas of BC's health system that both work well and that require improvement. This research paper was co-authored and published in *Health and Place* in August 2022.

I arrived in Canada after two flights from Abu Dhabi to Toronto and Toronto to Halifax. I was not forced to leave my home and did not have to stop temporarily on the way. I arrived with a study permit, which changed to a permanent residency document shortly after. My migration journey was privileged in terms of my class, English language fluency, im/migration status, age, and health status. My assumptions about this research topic, however, are informed by the migration experiences of friends and family members that look different from mine, including those of co-authors. I worked closely on this research with Elmira Tayyar, a Community Researcher and Project Coordinator on the IRIS project, which involved having regular and meaningful conversations about our different migration experiences and its impacts on our health and access to healthcare. My assumptions are also informed by the ways in which my expectations of experiences in Canada, healthcare and otherwise, have often been let down. Finally, they are informed by the reality that although my arrival in Canada was smooth, every experience that I have had in this country has been informed by an experience that I had in my home country. Yet, no one has asked me about my previous experiences in a way that has acknowledged its ongoing impacts.

Chapter 3: *“When I came to Canada, I almost forgot myself: where I am, who I am”*: The impacts of im/migration on pregnancy, motherhood, and marriage among young women

This chapter includes data from interviews conducted with young im/migrant women aged 15-30 within the IRIS project from May 2019 to February 2021. The analysis highlights how im/migration shapes experiences of pregnancy, motherhood, and marriage, particularly among young, temporary im/migrants. Within the larger dissertation, this chapter situates young women’s experiences within the im/migration landscape presented in Chapter 2, along with health and legal contexts, to understand its impacts using a structural lens.

The findings of this analysis are based on the experiences of 34 young im/migrant women who migrated alone or recently, and were married young, first-time mothers, and survivors of violence. Using real-life cases, the analysis highlights how unequal gendered roles and power dynamics, barriers to health insurance, unaffordable childcare, and harmful occupational environments associated with im/migration shaped women’s experiences of pregnancy, motherhood, and marriage. The findings of this work suggest structural changes necessary to support young im/migrant women, including decoupling im/migration status from health insurance, and providing all people with permanent residency status and maternity benefits regardless of labour contributions. Considering age, im/migration, and occupation offered a more comprehensive understanding of young im/migrant women’s experiences.

When I arrived in Canada at the age of 18, most of my friends were young women and international students. I noticed that our experiences were very different from those of young women and students who were born in Canada. These experiences were often related to race, im/migration status, and sexual activity and health. While I identify as a young im/migrant woman and share many similar experiences with participants in this study, they are different from the experiences of pregnancy, motherhood, and marriage described in this analysis. My assumptions about this research topic are, therefore, informed by experiences of pregnancy, motherhood, and marriage of other young im/migrants in my life, which helped me appropriately describe participants’ stories. They are also informed by the trust and strong rapport that I developed with young im/migrant women who I interviewed and who participated in this

analysis. I worked closely on this research with Reyna Villasin and Sajedah Zaki, Community Researchers and Advisors on the IRIS project, which involved having regular and meaningful conversations about our different migration experiences and its impacts on our lives and health. While our experiences are different from those of participants in this study, our identities as insider researchers supported our understanding and analysis of participants' experiences.

Chapter 4: *“A pandemic is very serious, but we can’t push other illnesses to the side”*: Impact of shifts in health service delivery during COVID-19 on young im/migrant women’s access to sexual and reproductive healthcare

This chapter includes data from interviews conducted with young im/migrant women aged 15-30 within the IRIS project from March 2020-January 2021. At the time at which the analysis was conducted, there was little published information on young im/migrant women’s access to healthcare during the COVID-19 pandemic. The findings of this work provide insights into how the transition to virtual services and restricted in-person care had different impacts based on access to social support, and im/migration and socioeconomic status. Within the larger dissertation, this chapter brings together migration and SRH contexts presented in Chapters 2 and 3 to understand how experiences of SRH care access shifted during the COVID-19 pandemic.

The findings of this analysis are based on the narratives of 22 young im/migrant women whose SRH care experiences during COVID-19 were shaped by time spent in Canada, English language fluency, workplace environments, and im/migration status. The analysis demonstrated how virtual SRH services saved travel and childcare costs but offered little privacy and follow-up; unjust links between im/migration status, employment status and health insurance contributed to unplanned pregnancies; and connections to a doctor prior to the pandemic contributed to positive healthcare experiences. The findings of this work point to the need for close follow-up and needs assessments in virtual SRH services, and permanent sick days for all workers. Situating young women’s SRH experiences within the context of labour and im/migration helped highlight recommendations for young im/migrant women and their families to thrive.

When the COVID-19 pandemic began, I experienced no changes related to employment, housing, and im/migration status. I occupied positions of privilege as a

student, researcher, and citizen living in Vancouver. I experienced no change in income, and I began working from home where I had access to stable internet, privacy, and technology. My assumptions about this research topic are informed by my experiences of SRH care access early during the COVID-19 pandemic. While I successfully utilized virtual services in the language of my choice, I had SRH concerns that required clinic-based care. Receiving this care in a timely manner was impeded by temporary clinic closures, restricted hours of operations, long wait times, and a fear of COVID-19 transmission in public transit. In many ways, I shared similar experiences with participants in this analysis. However, in other ways, participants helped me understand how much more challenging my experiences could have been if my positionings were different. I worked closely on this research with Elmira Tayyar and Reyna Villasin, which involved having regular and meaningful conversations about our healthcare experiences during the COVID-19 pandemic as young im/migrant women ourselves – both similar to and different from those of participants.

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Chapter 2. “It’s not just about being here, but what brought you here”: A qualitative study of the role of migration experiences in shaping im/migrant women’s access to healthcare

2.1. Introduction

International immigrants and migrants (which we collectively refer to as im/migrants) make up over 272 million of the world’s population, almost half of whom are women (48%)¹. People who migrate in search of safety and economic opportunities have often done so to escape poverty, violence, and insecure environments^{2,3} – conditions supported by resource extraction, political tensions, and financial dominance by imperial countries⁴, and resulting in climate-⁵, war-⁶, and economic-related migration⁷. In this study, we use the term ‘im/migrants’ to include immigrants and migrants with permanent and precarious im/migration status, the latter of which includes people with temporary and without immigration status⁸. In Canada, the government plans to admit over 400,000 im/migrants as permanent residents annually from 2022-23⁹; yet people will also arrive with other, more precarious im/migration statuses and live as temporary foreign workers, visitors, international students, without official im/migration status, and without the healthcare, mobility and employment rights associated with permanent residency and citizenship^{8,10,11}. Healthcare inequities faced by im/migrants have often been documented as resulting from destination healthcare experiences, including inadequate interpretation services, a lack of health system navigation support, high costs of services, and discrimination by providers¹²⁻¹⁴, but research has inadequately considered the impacts of migration health, social, emotional, and economic experiences, for example. This paper argues that experiences across migration may impact im/migrants’ access to healthcare in destination settings.

Various studies suggest that the immigration control of destination states can impact migration experiences in ways that impact health and healthcare access upon arrival. For example, destination states’ push for political and economic access and control has led to exclusionary policies and militarizing practices including visa restrictions, deportation and detention, and border policing⁴. This control has contributed to unsafe and irregular migration through dangerous routes for uncertain time periods¹⁵⁻

¹⁷, and resulted in physical and emotional harm ¹⁸⁻²¹. Despite this, little is published about the specific ways in which experiences while travelling may impact im/migrants' healthcare access upon arrival. Limited research demonstrates that wait times for secure im/migration status or escape from unsafe locations during migration are imposed by spatially and temporally manipulative immigration processes that control time spent in uncertain circumstances or dangerous transit locations, where im/migrants may live for temporary periods of time ²²; this can negatively impact health and increase the need for trauma-informed healthcare upon arrival. Understandings of healthcare access in destination countries would benefit from analyses that considered the impact of migration experiences and how they may be systemically shaped.

Limited research shows that migration healthcare experiences shape im/migrants' expectations of and access to healthcare upon arrival in destination settings, and im/migrant women may be uniquely impacted by gender stereotypes and restrictive destination health and immigration policies. For example, in a U.S. study, im/migrant women who independently used free or low-cost sexual and reproductive health (SRH) care in places of origin found it challenging to be sponsored im/migrants newly dependent on their male partners' health insurance to access care ²³. Moreover, women's expectations of treatment quality, healthcare costs, wait times, and provider interactions in destination settings, and the ways in which they impacted their desire for and use of healthcare, have been shaped by migration healthcare experiences and prior knowledge of how destination health systems operate ²⁴⁻³⁰. These findings begin to describe how im/migrant women's healthcare access in destination countries may be shaped by expectations developed from experiences across migration; however, most studies solely focus on its impacts on mental health outcomes ^{24,25} or are limited to populations with a specific im/migration status (e.g., refugees) or region of origin ^{27,29,30}. This provides critical yet limited understandings of how migration experiences shape healthcare access.

After challenging migration circumstances and exposure to public government statements that welcome im/migrants, many may arrive in destination settings with expectations of safety, security, and low-barrier healthcare access. Canada is a signatory to the Global Compact for Migration (GCM), one of whose objectives is to establish supportive and protective policies for all people across migration ³¹. However, the GCM is non-binding, and Canada supports unsafe migration by financing

immigration law enforcement and border security officials globally, leading to exploitation that shapes healthcare needs and barriers in destination settings ^{2,4,32}. Research also demonstrates that im/migrant women are distinctly impacted by resulting healthcare issues, where gendered inequities in healthcare access are shaped by health and immigration systems and policies ^{24,25,27,29,30}. Understanding how im/migrant women's migration experiences are shaped by Canada's health and immigration systems and, in turn, shape their needs, desire for, and expectations of healthcare may better highlight these systems' responsibility to address barriers.

Research that has documented how im/migrant women's destination experiences shape healthcare access is insufficient. We suggest that migration experiences, including healthcare experiences, social support, emotional challenges, and financial circumstances during migration, contribute to im/migrant women's needs, desire for and expectations of future healthcare access. The purpose of this study is to build a more nuanced understanding of the impact of migration experiences on im/migrant women's healthcare access in BC, Canada, a top destination province (Statistics Canada, 2017). Guided by a framework drawing attention to the migration process ³⁴ and patient-centered healthcare access ³⁵, we aimed to understand how origin, travel and transit experiences shape im/migrant women's healthcare needs, desire, and expectations in BC.

2.1.1. Theoretical Frameworks

Im/migrant health research has often conceptualized healthcare access without considering how im/migrants need, desire, seek, reach, and utilize healthcare – critical stages of patient-centered healthcare access ³⁵. Levesque et al.'s (2013) framework helps break down understandings of healthcare access into intermediate stages, recognizing that having healthcare needs or a desire for care alone, for example, is insufficient to utilize appropriate healthcare. However, while the authors portray the healthcare process as linear, we interpret it as cyclic, where negative experiences during healthcare utilization, for example, may create additional barriers to a desire for future care. Our study drew from this framework to explore how the impacts of migration experiences may manifest through these stages, but expanded this to consider how they may also shape healthcare expectations – a critical feature in previous research and conceptualizations of healthcare access ^{36,37}. We used a framework of the migration

process published by the International Organization for Migration in 2017, which highlighted the importance of considering experiences in origin, travel, transit, and destination settings to better understand health outcomes. The framework considered migration as a spatial process with time being largely implicit, consistent with most research; however, we built on this to discuss movement and waiting across time and places ³⁸ – processes that are inherent to migration and often controlled by immigration systems.

2.1.2. Canada's Health System

Understanding how destination health systems operate is critical to understanding how im/migrant women's healthcare access. Canada's health system is often described as universal ³⁹, yet legally, this is designed to only ensure access to healthcare for citizens and permanent residents, excluding people within other im/migration categories. Across Canada, primary care operates under a gatekeeping model, where access to specialist health services requires a referral from a primary care provider (family physician or nurse practitioner) ³⁹. Some services are exempt from this model, including abortion care, sexual and reproductive health clinics. Community health centres in BC also do not require referrals, and offer trauma-informed, holistic, team-based care for marginalized communities including im/migrants. However, they are not integrated into BC's health system ⁴⁰. Health insurance plans vary by province and territory, including in coverage for prescription drugs, mental healthcare, and midwifery services, and proof of residency in a province remains a requirement for public insurance across Canada. In BC, people with Canadian citizenship, permanent residency, or temporary work or study permits valid for six or more months are eligible for the Medical Services Plan (MSP) – the provincial health insurance program – with some conditions; people whose permits expire are ineligible ⁴¹. All people, including any women, arriving in BC from another country or Canadian province are expected to apply for MSP coverage as soon as possible after arrival, and must then wait for 3 months before they can access MSP.

2.2. Methods

2.2.1. Study Design

The qualitative data analyzed in this paper were collected with self-identified im/migrant women as part of a larger study, the Evaluating Inequities in Refugee and Immigrant Health Service Access (IRIS) project. IRIS is a longitudinal, community-based, mixed-methods study of im/migrants' access to health services in British Columbia, Canada. The project is built on partnerships with local im/migrant-serving community organizations (e.g., MOSAIC, PIRS, Sanctuary Health, Watari), an im/migrant advisory board, and a research team with im/migration experience and expertise in qualitative and health services research. IRIS holds ethical approval from the Simon Fraser University (SFU) and Providence Health Care/University of British Columbia (UBC) harmonized ethics review boards.

IRIS includes “community” as im/migrant participants and their communities, im/migrant team members, and community partners. We collaborated with im/migrant team members and community partners on the development of research materials, data collection, participatory analyses, and ethical procedures; the co-creation of clear, accurate dissemination products; and knowledge translation and exchange (Israel et al., 1998). SM (PhD student) and ET (IRIS Project Coordinator) are two self-identified im/migrant women with research lenses informed by migration and healthcare experiences both similar to and different from those shared by participants. A community-based research design was important to support cultural humility, transparent and respectful partnerships, and a collaborative process that involved im/migrant women leading this research (Israel et al., 1998).

2.2.2. Study Participants and Recruitment

Eligible participants (N=33) were im/migrants who self-identified as women; moved to Canada from another country; were aged 15-49; lived in Metro Vancouver; and provided informed consent. Recruitment of a purposive sample of women with precarious im/migration status was supported by personal and professional networks of our community-based research team, as well as study posters and outreach to community partners.

2.2.3. Data Collection

Multilingual and multicultural im/migrant interviewers (including SM and ET) conducted one-on-one interviews with participants to facilitate rapport. Interviewers explained the purpose of the study, the voluntary and confidential nature of participation, and obtained written informed consent. Interviewers conducted all sessions in participants' preferred language (English, Dari, Farsi, Spanish) between December 2018 and January 2020. Sessions were audiotaped and lasted 1.5-2 hours. Interviews explored im/migration background, experiences with health services, and recommendations for improving health service access. After each interview, participants completed an interviewer-administered socio-demographic questionnaire to contextualize the sample. We gave participants honoraria of \$40 CAD in recognition of their time, expertise, and travel; referrals to health, social, and legal support; and childminding support as needed.

Among 33 women included in this study (Table 1), most had experiences of precarious im/migration status: of 16 permanent residents and citizens at the time of the interview, 12 had prior experiences of living undocumented, and as asylum seekers, visitors, and temporary foreign workers. Participants with experience of being undocumented explained that losing their im/migration status was often a result of work permit and visitor visa expiration, im/migration status processing delays, or sudden unwarranted termination by exploitative employers.

Table 1. Socio-demographic characteristics of im/migrant women (N=33), December 2018-January 2020

Age – Median (range)	31 (18-41)
Region of origin – Number of women	
Region of the Americas (Colombia, Mexico, Venezuela)	22
Eastern Mediterranean & African Regions (Afghanistan, Eritrea, Iran)*	11
Im/migration status at time of interview – Number of women	
Permanent residents and citizens	16
Undocumented	8
Asylum seeker	5
Temporary residents (e.g., people with visitor visas and work permits)	3
Unknown	1
Years in Canada – Median (range)	1.5 (0.25-12)

*These regions were grouped together to protect participant confidentiality. Im/migration status was determined based on qualitative analyses of interview transcripts and includes status changes along the migration journey

2.2.4. Data Analysis

We transcribed interviews verbatim; multilingual transcriptionists simultaneously translated interviews not conducted in English and transcribed them. A team member who spoke the same language then accuracy-checked each interview transcript. We assigned unique codes and pseudonyms to participants and removed all personal identifiers from transcripts to ensure anonymity. We loaded transcripts into NVivo V12 for analysis.

Our first step in data analysis occurred as part of the coding process within the larger IRIS project. We coded each IRIS interview conducted between December 2018-January 2020 (N=66) using an iterative, team-based process and a combination of inductive and deductive approaches. Coders met regularly to co-generate code boundaries and themes. As part of this process, we reviewed interviews to assign a priori codes ‘Arrival Experiences’, ‘Pre-migration Experiences’, and ‘Travel and Transit Experiences’. These deductive codes were applied to text that included participant descriptions of social and economic situations, health needs, and experiences accessing health and social services across these stages of migration.

In our second step in data analysis, SM used NVivo to extract all excerpts that were assigned to codes 'Arrival Experiences', 'Pre-migration Experiences', and 'Travel and Transit Experiences', which were part of 33 interviews. SM then manually applied a second set of codes to these excerpts using inductive coding to attend to how distinct origin, travel, and transit experiences shaped access to healthcare in BC for these 33 im/migrant women. Examples of inductive codes included "Healthcare Experiences/Comparisons", "Immigration Processes", and "Economic Shifts". Most data for this analysis came from participant responses to a question of how healthcare experiences in Canada compared with those in home countries, as responses often described how origin experiences shaped healthcare needs and expectations.

After coding was complete, SM and ET met periodically to co-generate themes using a framework of the migration process ³⁴ to understand how im/migrant women's needs, desire for, and expectations of healthcare in BC ³⁵ were shaped by migration experiences – operationalized by analyzing experiences in origin, travel and transit settings. As part of reflexivity within qualitative research, SM and ET met across the analysis process to recognize and reflect on their positions as researchers and im/migrants, particularly as Canadian citizens who have previous experience of precarious immigration status, are fluent in English, and are equipped with resources to navigate the impacts of migration-related trauma and unmet expectations of healthcare in BC. Through regular discussions, we unpacked how our experiences and positions may shape the analysis and worked to center the perspectives of participants.

Once the analysis was complete, we shared a multilingual mobile summary of the findings included in this study to all participants who consented to future contact via text message and email, including community advisory board members. This summary included a survey that asked im/migrant women to indicate their preferences for where the findings should be shared. Community advisors also met to discuss the survey responses. Finally, we shared a document of quotes and pseudonyms to those whose specific migration experiences were discussed. We invited each participant to participate in a paid follow-up interview to refine the information pertaining to their experience.

2.3. Results

We found that im/migrant women's (i) needs and desire for healthcare were shaped by impacts of traumatic origin, travel, and transit experiences, and (ii) expectations and experiences of health system navigation, quality of care, and availability of services in BC were shaped by origin and transit healthcare experiences, limited prior information on how BC's health system operates, and popular narratives of Canada's health system as free and accessible. Participants primarily described experiences of accessing care for sexual health, mental health, and chronic conditions. Migration journeys lasted days, months and years, and involved spending extended time in places of transit including refugee camps, shelters and homes in the U.S., Ethiopia, Iran, Turkey, Russia, India, and Mexico.

2.3.1. Impacts of traumatic experiences in places of origin, travel and transit on women's needs and desire for healthcare

For many women, the impacts of traumatic origin, travel, and transit experiences increased healthcare needs upon arrival in BC. Participants' need for mental health support, for example, was often shaped by the unexpected reality of being forced to escape insecurity, political violence, religious discrimination or sexual abuse in places of origin and transit. Amina¹ (permanent resident, 1.5 years in Canada) spent over two years in transit and lived in a refugee camp before arriving to Canada. Over the two years, their arthritis went untreated, and they faced language barriers, lived undocumented, and were separated from their younger brother. However, despite the unpredictability and trauma that resulted from their migration journey, Amina expressed that leaving their home country with their cousin was urgently needed to escape gendered discrimination and violence: *"we [Amina and their cousin] wanted to be somewhere safe and where women are not treated badly... it didn't matter where we went, we just wanted to get out of there."* Like many participants, Amina did not describe experiences of discrimination and violence in detail; however, these experiences resulted in needs for mental health and chronic pain support that continued to persist at

¹ All participant names in this dissertation have been changed to protect confidentiality.

the time of the interview. Amina described low expectations for healthcare in BC shaped by poor experiences to date.

For several women, the impacts of traumatic and oppressive migration experiences reduced their desire for healthcare in BC and delayed their service use. Women who experienced extortion by criminal organizations, for example, continued to fear people with authority and power, including health providers, impeding a desire for and use of needed care. Participants who survived sexual abuse during migration described patient-provider gender discordance in BC as contributing to decisions to not seek future care. Other participants also expressed concerns about having no option but to see doctors who were men. Maria sought refuge in Canada after transiting and arriving in BC seven months pregnant and in need of care (permanent resident, 2.1 years in Canada). Uncomfortable travel and transit experiences with male immigration officers created a distrust of male care providers in Canada. Maria's hesitance in using care demonstrated how negative interactions with immigration personnel created concerns with provider interactions with similar power dynamics, and impeded women's ability to reach and use needed care.

2.3.2. Impacts of experiences in places of origin and transit on women's expectations of health system navigation

Many participants expressed that poor perceptions of origin and transit healthcare experiences contributed to higher expectations of healthcare in BC for a destination health system. For example, as some used specialist services quickly and with relative ease in places of origin, women found the requirement to obtain referrals from primary care providers to reach services like gynecology in BC surprising and obstructive. Maria said, "When I came [to Canada], I had the need to see a gynecologist because I came pregnant. Well, we have found out the situation here is that one cannot apply directly to a specialist doctor, but instead you have to have your family doctor refer you ... in my country, one goes directly to the doctor one wants." (permanent resident, 2.1 years in Canada). Maria's experience suggested that they expected to access healthcare in BC with a similar, if not greater, level of ease than that in their home country; however, system navigation challenges created barriers to timely access. This was complicated for participants who, as im/migrants, were also contending with isolation upon arrival in Canada, language barriers, long wait times, housing issues

and unemployment, and limited information on how BC's health system operated. Zainab was forced to wait six months to connect to a provider and said, "In [transit], my kids asked what the difference was between a first world and second world country and I told them 'well, we are about to find out...' [laughter], but when we came here I didn't have an answer for them." (permanent resident, 6 months in Canada). Zainab's experience demonstrated that movement to Canada resulted in greater barriers to healthcare and unmet expectations of timely primary care access due to unfamiliarity with the health system and long wait times.

Several women also described having social support in the form of accompaniment for health appointments and accessing health service information in places of origin and expected similar in BC, only to experience isolation as a barrier to health system navigation. Participants wondered whether having better social support and earlier connections to community-based organizations in BC would have facilitated their access to information on available health services or accompaniment for appointments. This sentiment was particularly important to pregnant women and single mothers who had urgent healthcare needs and arrived alone, or whose partners worked long hours. The connection between social isolation and healthcare access was heightened for those with precarious im/migration status, who depended on connections to community-based organizations to receive care as BC's health system excluded people with temporary or without im/migration status. Rosa said, "Here in [community-based organization] they have helped me a lot and I am receiving medical care, but if I wouldn't have known about them, I don't know what would have happened because they [hospitals] wouldn't have provided me the service, they wouldn't have wanted to see me." (visitor, 5 months in Canada). Rosa was legally entitled to care that prioritized and appropriately responded to their needs in their home country and expected similar in BC. Instead, they were denied care as visitors are ineligible for health insurance. Other participants also noted the difficulty of accessing care for women who lived without connections to community-based organizations and/or with precarious im/migration status. Transitioning from having ample social support previously to being isolated in BC drove barriers to health system navigation, where these connections were often main drivers of healthcare access.

2.3.3. Impacts of experiences in places of origin and transit on women's healthcare experiences

Participants described that poor origin and transit healthcare experiences, combined with popular narratives of Canadian healthcare being free and exceptional, shaped expectations of positive health service experiences in BC; however, these were often unmet. Farah lived as a refugee in transit, where they were pregnant, had no health insurance, and experienced financial barriers and racism when using care. Upon arrival in BC, Farah was surprised to receive pregnancy care that was worse than that in transit. They were charged exorbitant ambulance fees and unwillingly sent home from the hospital while experiencing bleeding and severe pain. Farah expressed feeling uncertain about their expectations of future healthcare in BC after this experience: *“Although we were in a very bad condition [in transit] I did not face these many problems compared to here. I was under stress during pregnancy and after that too”* (permanent resident, 7 years in Canada). Like others, Farah spent time in transit and origin paying for or accessing free healthcare that they did not expect to be of high-quality due to low-resource contexts; however, the unexpected reality of paying high amounts to be rapidly discharged from hospitals and have poor healthcare experiences in Canada, a top destination country, was unfathomable and had long-lasting health impacts. Moreover, despite a shift from refugee to permanent resident status upon arrival, Farah's experience still demonstrated worse quality healthcare than that in previous settings.

Several women described disrespectful interactions with health personnel in BC as contributing to unexpectedly poor healthcare, realizing later that origin and transit experiences were often better than they had initially perceived and supported their ability to reach necessary health services. For example, some expressed that they only realized how respectful the delivery of medical results was in home settings when they faced a process in BC that was insensitive, dismissive, and forced them to spend time under stress. Iman said, *“In [home country] you receive your test results in some form of letter [...] here in Canada it seems to me that it's a little bit harsher. [changing intonation] ‘We will call you. And if we do not call you, then you don't have anything.’ It's like, you're waiting for the call”* (undocumented, 1.4 years in Canada). Realizing that origin and transit health service delivery were sometimes more attentive than that in BC often thwarted women's expectations of healthcare in BC. In other cases, women expressed being relatively satisfied with diagnoses and treatments received in places of origin until

Canadian doctors disregarded them or claimed they were incorrect. This invalidated origin experiences, and left women feeling uncertain and fearful about their health. Descriptions of interactions with health personnel highlighted that some providers in Canada perceived healthcare provided in other countries as inferior to that in Canada, demonstrating disrespect and paternalism that reduced women's desire for healthcare, and was a barrier to health service use: *"Arriving here, they scared me. They asked me 'how many [ultrasounds] did they [doctors in home country] do?' They said it can harm the child."* (permanent resident, 1.8 years in Canada).

2.3.4. Impacts of experiences in places of origin and transit on women's experiences of service availability

In few situations, im/migrant women described the availability, reachability and use of health information in BC being well-addressed after facing challenges in this area in origin and transit settings. For example, some shared that the lack of discussion around stigmatized health issues in places of origin, including sexual and reproductive health, contributed to prior unmet healthcare needs. This shaped positive healthcare access experiences upon arrival in BC; Maher described increased availability and variety of health services and information provided by im/migrant-specific community programs: *"Every Thursday the nurses used to come to the program and talk about health [...] From there we collect a lot of information [...]. For example, PAP test; we don't have PAP test in [home country]"* (permanent resident, 6.5 years in Canada). Women explicitly noted, however, that information was primarily provided by community-based organizations as opposed to providers part of BC's formal health system, reflecting again the central role of community connections in supporting im/migrant women's access to care.

A few participants also described that the unavailability of testing and treatment for specific conditions in origin settings shaped expectations for more comprehensive and advanced health services in BC, and these were appropriately met. Berta described positive experiences accessing specific, time-sensitive healthcare in BC that would have not been used in other places: *"If I hadn't gone to a doctor [in Canada], I wouldn't even have known about that illness [...], pre-eclampsia, because in [home country] they don't treat you for that"* (undocumented, 5 years in Canada). In these instances, women praised BC's health system for its availability of testing and treatment for specific

pregnancy concerns as compared to that of origin and transit settings. Such comparisons of healthcare access experiences are important to understanding the needs, desire for, and expectations of healthcare with which im/migrant women arrive.

2.4. Conclusions

Our findings demonstrate that migration experiences shape im/migrant women's healthcare needs, desires, and expectations in destination settings, and are important to understand to improve healthcare access. We found that traumatic origin, travel, and transit experiences, including economic insecurity, sexual abuse, violence, and harmful interactions with immigration officials shaped im/migrant women's needs and desire for healthcare in BC. Inadequate health system navigation support, high out-of-pocket payments, and insensitive provider interactions in BC were shaped by exclusionary health and im/migration policies, expectations based on more positive experiences across migration and limited information on how BC's health system operated, as well as perceptions of Canada as a resourceful destination country due to popular narratives of its health system as free and accessible. Healthcare experiences were especially challenging for women with precarious im/migration status, many of whom spent extended time in uncertainty across migration and depended on community-based support to access care. Positive experiences among a few women were often a result of movement from places with limited testing and treatment options to a greater variety of services in BC.

Participant narratives suggested that destination health system may not be designed to attend to healthcare needs informed by migration experiences, which hinders their ability to address inequities in healthcare access. This was clear for women who experienced sexual abuse or had traumatic experiences with male immigration officers during migration; requests to see a doctor of the same gender in BC were disregarded by doctors who did not understand how this was tied to a need for safety and trust that resulted from migration experiences and created uncomfortable experiences. This aligns with recent U.S. evidence highlighting that providers' limited understanding of how traumatic forced migration experiences shaped their healthcare needs was a barrier to migrant-centered and trauma-informed healthcare⁴³. Doctors' claims that incorrect healthcare was received in previous settings also symbolized an individual-level erasure of im/migrant women's experiences, exposing a lack of cultural

humility and ignorant perceptions of healthcare in Canada as superior. This dismissiveness of migration experiences is reflective of historical and ongoing xenophobia embedded in Canada's health and immigration systems, which has translated into medical education⁴⁴ and healthcare settings. While im/migrants are unjustly expected to be infinitely grateful for destination countries and systems – an example of unequal power that emphasizes their marginalization^{45,46} – our findings demonstrate that BC's health system falls short and should earn their gratitude by meaningfully understanding and addressing healthcare needs shaped by migration experiences.

BC's health system's lack of priority to address healthcare needs shaped by migration experiences was demonstrated by the little prior information that im/migrant women had on how the system operated, as well as their expectations that healthcare in Canada as a high-income destination country would be better than that in previous low-income settings. While participants did not explicitly attribute their assumptions to the Canadian government's commitments to accessible healthcare, this has previously been documented. A 2017 audit of settlement services provided to Syrian refugees showed that despite commitments to integration support made by the government while im/migrants were still in places of origin and transit, no action was taken to connect them to health providers upon arrival⁴⁷ – a time when participants in this study described facing urgent needs. This disconnect between promise and action mirrors the Canadian government's lack of legal commitment and effort towards achieving universal healthcare for all people regardless of im/migration status^{32,48}, as well as the role of immigration systems in shaping im/migrant women's needs, desire for and expectations of healthcare before their arrival in destination settings and throughout migration.

Finally, our findings highlighted the impacts of spending time in unsafe locations for uncertain periods of time during migration, expanding previous research that has considered the impacts of place on healthcare access alone³⁸. Research from Europe found that extended time spent in harmful and insecure transit conditions, including restrictive migration policies, resulted in greater healthcare needs among im/migrants upon arrival⁴⁹. This evidence mirrors our findings, and reflected the experiences of women with precarious im/migration status who had perilous migration journeys, and waited in origin and transit settings while excluded from protective policies. Our findings also highlighted the ways in which Canada does not comply with the GCM principles,

including the “respect, and protection and fulfillment of the human rights of all migrants”³¹. Waiting in uncertainty across migration mirrored im/migrant women’s experiences of long wait times imposed by BC’s health system, which enhanced barriers and fear in accessing healthcare. Long wait times to be connected to a family doctor were common yet severe as timely healthcare access was critical for many who arrived with urgent healthcare needs resulting from migration experiences. This is linked to recent evidence of delayed or unmet healthcare needs for im/migrant women in BC who arrived pregnant⁵⁰. Considering time and place through participants’ comparisons of healthcare experiences between home and destination settings highlighted conflicting healthcare needs, desires and expectations associated with different contexts³⁸, and facilitated understandings of areas within BC’s health system that both work well and require improvement.

2.4.1. Strengths and Limitations

Recruitment of the study population was conducted in collaboration with IRIS community partners, where interviews included a high representation of Latin American women with precarious im/migration status. This is an important strength of our study given that women with temporary or without im/migration status have often been excluded from research. Our ability to learn from their experiences is attributed to the trusting relationships and rapport built between our partners, community-based research team, and local im/migrant communities. While qualitative research does not aim to be representative, our findings still fill a critical gap in understanding how migration experiences shape im/migrant women’s healthcare access in Canada. A limitation, however, is that the overrepresentation of experiences of im/migrant women from Latin America may underrepresent those of im/migrant women from countries in Asia and Africa. Our interview guide asked participants about their migration journeys to Canada and healthcare experiences in origin and destination settings; future research using specific probes regarding travel and transit experiences may elicit more detailed information on migration experiences. Finally, the community-based nature of this study supported collaboration with im/migrant women in all stages of the research, strengthening its validity, quality, and rigor.

2.4.2. Recommendations

Understanding healthcare access in destination settings is critical, but the ways in which migration experiences shape im/migrant women's healthcare access suggests that research with limited consideration of this context has been insufficient in understanding im/migrant women's healthcare needs, desires, and expectations. On a global level, our findings suggest that collaboration between immigration systems, im/migrant communities, and im/migrant-serving organizations is needed. In Canada, this is needed to establish measurable goals to abide by GCM principles and hold the government accountable to the health, safety, and rights of im/migrants across migration. Accountability may look like monitoring goals through publicly accessible annual progress reports to support transparency ⁴⁹. Our findings also propose that immigration and health systems work collaboratively with im/migrant communities to provide honest, language-specific health system information while im/migrant women are in origin and transit settings, and upon arrival in each province in Canada ⁴⁹.

Within BC's health system, our findings highlight the need to implement post-arrival health assessments that center migration journeys, including prior experiences related to healthcare, gender-based violence, and family separation ⁵¹⁻⁵³. To support health services that adequately respond to migration experiences ^{24,54,55}, system officials must also work with im/migrant communities to appropriately understand what it means to provide trauma-informed care, and develop a training that recognizes the impact of history in healthcare experiences. Our use of a patient-centered healthcare access framework highlighted the need for providers to use trauma-informed practices and cultural humility to recognize and attend to unequal power dynamics, mistrust, and a lack of safety embedded in some patient-provider interactions, which may reflect harmful interactions across migration ^{51,56,57}. This will require collaboration ⁴³ with im/migrant women and medical colleges to support providers with the time and compensation to engage in such training; in BC, this includes the College of Nurses and Midwives and College of Physicians and Surgeons. Finally, to support health system navigation while drawing on positive healthcare experiences with community-based services, our findings suggest integrating community health centres into BC's health system, and sustainably fund community-based clinics (e.g., Umbrella Multicultural Health Co-operative, Nesting Doula Collective, Watari Counselling and Support Services) to expand service eligibility to include all im/migrant women.

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Chapter 3. “*When I came to Canada, I almost forgot myself: where I am, who I am*”: The impacts of pregnancy, motherhood, and marriage on the health of young im/migrant women

3.1. Introduction

Being a young person, which we define as aged 15-30,¹ is typically characterized by changes in education, employment, and family domains that may be abrupt, involve new roles, and have long-lasting impacts that can shape health.² As of 2021, young people make up over 16% of the world’s population³; over seven million of them reside in Canada, and almost half are women.⁴ Young im/migrants represented over a quarter of all im/migrants to the country in 2021,⁵ many of whom may have been pursuing education or employment, reuniting with family, or escaping insecure environments.^{6,7} We use the term im/migrants to include migrants and immigrants with permanent and precarious im/migration status, the latter of which includes people with temporary and without official im/migration status.⁸ The lives of young im/migrants may be complexified by uncertain migration journeys,^{9–11} challenging immigration system processes,^{11–13} and contextual differences between settings,^{14,15} where women may face unique gendered health impacts. These include having little information on contraception and STIs;^{16,17} experiencing barriers to health services related to isolation, cost, stigma, and the geographical location of clinics;^{16–18} experiencing physical and emotional violence;^{16–19} and experiencing unplanned pregnancies.¹⁶ However, health research conducted with young im/migrants has often described physical and mental health outcomes without adopting a structural lens or explaining clear pathways through which im/migration impacts health. The structural determinants of health refer to dynamic and interconnected power structures that shape the social determinants of health, including income, employment, and access to health services.^{20,21} In this study, we explore young women’s experiences of pregnancy, motherhood, and marriage to deepen perspectives on the structural and social impacts of im/migration.⁸

Several studies conducted with young people have focused on pregnancy and motherhood, but only a few have adequately considered how im/migration shapes these experiences.^{22–25} Studies of pregnancy among young im/migrants in the U.S. have found

that women experienced greater changes than young men due to greater caregiving expectations associated with motherhood.^{26,27} Research has also found that unplanned pregnancies are more common among racialized women and young people without consistent family support or income,²⁸ and combined with experiences of unemployment and isolation contributed to postpartum depression.²⁹ Evidence suggests that these pregnancy experiences may be especially severe for young women who may have migrated at younger ages, have precarious im/migration status, or have insecure employment as recent im/migrants.³⁰ For example, a Canadian study of condom use among youth found that people of younger ages, newcomer youth, and low-income youth were more likely to avoid contraception and experience unplanned pregnancies; however, this study used survey data and did not qualitatively explain how this pattern was shaped by im/migration.³¹ A few studies in Canada have highlighted employment and im/migration status as determinants of health for young pregnant women. Evidence from Montreal, Quebec, for example, found that young women with precarious im/migration status who worked during their pregnancy experienced increased stress, as well as barriers to workplace safety, maternity benefits, income, and health insurance.³² Even after childbirth, young im/migrant women described being financially dependent on their partners due to unaffordable childcare, and being reliant on social networks for employment referrals.³² These findings suggest that young women's pregnancy experiences cannot be examined or understood in isolation from structural and social factors, including employment and im/migration status.

Studies that have examined the impacts of im/migration on young people's health have often relied on behavioural and cultural explanations for sexual and reproductive health with little consideration of structural factors. For example, studies in Europe have described determinants of inconsistent condom use as most often relating to family and parental characteristics, including cultural norms and controlling parental behaviours.³³⁻³⁵ Research has also frequently attributed sexual behaviours to young im/migrants' awareness of contraceptives, STI transmission, and available services,^{18,33} which places responsibility on the individual as opposed to the education, health, and im/migration systems' provision of accessible sexual health information. A recent study conducted with young im/migrants attributed experiences of intimate partner violence to cultural differences between origin and destination settings, and described situations where young im/migrants experienced more or less violence depending on their level of

adoption of the destination culture, which in this case were dominant Western cultures in the United States and New Zealand.³⁶ These studies accomplished their goals of examining potential determinants of pregnancy, STIs, and intimate partner violence among young im/migrants; however, a focus on behavioural and cultural approaches limits our understanding of how structural and social im/migration contexts³⁷ shape young im/migrant women's well-being.

Our analysis drew from the structural and social determinants of health and intersectionality theory – the combination of which helped explain the ways in which health, im/migration, and labour structures interacted with processes of marginalization to shape inequities and opportunities in pregnancy, motherhood, and marriage among young im/migrant women. Coined in Black feminism and race and civil rights activism in 1989, intersectionality theory attends to the cumulative effect of different forms of marginalization in informing people's experiences,³⁸ and explains why their intersection is needed to identify and address experiences of racism, xenophobia, and gender-based discrimination, for example.^{38,39} These frameworks demonstrated how young im/migrant women's experiences of pregnancy, motherhood, and marriage were informed by employment, im/migration status, eligibility for health insurance, and access to social support and workplace safety. An intersectional and structural framing of young im/migrant women's experiences was essential to support a more comprehensive interpretation of the impacts of im/migration and structure.⁴⁰

Research has demonstrated that im/migration may have serious impacts on young im/migrant women's experiences of pregnancy, motherhood, and marriage. These impacts may be informed by structural and social determinants, including precarious occupations and im/migration status, that intersect with racism and xenophobia to place young im/migrant women in positions of increased vulnerability with low wages and limited rights.⁴¹ In this study, we examine how im/migration shapes experiences of pregnancy, motherhood, and marriage among young im/migrant women in British Columbia (BC). We aim to contribute more nuanced research in this area by demonstrating the importance of considering how structural and social factors intersect with processes of marginalization to impact young im/migrants' well-being.

3.1.1. Immigration and employment in Canada

The connections between im/migration and employment in Canada came with the creation of borders by European settlers and through Indigenous nations during colonization.^{42,43} Today, international borders regulate entry and exit through travel documents and screening.⁴⁴ Given Canada's colonial history, the country's im/migration patterns are marked by systemic racism and xenophobia. Im/migrants to Canada have previously been chosen based on race, ethnicity, or place of origin, and this racism continues to be covertly embedded in programs and policies. The Temporary Foreign Worker (TFW) program, for example, began in 1973 and supports employers in hiring primarily young, non-white people living in other countries to temporarily im/migrate to Canada to work in positions unoccupied by Canadian citizens.⁴⁵ The TFW program continues to be used to boost the country's economy while restricting im/migration and exploiting people to provide cheap temporary employment while denying full access to rights and health.^{46,47} As temporary im/migration programs have become a central feature of Canada's im/migration system and continue to expand,⁴⁸ considering how the system is built upon the labour of young, temporary im/migrants is critical for understanding its impacts on the health and well-being of young im/migrant women. Decades of advocacy to uphold health and human rights of people with precarious im/migration status have led to important promises and potential for change,^{49,50} including the Canadian government's recent commitment to develop a pathway to permanent residency for workers without official im/migration status.⁵¹ However, this is taking place after years of exclusion of people without official im/migration status, who have experienced no entitlements to workplace protection, mobility rights, or access to health services for pregnancy, contraception, and other critical forms of care.^{52,53}

3.2. Methods

3.2.1. Study Design

The qualitative data analyzed in this paper were collected with im/migrant women as part of the Evaluating Inequities in Refugee and Immigrant Health Service Access (IRIS) project. IRIS is a longitudinal, community-based, mixed-methods study of im/migrants' access to health services in British Columbia (BC), Canada. The project is built on partnerships with local im/migrant-serving community organizations (e.g.,

MOSAIC, PIRS, Sanctuary Health, Watari), an im/migrant advisory board, and a research team with im/migration experience and expertise in qualitative and health services research. IRIS holds ethical approval from the Simon Fraser University (SFU) and Providence Health Care/University of British Columbia (UBC) harmonized ethics review boards.

IRIS includes “community” as im/migrant participants and their communities, im/migrant team members, and community partners mentioned above. We collaborated with im/migrant team members, participants, and community partners on the development of research materials, data collection, participatory analyses, and privacy and confidentiality agreements; the co-creation of clear dissemination products; and knowledge translation and exchange.⁵⁴ SM (PhD student), RV (IRIS Community Researcher & Advisor) and SZ (IRIS Community Researcher & Advisor) are three self-identified im/migrant women with research lenses informed by migration and healthcare experiences both similar to and different from those shared by participants. A community-based research design was important to support cultural humility, transparent and respectful partnerships, and a collaborative process that involved young im/migrant women leading this research.⁵⁴

This research is based on two different sets of data from the IRIS project. We first conducted one-on-one, in-depth sexual and reproductive health (SRH) interviews with im/migrant women aged 15-49 that explored im/migration background, experiences with SRH and related health services, and recommendations for service access. However, we found that few interview participants included women aged 15-30. Given this, we developed a youth-specific arm of IRIS that specifically attempted to recruit more young women. This arm included a separate interview guide that involved high-level explorations of the specific health priorities and needs of young im/migrant women aged 15-30. Preliminary conversations with community partners that served young im/migrants also suggested that focus group sessions could allow for greater comfort, safety and in-depth responses than one-on-one interviews. Thus, when recruiting young women, we provided the option of one-on-one interviews or participation in a focus group.

3.2.2. Study Setting

British Columbia, Canada provides an important setting to understand how im/migration shapes young women's lives, including their health, social, and economic experiences. Research has found that young im/migrant women in Canada often live with a partner and have a lower income compared to Canadian-born women,⁵⁵ and many recent im/migrants are young, of working age, and have temporary im/migration status. Im/migrants in Canada also represent over half of young people in BC,¹ which is a top destination province for im/migrants. On starting this study, partnering community organizations reported observing a recent increase in young women arriving pregnant, as new parents, and with precarious im/migration status.⁵⁶ This is important given evidence that pregnancy and motherhood are experiences that may directly impact young im/migrant women's health.

3.2.3. Study Participants and Recruitment

Eligible participants (N=34) were im/migrants who self-identified as women; moved to Canada from another country; were aged 15-30; and provided informed consent. We did not include having experience of pregnancy, motherhood, or marriage as an eligibility criterion, but these experiences were key themes identified during the analysis stage. Recruitment of a purposive sample of young women and women with precarious im/migration status was supported by personal and professional networks of our community-based research team, as well as study posters and outreach to community partners.

3.2.4. Data Collection

To facilitate rapport, multilingual and multicultural im/migrants (including SM) conducted all data collection activities; due to pandemic conditions, interviews and focus groups were virtual (e.g., Zoom, WhatsApp, FaceTime). We used the same procedures for interviews (N=28) and focus groups (1 focus group; N=6). Facilitators explained the purpose of the study, the voluntary and confidential nature of participation, and obtained verbal informed consent. Interviews and focus groups were conducted in participants' preferred language (English, Dari, Farsi, Spanish, Tigrinya), were audiotaped and lasted between 1.5-2 hours. Interviews with im/migrant women as part of the main IRIS project

were conducted between May 2019 and February 2021, while interviews and focus groups with young im/migrant women as part of the youth-specific arm were conducted between August and November 2020. All participants completed an interviewer-administered socio-demographic questionnaire to contextualize the sample and were given an honoraria of \$40 CAD in recognition of their time, expertise, and travel; referrals to health, social, and legal support; and childminding support as needed.

3.2.5. Data Analysis

We transcribed interviews and focus groups verbatim; multilingual transcriptionists simultaneously translated sessions not conducted in English. A team member who spoke the same language of the interview then accuracy-checked each transcript. We assigned unique codes and pseudonyms to participants and removed all personal identifiers from transcripts to ensure anonymity. We loaded transcripts into NVivo V12 for analysis.

Our first step in data analysis occurred as part of the coding process within the larger IRIS project. We coded each transcript (interview and focus group) conducted between May 2019 and February 2021 using an iterative, team-based process and a combination of inductive and deductive approaches. Coders met regularly to collaborate on code boundaries and themes.^{57,58}

In our second step in data analysis, SM reviewed transcripts of young im/migrant women aged 15-30 who were interviewed between May 2019 and February 2021 to extract quotes that described impactful life experiences shaped by im/migration. SM, SZ and RV then met weekly to co-analyze quotes, manually recode them, and co-generate initial themes. This second pass used inductive coding, where we identified experiences of pregnancy, motherhood, and marriage as three key experiences shaped by im/migration. The subset of data included in this analysis, therefore, included interviews with young im/migrant women who described having at least one of these experiences. In this step, we were guided by intersectionality theory and the structural and social determinants of health to understand how im/migration shaped young women's experiences of pregnancy, motherhood, and marriage in complex ways based on their different social locations, including socioeconomic and im/migration status, age, and occupation. We selected three participant cases to elaborate on this complexity, where

each experience described how im/migration shaped pregnancy, motherhood, and marriage by way of shifted family and partner dynamics, sacrificed educational and career goals, new identities and caregiving responsibilities, and access to rights and safety at home and in the workplace. SM interviewed the three participants represented in these cases, which she wrote by drawing on her field notes.

As part of reflexivity within qualitative research, SM, SZ, and RV met across the analysis process to recognize and reflect on their positions as researchers and young im/migrant women, particularly as Canadian citizens who are fluent in English and have navigated the impacts of experiences both similar and different from those shared by participants in this study. Through regular discussions, they unpacked how their experiences and positions may shape the analysis and worked to center the perspectives of participants. Describing three participant cases also helped provide a more detailed understanding of young im/migrant women's experiences while intentionally considering the relationship between interviewer and participant as two young im/migrant women themselves.

Once the analysis was complete, we shared a multilingual summary of findings and recommendations included in this study to all young im/migrant women who consented to future contact via text message and email, including community advisory board members. The summary included a survey that asked participants to indicate their preferences for where and with who the findings should be shared. We also shared a document of quotes and pseudonyms to those whose specific experiences were discussed. Similarly, we shared the cases with the three participants whose stories were described in detail to obtain additional consent. We invited each participant to participate in a paid follow-up interview to refine and check the accuracy of the information pertaining to their experience.

3.3. Results

Young women's narratives highlighted different ways in which im/migration shaped the health, economic, legal, and social drivers and impacts of their pregnancy, motherhood, and marriage experiences, which often overlapped across participants. For example, many young women who experienced pregnancy also described experiences of motherhood and marriage; however, not all participants who were married

experienced pregnancy or motherhood. Factors driven by im/migration had different impacts on young im/migrant women’s pregnancy, motherhood, and marriage experiences based on their access to social support, workplace protections, household safety, health insurance, and im/migration and socioeconomic status. These factors also shaped participants’ circumstances, including the planned or unplanned nature of pregnancies, the age at young im/migrant women became mothers, and the age at or arrangement through which marriage took place.

We begin each section of the Results with a participant case that illustrates the complex context behind how im/migration shaped young women’s experiences. The cases importantly highlight how participants navigated these experiences at the intersection of being young people, women, and im/migrants. Among 34 participants (Table 1), most had experiences of precarious im/migration status: participants held no official status, work permits, or were seeking asylum. A few young women were permanent residents. Participants with experience of having no official status explained that losing their im/migration status was often a result of work permit and visitor visa expiration or im/migration status processing delays.

Table 2. Socio-demographic characteristics as reported by young im/migrant women (N=34), May 2019-February 2021

Age – Median (range)	24.5 (17-30)
<hr/>	
Origin – Number of women	
Region of the Americas & Europe (Colombia, Mexico, Spain, Venezuela)	23
Eastern Mediterranean & African Regions (Afghanistan, Ethiopia, Iran)*	6
South-East Asian & Western Pacific Regions (Bangladesh, India, Philippines)*	4
Unknown	1
<hr/>	
Experiences of pregnancy, motherhood and marriage since arrival in Canada – Number of women	
Pregnancy	15
Motherhood	15
Marriage	11
<hr/>	
Years in Canada – Median (range)	1.4 (0.16-11)
<hr/>	

*These regions were grouped together to protect participant confidentiality

3.3.1. ***“It was like a bucket of water fell over us”***: The health, economic and legal drivers of pregnancy experiences among young im/migrant women

Hema and I looked forward to catching up after speaking a year ago. Last year, she was recently married and lived in BC for a few months. She was working two jobs – three including the hours she spent cooking and cleaning while living with 13 of her in-laws – and was burnt out. Early in our phone conversation, Hema shared that she was now a mother. I was surprised by this as she previously said she wasn’t ready to have children, despite some pressure from family members, and wanted to focus on her educational and career goals. Now, she was on her fourth month of maternity leave. Her pregnancy was unplanned and difficult to accept at first, but she was happy now. She was relieved to experience her pregnancy in a separate home from most of her in-laws, but grateful to have them close by for support. She relied on support from her partner and daily phone calls with her mother back home. She was exhausted, but still excited to achieve her goals. She just needed more time.

Most participants described experiencing their first pregnancy when they arrived to BC or shortly after, including Hema. Pregnancies were often unplanned. When asked about the factors that contributed to unplanned pregnancies, several participants stated that “it just happened”; others who were more recent im/migrants, however, attributed this experience to a lack of prior information on reproductive counselling, abortion care and family planning services, limited support in navigating BC’s health system, and the unjust coupling of im/migration status and health insurance: *“I came thinking that if I went to the drugstore, I would get birth control and have it applied. And well, wrong. They said, “no, in order for you to take birth control, you need to see a doctor and the doctor will prescribe the method”. Well, when we first arrived we had no ID, no doctor, nothing. We had to wait 2-3 months for immigration to give us documents so that we could then go look for a contraception method... if I would have had the possibility of accessing a family planning method, then I would not have gotten pregnant.”* (age 29, 1.3 years in BC, asylum seeker). Participants who wanted to prevent pregnancy were often unable to do so, which was especially concerning for those who recently arrived to BC and were undergoing the 3-month wait period for health insurance – a significant barrier to needed healthcare as highlighted by previous IRIS research.⁵⁹ Upon arrival, women were met with system navigation challenges and exclusionary health and

im/migration policies that impeded timely contraception access and resulted in unplanned pregnancies that were life-altering yet preventable.

Young im/migrant women's pregnancies took place within the context of interconnected challenges related to language barriers, im/migration status, secure employment, and affordable housing, all of which were often prioritized over health. One person, who opted not to share sociodemographic information, described this: *"Usually when a person arrives, the least you worry about is your reproductive health. It's more about, 'where am I going to live and what am I going to eat?' and 'where am I going to work?'"* For young women with precarious im/migration status, perceptions of their pregnancies and the anticipated financial and healthcare challenges given their limited rights in Canada were especially challenging. They described having always imagined to feel happy about their first pregnancy, and although this was the case, their happiness was supplemented with a sense of fear associated with not having the healthcare, employment, or financial support accompanied by permanent residency or citizenship. The compounding health and economic impacts of living within the context of precarious im/migration status, poverty, and an unplanned pregnancy, were described: *"I entered a bit of depression because I always had my life planned. Like at a certain age I was going to have a baby, at 28-29 years old"*. (age 24, 1 year in BC, no official im/migration status).

With regards to navigation challenges in accessing pregnancy care, a few participants spoke to experiences with youth clinics. Youth clinics in BC offer health services to young people under 25, including immunizations, mental health support, pregnancy and STI/HIV testing, reproductive counselling, and low-cost or free contraception.⁶⁰ While some found relief in accessing youth clinics, few knew that these existed: *"I searched for walk-in clinics on the Internet; when I went, they told me there was a policy that until the age of 25 they attend you for free... whether you have insurance or not, they just ask for your name. I was like, 'I didn't know, I should have come here when I felt sick."* (age 29, 4.1 years in BC, worker). While primary care operates under a gatekeeping model in Canada, where access to specialist health services requires a referral from a primary care provider (family physician or nurse practitioner),⁶¹ youth clinics are exempt. People can self-refer or drop in at a youth clinic directly; however, any further needs for specialist services, including gynaecology, would

require a referral that could be provided from a youth clinic or primary care provider, often posing barriers to additional care.

Finally, some participants described how their pregnancy experiences were exacerbated by precarious occupational roles common among young people with precarious im/migration status and/or newly arrived in Canada. Understanding these experiences within the context of labour, migration, and power was important to understand its health, social, and economic impacts. Exploitative workplace environments were especially common among young im/migrant women who held physically demanding jobs, including janitorial and serving positions. Some described feeling forced to quit after they were discriminated against for being pregnant; Aleysha's employer illegally cut her hours, which negatively impacted her financial situation and well-being: *"I left my job. They gave me lots of pressure, didn't give me more hours because I was pregnant. I felt mentally stressed. If I wanted to get my maternity benefits, I had to complete 600 hours."* (age 26, 2.8 years in BC, permanent resident). Aleysha's experience highlighted the power that employers have over the bodies of young im/migrant women, in a system where access to financial assistance for people away from work while pregnant is contingent upon labour. Her experience also demonstrated how being an im/migrant with low income and precarious employment in BC can create a uniquely difficult pregnancy experience compared to what low-income non-im/migrant women may experience, particularly as Canadian employers and the im/migration system work together to shape employment opportunities among young im/migrants.

On the other hand, a few women described being well supported by their employers during their pregnancy, and this support permitted them to continue pursuing their career goals, access healthcare, and flourish. These women often had more security in im/migration status and English fluency; however, their experiences were still contingent upon the nature, quality, and duration of their work. Hema shared: *"The office supported me a lot. They knew that I was pregnant, and I was leaving for maternity leave, but they still gave me the position because I worked with them for a long time and they were very happy about my work. Now I have MSP and also benefits from my office."* (age 26, 1.1 years in BC, permanent resident). Hema's positive pregnancy experience contrasted those of other young women in this study who held precarious employment or im/migration status while pregnant, who were seemingly treated as undeserving of the same rights and support.

3.3.2. “It’s like a 24/7 job; you can’t refuse it for a moment”: The social and economic drivers of motherhood experiences among young im/migrant women

Kiran answered the phone with a quiet voice. Her partner was at work and her newborn twins were asleep beside her. When I asked how her life in BC compared to her life back home, she had lots to share. She had just completed the 10th grade and was used to spending most of her spare time with family and friends when she was arranged to be married. She arrived in BC and experienced the shock of being in a new country, without any family or friends, and with new responsibilities as a wife and daughter-in-law. Everything seemed to happen suddenly, including her pregnancy. She felt unprepared to be a mother and spent several months in postpartum pain while caring for the twins and her partner, in accordance with marriage expectations. The combined efforts of childbirth, childcare and household work left her feeling physically unwell. To support her well-being, she tried to fit in a daily, 10-minute evening walk, but this was all she could manage before being in pain and rushing home to cook dinner.

As newly arrived young im/migrant women whose im/migration represented increased opportunities for education and employment, many participants described motherhood being accompanied by delayed or sacrificed educational and career goals resulting from unexpectedly demanding caregiving roles and responsibilities. Hema planned to study and work after migrating to Canada, but described being unable to do so after becoming a mother. Similarly, other participants described experiencing a loss of independence after having to spend more time at home: *“Staying at home was difficult for me. When I was in [home country] I was never at home. I was always busy at work, participated in different occasions, or was passionate about going out and doing something. It was hard to stay at home, having a baby... It did have stress.”* (age 27, 1.11 years in BC, permanent resident). Caring for children while having no paid employment was difficult for several young women, but as most had little to no household income, they explained that unaffordable childcare in BC left them with no other options: *“Taking her to a daycare would cost me what I would make. Apart from the fact that psychologically I was going to be crazier than I already am, I had to do household chores, plus take care of my daughter, bathe her, prepare lunch. Everything that implies being a housewife, right? And having an additional job and for a pay that wasn’t going to work out, well, I dismissed the option of working.”* (age 24, 2 years in BC,

im/migration status not disclosed). While unaffordable childcare is a common issue in Canada, participants highlighted that their experience as im/migrants was compounded by low wage, precarious jobs, making access to childcare a further reality than it may be for non-im/migrants with higher paid employment.

Finally, caregiving was especially challenging for young women who navigated motherhood for the first time, had no family or friends in BC, and whose partners worked long hours due to the low-paid nature of their employment and the gendered division of labour. This was the case for Aleysha: *“It was a hard time with a newborn baby. I didn’t know how to take care of her, feed her, bathe her. At that time I was just 24 years old, so it was totally new for me and without some elders those things are a little hard for us. The baby is crying a lot, I cannot sleep properly and at the same time I have to cook for her, my daughter, my husband.”* (age 26, 2.8 years in BC, permanent resident). Like other participants in this study, Aleysha highlighted the burden of unequal gender roles as a new, young mother and im/migrant, as well as unique experiences of isolation faced by young women who migrate alone.

3.3.3. *“I understand things change, but for me the change was quite sudden”*: The social, legal and health drivers of marriage experiences among young im/migrant women

Aleysha walked around her neighborhood while we spoke over the phone. She was married, had a young daughter, and worked in the food industry. She completed a degree in dentistry in her home country, but her credentials were unrecognized in Canada. Her social network mainly included friends that she met through community programs, and a social worker that she was introduced to during her pregnancy. Since moving to BC, her relationship with her husband had been challenging and they experienced financial hardships. When I asked Aleysha how she was coping, she said that she was simply trying to survive as a new immigrant. She focused her attention towards supporting her daughter’s safety and happiness. She was also excited to go back to dentistry school soon and validate her expertise in Canada.

Young women often described the ways in which isolation associated with the im/migration experience shaped their marriage over time, including Kiran and Aleysha. Aleysha arrived to Canada through the spousal sponsorship program with little to no

family or friends in BC. She described how this isolation exacerbated experiences of violence in her marriage: *“I’m not physically able and I’m in mental stress. In [home country] it’s [physical and emotional violence] really normal, but here it is not. But still, you don’t want to fight with your husband, with the police, or the government. I know that my daughter needs me and my husband too. If I divorce him and find another guy, there is no assurance about him being good for me or my daughter. I’m educated and understand my rights. But at the same time, I don’t want to fight with anyone. Here I don’t have anybody, not my mother, father or brother. And my in-laws are always on my husband’s side.”* (age 26, 2.8 years in BC, permanent resident). Aleysha’s hesitancy in leaving her partner or speaking with authorities about her experiences is complex and directly related to a fear and distrust of societally dominant figures and institutions, including men, the im/migration system, and the legal system. Connecting her employment and im/migration experiences, Aleysha demonstrates how precarity in both realms worked together to isolate and make her vulnerable within her marriage and employment, and left her in a financial trap with no ability to pursue her human rights at home or in her workplace.

Young im/migrant women often described how im/migration simultaneously impacted marriage and motherhood, and expressed challenges adapting to these new kin roles on their own after migrating to BC. Kiran’s experience demonstrated how the sudden change associated with these experiences, along with the gendered division of labour, resulted in a loss of her identity and health burden: *“I was the youngest person in my family, married suddenly, then came to Canada and being independent, working a job, doing household work. Everything came really suddenly for me. When I came to Canada I almost forgot myself, where I am, who I am. As a daughter-in-law, a wife, a worker, a student, there were so many things going on with me at the same time. I wasn’t able to understand what’s going on... I don’t really feel in good condition, like healthy.”* (age 24, 3.8 years in BC, permanent resident). While being the youngest child, a partner, a worker, and student are often identities adopted by non-im/migrant women as well, the experience of im/migration, precarious employment and im/migration status, and an arranged marriage creates an added risk of isolation for young im/migrants.

As several participants migrated at young ages after recently being married, some expressed this as important in contributing to needs for sexual health support and information to navigate family planning and new sexual experiences. Hema was one of

few people who described being connected to a family doctor and able to access this information. However, she still expressed a need for additional and ongoing sexual health support, suggesting that this may be a particularly important need for young women who recently arrived and were not similarly connected to a health professional. *“I ask my doctor for information on sexual and reproductive health services and my personal life, because I was new to this relationship and I didn’t know anything about that. My doctor provided me with a lot of information so I never felt any problem... But still, I need more information about that because there are a lot of long journeys ahead in my life.”* (age 26, 1.1 years in BC, permanent resident). Hema’s need for support echoes those of other participants in this study, which suggest a need for Canada’s health and immigration system to intentionally consider the experiences of young im/migrant women who face additional barriers related to language, system navigation, and policies related to im/migration status and health insurance that prevent access to health information when needed.

3.4. Discussion

Participants in this study contributed new evidence of how im/migration shapes young women’s experiences of pregnancy, motherhood, and marriage. Using an intersectional lens and the structural and social determinants of health, we learned how the impacts of im/migration were driven by the combination of health, economic, social, and legal factors. This included barriers to health insurance for people with precarious im/migration status, little to no income due to precarious employment and low-paid job opportunities, feelings of isolation after im/migration, and exclusionary im/migration and employment policies that increased precarity at home and in the workplace.⁴¹ Including three participant cases helped elaborate on these complex impacts in more detail; while these cases are not meant to be representative of all young im/migrant women’s pregnancy, motherhood, and marriage experiences, they provide important context for framing how im/migration systematically shapes young women’s lives.

Participants’ accounts of pregnancy often highlighted how im/migration, health, and employment systems worked together to shape security or precarity in young im/migrant women’s lives. For example, experiencing an unplanned pregnancy while being a new im/migrant often involved having no health insurance due to precarious im/migration status or during a mandatory 3-month wait period, or having low income

and little information on available SRH services. For example, participants clearly articulated that having timely access to contraception would have allowed greater control over their health, and that having timely information on youth clinics would have eased their access to pregnancy care. Others described the added and insurmountable challenge of experiencing a pregnancy while attempting to secure housing, employment, and food soon after arriving to Canada. While some of these issues have previously been documented,^{30,62} our findings further highlight their concentration among young im/migrant women's experiences and the urgency of addressing them.

While a few participants described supportive work environments during their pregnancy, others demonstrated the intricate ways in which Canada's im/migration and employment systems worked together to shape experiences of discrimination. In Canada, people are required to work a specific number of hours to be eligible for maternity benefits.⁶³ However, through Aleysha's experience, we learned that being pregnant led to workplace discrimination and illegal action in the form of reduced work hours, violating policies outlined in the Canadian Human Rights Commission that state that "employment should not be denied simply because a woman is pregnant".⁶⁴ Her reduced hours resulted in a loss of maternity health benefits, an unjust experience that has previously been highlighted among young im/migrants in Canada.³² In fact, a 2021 reports state that 1 in 3 women in Canada face discrimination by employers after becoming mothers.⁶⁵ Aleysha's experience additionally demonstrated how being a young im/migrant whose im/migration and financial status were tied to an abusive partner created additional layers of vulnerability – an experience that was not explicitly shared by other participants but has been reported by other im/migrant women.^{66,67} Our findings emphasize that young im/migrant women's pregnancy experiences must be understood with reference to how health, economic, and legal drivers collude to exert control over their health.

With regards to motherhood and marriage, young women who migrated alone, were married young, were first-time mothers, and were financially dependent experienced challenging impacts of unequal gender roles and power dynamics within marriages and family units; however, this dynamic has been unexplored in prior research of young women's experiences.^{26,27} Several participants anticipated increased opportunities for education and employment after arriving in Canada; however, as partners worked long hours, caregiving roles and responsibilities took precedence.

Working long hours, however, may also be a result of im/migration and gender dynamics, the availability of low-paid work,⁴⁵ and gendered expectations that push male partners to be breadwinners.⁶⁸ Participants also importantly connected the issue of low-paid work to that of unaffordable childcare, stating that the cost of childcare would often be the same, if not more, than their employment income. This, along with the unpaid nature of domestic work, had further detrimental impacts for young women with precarious im/migration status and without social support. Experiences of being let down by the im/migration and legal system were described by several participants, and highlighted the ways in which these systems can be particularly exploitative towards im/migrants, result in financial dependency on partners,³² exacerbating gender and economic inequities,⁶⁹ and male partners' control over women's lives.

Studies that have adopted behavioural and cultural approaches to young im/migrant women's well-being have recommended future research that centers im/migration experiences and status,²³ which we intentionally carried out in this study. Research has also suggested brief interventions to promote healthy behaviours, expand social networks, and reduce potential for harm associated with unhealthy behaviours.^{70,71} While participants in this study highlighted the importance of having social support when navigating experiences of pregnancy, motherhood, and marriage as recent im/migrants, our findings suggest that behavioural interventions on their own may be insufficient to address structural issues such as accessing maternity benefits and affordable childcare while having a temporary or no official im/migration status, for example. Our findings emphasized the value of understanding young women's pregnancy, motherhood, and marriage experiences from an im/migration perspective and directs us to important areas for action.

The few pregnant participants who experienced workplace discrimination demonstrate the harmful ways in which im/migration status is linked to employment and access to healthcare in Canada. Our findings suggest that BC's health system decouple im/migration status from health insurance eligibility – an act that would protect the rights and health of young im/migrants. The requirement to work 420 hours to be eligible for maternity benefits is ableist and ignores the vulnerability of young im/migrants in precarious work environments.⁶³ Our findings suggest that the government eliminate this policy and instead focus efforts towards providing all people with maternity benefits as a human right.

Finally, our findings support decades of advocacy for universal childcare – a longstanding issue in BC and Canada. Young im/migrant women described how caregiving responsibilities associated with motherhood were accompanied by unaffordable childcare, which led to mental and physical harm in the form of a loss of identity, feelings of isolation, sacrificed goals, and exposure to violence. Our findings support calls for provincial and federal leadership to build public systems of childcare in BC.⁷² Given the prominent role of caregiving in young im/migrant women’s experiences of pregnancy, motherhood, and marriage, our findings also recommend that the government fund community-based efforts towards dismantling structures of patriarchy. This includes community-led discussions around shared unpaid labour as an effort to increase participation in caregiving work across gender identities and within households,⁷³ and address sacrificed educational and career goals.

3.4.1. Strengths and Limitations

Our findings fill a critical gap in exploring how im/migration shapes experiences of pregnancy, motherhood, and marriage among young women. Recruitment of the study population was conducted in collaboration with IRIS community partners and supported by a youth-specific arm to learn about the experiences of young im/migrant women. This led to a high representation of young im/migrant women with precarious im/migration status, an important strength of our study given that women with temporary or without im/migration status have often been excluded from research with young im/migrants. Our ability to learn from their experiences is attributed to the trusting relationships and rapport built between our partners, community-based research team, and local im/migrant communities. Future research is needed to expand evidence on the pregnancy, parenthood, and marriage experiences of young im/migrants of all genders, including transgender and non-binary persons, particularly as we did not ask questions around participants’ gender identity. The community-based nature of this study supported collaboration with im/migrant women in all stages of the research, strengthening its validity, quality and rigor. A limitation is that these findings may not be representative of the experiences of all young im/migrant women; for example, we intentionally interviewed women with precarious im/migration status and that spoke English, Dari, Farsi or Tigrinya to match the languages spoken by our interview team. Additionally, as SM was the only author who conducted interviews with young im/migrant

women, the three participant cases were limited to interviews conducted by SM. The community-based and participatory nature of this study supported collaboration with young im/migrant women in all stages of the research, including the use of these three cases to articulate complex and rich life experiences.

3.5. Conclusion

Young women's experiences of pregnancy, motherhood and marriage as shaped by im/migration have been limited in research to date; our findings demonstrate why these perspectives are needed. As parents, spouses, workers, students, and survivors of violence, our findings demonstrate that many of the hardships brought about by pregnancy, motherhood, and marriage are shaped by im/migration, health, and employment policies and practices with serious impacts for young im/migrant women. Drawing on an intersectional lens, participant narratives highlight how young im/migrants face unique challenges based on their age, im/migration status, occupation, and access to safety that must be considered. We hope that this study inspires future research and practice to understand young im/migrant women's experiences more deeply through the context of interconnected structures and lived experiences. Listening to people speak of their own experiences offers a fuller picture necessary to understand how im/migration shapes young women's well-being. Our findings call for the decoupling of im/migration status from health insurance, accessible childcare and maternity benefits for all, and funded community-based efforts towards dismantling structures of patriarchy.

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Chapter 4. “A pandemic is very serious, but we can’t push other illnesses to the side”: Impact of shifts in health service delivery during COVID-19 on young im/migrant women’s access to sexual and reproductive healthcare

4.1. Background

The COVID-19 pandemic has disproportionately impacted communities who are systemically marginalized, with recent research demonstrating exacerbated sexual and reproductive health (SRH) care inequities faced by young people¹⁻⁴ and im/migrant women.⁵⁻⁸ We define young people as persons aged 15-30,⁹ and im/migrants as migrants and immigrants with permanent and precarious im/migration status, the latter of which includes people with temporary and without immigration status.¹⁰ SRH inequities include those stemming from inadequate choice in and access to contraception, protection from STIs and reproductive cancers, access to sexual health information and counselling, and access to safe pregnancy and childbirth experiences.¹¹ SRH care is one of the primary reasons for young people’s interactions with healthcare, relative to other age groups.¹² Globally, early responses to the COVID-19 pandemic included many clinic-based health services temporarily halting, operating on restricted hours, or being provided virtually to protect people from virus transmission.¹³ While clinic-based and virtual SRH services continue to be offered, little is published about how COVID-related shifts in service delivery impacted young im/migrant women’s choices in and access to SRH care.

Young im/migrant women are overrepresented in essential occupations as clinic staff, caregivers, and domestic workers, often hold temporary or no official im/migration status,¹⁴ and are increasingly exposed to COVID-19 transmission and labour exploitation. Young im/migrants’ work environments may also contribute to more acute impacts of changes in health service delivery during the pandemic, where recent reports of employers exploiting temporary workers have increased.^{15,16} For example, although employers are responsible for providing people with time off work to attend appointments or transportation to health clinics, young im/migrants have reported not having such support.^{16,17} Their experiences vary, however, and an intersectional approach¹⁸ is

needed to appropriately understand how systems of oppression, including xenophobia, sexism, and capitalism, intersect to shape healthcare access. As little research has examined young im/migrant women's SRH care experiences early in the COVID-19 pandemic, we reviewed literature to first examine young women and im/migrant women's SRH care access during the pandemic. We attempted to review the literature using an intersectional approach to understand the impacts of being a young im/migrant woman accessing SRH care during the pandemic; however, this research was limited. Therefore, we used an additive approach to begin by exploring the impacts of being a young person and an im/migrant as singular determinants.¹⁹ This is different from an intersectional approach, which helps us understand the cumulative impacts of these identities. An additive approach was a helpful first step to understand how SRH care experiences during COVID-19 may have been different for young im/migrant women.

Scholarship attending to young cisgender women's access to SRH care early during the COVID-19 pandemic has often discussed the benefits and drawbacks of virtual services. Some studies have noted value in the electronic communication, remote interpretation, privacy, and confidentiality provided by virtual SRH care,^{2,20,21} where young women have expressed appreciation for virtual contraception consultations and prescription access²¹ and experienced few technical barriers.²⁰ In other studies, young women have described virtual SRH care as less personal, uncomfortable, and culturally insensitive and exclusive, noting that it offered less privacy and confidentiality compared to clinic-based SRH care.^{4,20-22} Experiences were deeply shaped by context; barriers to virtual SRH care were more severe for those who had no pre-existing relationship with a doctor,⁴ lived in unsafe home environments²⁰ or with parents,^{3,4} or had limited access to Internet or technology.^{2,4,20} Experiences were also shaped by type of SRH care needed;²⁰ virtual services were not suitable for IUD insertions and STI testing,^{21,22} and young women had difficulties finding trusted, accurate sources of sexual health information online in order to make informed SRH decisions.⁴ Across studies, researchers expressed that virtual SRH care may be more appropriate for young women with digital literacy and higher socioeconomic status, acknowledging limitations to its feasibility for systemically marginalized populations, including young im/migrant women.^{2,4,20}

Given that some types of SRH care require clinic-based services, including IUD insertions and pregnancy ultrasounds, as well as evidence that young women desire in-

person SRH care alongside virtual services,^{2,20} understanding how COVID-related shifts within clinic-based care impacted young women's SRH care access is important to inform health and immigration research, policy, and practice. Barriers to clinic-based SRH care faced by young women during the pandemic have included fear related to potential COVID-19 transmission in health care settings,^{4,21} far locations of clinics,^{7,23} experiences of ageism and SRH stigma in healthcare settings,^{1,2,4} limited knowledge and availability of services,²¹ and insensitive provider attitudes.^{4,7} Young women have also specifically described temporarily halted maternity services and a lack of appropriate follow-up after abortions as challenging,² particularly as rates of unplanned pregnancies, and intimate partner violence increased during the pandemic.²² Given important evidence of barriers to in-person and virtual SRH services faced by young women during COVID-19, it is important to understand how these barriers intersect with the context of im/migration to impact young im/migrant women's access to SRH care.

Limited evidence specific to im/migrant women's SRH care access early in the COVID-19 pandemic showed that women with no official im/migration status in Canada and the U.S. faced exacerbated barriers related to the fear of deportation, unaffordable childcare, language barriers, xenophobia in healthcare settings, and high costs of care if uninsured.^{7,23} In the midst of increased unemployment and income loss during the pandemic, and exclusion from government income support,⁷ many were forced to rely on financial and health system navigation support from community-based organizations.²⁴ In Canada, where people aged 15-34 make up the highest proportion of im/migrants (20%),²⁵ understanding how these findings may translate for young im/migrant women is important. In addition to holding precarious occupations and im/migration status,¹⁴ their experiences may be shaped by immigration policies that are designed to exploit their labour at the expense of their health through temporary work programs.²⁶ Shifts within Canada's immigration system driven by the pandemic, including delayed processing for im/migration status renewal after expiration, for example, has already impacted im/migrants.²⁷ Understanding how im/migration and employment intersect to affect young im/migrant women's experiences with SRH care during COVID-19 is critical to improving healthcare access.²⁸

Canada presents an important environment to explore young im/migrant women's experiences with SRH care during the COVID-19 pandemic. In March 2020, many clinic-based services were temporarily halted. Although clinic-based healthcare

gradually resumed over time, virtual healthcare continues to be offered in Canada and has persisted as a larger proportion of healthcare visits than ever before.²⁹ In the midst of this, community organizations in Vancouver, British Columbia (BC), have observed a recent increase in young women arriving pregnant, as new parents, and with precarious im/migration status,³⁰ demonstrating the need for accessible SRH services and information. As such, our study aims to explore the following research question: What are the impacts of shifts in health and im/migration service delivery made early during the COVID-19 pandemic on young im/migrant women's access to and experiences with SRH care? Given evidence of barriers to SRH care faced by several populations early during the COVID-19, we anticipate that the experiences of young im/migrant women will be especially challenging due to the exclusion from government income support, precarious occupational environments, and temporary or unofficial im/migration status.

4.1.1. Theoretical Frameworks

This research was guided by the application of anti-oppression frameworks to understand how systemic and structural forces differentially contribute to inequities in young im/migrant women's reproductive lives. Specifically, we were guided by a reproductive justice lens³¹ and an important accompanying building block, intersectionality theory.^{18,32} Framing our study through a reproductive justice lens meant prioritizing young im/migrant women's understandings of how structures and systems constrain or support their human rights and control over their body.³² It also meant accounting for the full spectrum of young im/migrant women's SRH well-being, including physical, mental, political, social and economic considerations in SRH care experiences.³¹ An intersectional approach helped us differentiate how facets of young women's identities, including im/migration status and socio-economic status, shaped their lived experiences. Coined in 1989 to further Black feminism and race and civil rights activism, intersectionality theory analyzes the cumulative effect of intersecting forms of marginalization and axes of oppression in informing people's experiences.¹⁸ As evidence of young women's SRH care access during COVID-19 lacks a focus on im/migrants, we drew from what we learned in our additive literature review and used an intersectional lens to understand how the cumulative and complex impacts of xenophobia and capitalism, for example, shaped young women's SRH care experiences during the pandemic. Taken together, our theoretical framework attends to whether and

how young im/migrant women had the information to make informed SRH decisions, had access to a variety of SRH services to make full SRH choices, and experienced no barriers or coercion to make free SRH choices³³ early during the COVID-19 pandemic.

4.1.2. Accessing Healthcare in Canada

Canada's health system is described as universal,³⁴ yet legally, it is designed to only ensure access to healthcare for citizens and permanent residents, excluding people within other im/migration categories. Across Canada, primary care operates under a gatekeeping model, where access to specialist health services requires a referral from a primary care provider (family physician or nurse practitioner).³⁴ Some services are exempt from this model, including abortion care, SRH clinics, and youth clinics. Health insurance plans vary by province and territory, including in coverage for prescription drugs, mental healthcare, and midwifery services, and proof of residency in a province remains a requirement for public insurance across Canada. In BC, people with Canadian citizenship, permanent residency, or temporary work or study permits valid for six or more months are eligible for the Medical Services Plan (MSP) – the provincial health insurance program – with some conditions; people whose permits expire are ineligible.³⁵ All people, including any young women, arriving in BC from another country or Canadian province and who are eligible are expected to apply for MSP coverage as soon as possible after arrival, and must then wait for 3 months before they can access MSP. In April 2020, people with expired work or study permits were provided extended temporary MSP coverage. COVID-19 treatment for uninsured im/migrants could also be reimbursed by the province,³⁶ but this did not apply to other types of care.

4.2. Methods

4.2.1. Study Design

The qualitative data analyzed in this paper were collected with im/migrant women as part of the Evaluating Inequities in Refugee and Immigrant Health Service Access (IRIS) project. IRIS is a longitudinal, community-based, mixed-methods study of im/migrants' access to health services in British Columbia (BC), Canada. The project is built on partnerships with local im/migrant-serving community organizations (e.g., MOSAIC, PIRS, Sanctuary Health, Watari), an im/migrant advisory board, and a

research team with im/migration experience and expertise in qualitative and health services research. IRIS holds ethical approval from the Simon Fraser University (SFU) and Providence Health Care/University of British Columbia (UBC) harmonized ethics review boards.

To honour our commitments to a reproductive justice framework and intersectionality theory, as well as the particular ethical commitments offered by a research justice approach, our research design prioritized collaboration with and shared decision-making control between researchers and im/migrant women.³⁷ IRIS includes “community” as im/migrant participants and their communities, im/migrant team members, and community partners mentioned above. We collaborated with im/migrant team members, participants, and community partners on the development of research materials, data collection, participatory analyses, and privacy and confidentiality agreements; the co-creation of clear dissemination products; and knowledge translation and exchange.³⁸ SM (PhD student), RV (IRIS Community Researcher & Advisor) and ET (IRIS Project Coordinator) are three self-identified im/migrant women with research lenses informed by migration and healthcare experiences both similar to and different from those shared by participants. A community-based research design was important to support cultural humility, transparent and respectful partnerships, and a collaborative process that involved young im/migrant women leading this research.³⁸

This research is based on two sets of data from the IRIS project that had important commonalities that lend themselves to a joint data analysis. We first conducted one-on-one, in-depth sexual and reproductive health (SRH) interviews with im/migrant women aged 15-49 that focused on im/migration background, experiences with SRH and related health services, and recommendations for SRH service access from March-August 2020. As these interviews and analyses progressed, we learned that the unique issues faced by young women (ages 15-30) required additional youth-specific data collection approaches. Given this, we subsequently developed a youth-specific supplementary set of interviews that specifically attempted to highlight the experiences of young women aged 15-30, which were conducted between August-November 2020. These interviews were facilitated using an interview guide that addressed the specific SRH and related health priorities and needs of young im/migrant women. For example, as both interview guides asked about specific SRH care experiences of im/migrant women, the interview guide used with younger participants asked how they anticipate or

experience SRH care access being different for young im/migrant women. Although this interview guide did not include questions related to COVID-19, participants often described how the pandemic impacted their SRH care access. Preliminary conversations with community partners that served young im/migrants suggested that group interviews could allow for greater comfort, safety and in-depth responses than one-on-one interviews due to the sense of community that they offered. Thus, when recruiting young women for the youth-specific interviews, we provided the option of one-on-one interviews or participation in a group interview. This study includes data from both individual and group interviews to more fully understand the experiences of young im/migrant women.

4.2.2. Study Participants and Recruitment

Eligible participants (N=22) were im/migrants who self-identified as women; moved to Canada from another country; were aged 15-30; lived in Metro Vancouver; and provided informed consent. Recruitment of a purposive sample of young women and women with precarious im/migration status was supported by personal and professional networks of our community-based research team, as well as study posters and outreach to community partners.

4.2.3. Data Collection

To facilitate rapport, multilingual and multicultural im/migrant interviewers (including SM and ET) conducted all data collection activities; due to pandemic conditions, interviews were virtual (e.g., Zoom, WhatsApp, FaceTime). All individual interviews (N=16) and the group interviews (N=6) used the same procedures. Facilitators explained the purpose of the study, the voluntary and confidential nature of participation, and obtained verbal informed consent. Interviews were conducted in participants' preferred language (English, Dari, Farsi, Spanish, Tigrinya), were audiotaped and lasted 1.5-2 hours. Interviews with im/migrant women as part of the main IRIS project were conducted between May 2019 and February 2021, while interviews with young im/migrant women as part of the youth-specific arm were conducted between August and November 2020. All participants completed an interviewer-administered socio-demographic questionnaire to contextualize the sample

and were given honoraria of \$40 CAD in recognition of their time and expertise, referrals to health, social, and legal support, and childminding support as needed.

4.2.4. Data Analysis

We transcribed interviews verbatim; multilingual transcriptionists simultaneously translated sessions not conducted in English. A team member who spoke the same language of the interview then accuracy-checked each transcript. We assigned unique codes and pseudonyms to participants and removed all personal identifiers from transcripts to ensure anonymity. We loaded transcripts into NVivo V12 for analysis.

Our first step in data analysis occurred as part of the coding process within the larger IRIS project. We began with coding each transcript (one-on-one and group interviews) using an iterative, team-based process and a combination of inductive and deductive approaches. Coders, members of the IRIS team (including SM and ET), met regularly to collaborate on code boundaries and themes.^{39,40}

In our second step in data analysis, SM reviewed interview transcripts of young im/migrant women to extract quotes that described SRH care experiences during the COVID-19 pandemic. SM and RV then met weekly to co-analyze quotes. They used an iterative and inductive approach to create a codebook specific to this analysis, and manually recoded the quotes. They co-generated initial themes using a thematic analysis approach.⁴¹ This second pass used inductive coding to understand young im/migrant women's access to and experiences with virtual and in-person SRH care during COVID-19. In this step, we were guided by intersectionality theory to understand how shifts in health and im/migration service delivery made during the pandemic shaped young im/migrant women's access to SRH care differently and in complex ways based on their intersecting social locations, including socioeconomic and im/migration status, age, and occupation. We were also guided by a reproductive justice lens, which we drew on to analyze experiences of SRH care in the context of power relations and systems and intersecting forms of oppression,³² including health and im/migration policies, xenophobia, and unequal gendered power dynamics.

As part of reflexivity within qualitative research, SM and RV met with ET across the analysis process to discuss and refine themes. During this time, they recognized and

reflected on their positions as researchers and young im/migrant women, particularly as naturalized Canadian citizens who are fluent in English and have navigated shifts in health and im/migration service delivery made early during the COVID-19 pandemic in BC. Through regular discussions, they unpacked how their experiences and positions may shape the analysis and worked to center the perspectives of participants.

Once the analysis was complete, we shared a multilingual mobile summary of findings and recommendations included in this study to all young im/migrant women who consented to future contact via text message and email, including community advisory board members. This summary included a survey that asked im/migrant women to indicate their preferences for where the findings should be shared. We also shared a document of quotes and pseudonyms to those whose specific SRH care access experiences were discussed. We invited each participant to participate in a paid follow-up interview if they wished to refine the information pertaining to their experience. Participants who responded expressed approval of their quotes and pseudonyms, as well as appreciation for considerations made around confidentiality.

4.3. Results

Among 22 young women included in this study (Table 1), most had experiences of precarious im/migration status, including no official im/migration status, work permits, and asylum claims. A few participants were permanent residents and citizens. Participants with experience of having no official im/migration status explained that losing their im/migration status was often a result of work permit and visitor visa expiration or im/migration status processing delays. To our knowledge, all participants were cisgender heterosexual women, consistent with most literature we reviewed.

Table 3. Socio-demographic characteristics of young im/migrant women (N=22), March 2020-January 2021

Age – Median (range)	25 (17-30)
Region of origin – Number of women	
Region of the Americas & Europe (Colombia, Mexico, Spain, Venezuela)	12
Eastern Mediterranean & African Regions (Afghanistan, Eritrea, Iran)*	5
South-East Asian & Western Pacific Regions (Bangladesh, India, Philippines)*	4
Unknown	1
SRH services needed and/or used during the COVID-19 pandemic - Number of women	
Pregnancy and postpartum care	8
Contraception services	7
SRH information and resources	5
Other SRH needs/services (e.g., ovarian cyst treatment, menstrual pain, STI testing)	4
None	3
Years in Canada – Median (range)	2.1 (0.5-9.2)

*These regions were grouped together to protect participant confidentiality

Narratives of young im/migrant women highlighted different ways in which shifts in health and im/migration service delivery made during the COVID-19 pandemic in BC shaped their choices in and access to pregnancy care and contraception. While previous research with young people has examined access to STI screening and treatment, these SRH services were not raised in the interviews analyzed. Participants described impacts of the (i) transition to virtual SRH services, (ii) restricted in-person SRH care, and (iii) im/migration status and health insurance processing delays as key factors that shaped their access to virtual and clinic-based SRH care during the pandemic. These factors had different impacts for young women based on their social locations and the structures that influence them, including their access to social support, employment protections, time spent in destination settings, language ability, household safety and health insurance, and im/migration and socioeconomic status. Participants who became mothers, navigated contraception use for the first time, or had precarious im/migration status or employment during COVID-19 often faced especially complex barriers to SRH care and uncertain virtual and clinic-based SRH care experiences. The significance of these findings is that young im/migrant women’s sexual and reproductive lives and experiences are complex, and there is no singular experience and no one-size-fits all

protocol to addressing them. Our findings point to how intersectionality in connection with a reproductive justice framework can be useful conceptual lenses for understanding this complexity and leading to efforts that are appropriately nuanced.

4.3.1. Impacts of the transition to virtual pregnancy and contraception services on young im/migrant women's access to pregnancy and contraception services during COVID-19

Focusing on pregnancy and contraception services, participants' narratives alluded to the reality that these types of care were solely offered virtually early in the COVID-19 pandemic in BC. During this time, young im/migrant women's experiences of virtual SRH care access varied based on their personal circumstances and the type of service needed. In accessing pregnancy care, for example, participants who were connected to a family doctor prior to the pandemic had relatively smooth transitions to virtual care. They continued to have the information to make informed SRH decisions, and had access to SRH services to make full choices. Fatima said:

I still have the same family doctor. I receive a lot of support from [them]. She was the only doctor that knows a lot about my background [...] she's very supportive. For almost two months I had appointments with my family doctor through phone. I was able to discuss everything with her (age 26, permanent resident, 2 years in BC).

However, participants also described how having a family doctor alone was insufficient to fully support their pregnancy care experiences. Fatima was a first-time mother in the early stages of their pregnancy when the transition to virtual SRH care took place, and described concerns that virtual pregnancy care alone provided little assurance about the health of their child: *"I was worried because I didn't know how the baby was. The doctor told me to focus on the baby's movement, and if the baby is moving, then everything is okay"* (age 26, permanent resident, 2 years in BC). Such narratives demonstrated that having a pre-existing relationship with a family doctor may have eased the transition to virtual SRH care for young im/migrant women during COVID-19, but that virtual pregnancy care alone still posed barriers to supporting confidence in their child's health. These examples also suggested that young im/migrant women who were not connected to a family doctor prior the pandemic may have had particularly challenging experiences navigating the transition to virtual SRH care.

Interestingly, participants in this study explained how virtual contraception services often fell short of young im/migrant women's SRH service delivery needs during the pandemic. A few women described virtual contraception consultations as unsupportive with regards to unaccommodated preferences for female health providers. They noted, however, that urgent needs to begin or stop their use of contraception during COVID-19 took precedence over personal safety or comfort. Roma described their virtual consultation for an IUD insertion:

It was with a male doctor, so that was a little bit uncomfortable, but at the same time I had no choice. I really needed to get off the pills because I was getting chronic migraines. Yes, in a way I was able to access that, but there wasn't much support that I got... that I really wanted to have. (age 24, citizen, 9.2 years).

For Roma, "access" was much more than their ability to see a doctor. Having needs-specific contraception support was especially important as Roma lived with their family at home, where SRH was stigmatized. As such, they hid their desire for and use of contraception and had limited privacy in using virtual care. Roma expressed a desire for ongoing virtual support and information from their doctor after the in-person IUD insertion appointment; however, this was not offered: *"It was very much a transactional business... What if something happens with my IUD, especially in a pandemic? Nobody knows in my family. What if it becomes dislodged, where do I go? Who do I ask for support?"* (age 24, citizen, 9.2 years). Having to solely depend on virtual care while in-person SRH care was temporarily restricted, Roma was concerned about having no ongoing support from their doctor in the midst of uncertainty during the pandemic. Although they successfully used contraception, Roma's example highlighted the layered complexities faced by young im/migrant women who needed patient-centered and ongoing SRH support during COVID-19, and the ways in which virtual SRH care did not adequately provide this.

On the other hand, despite there being a general preference for in-person pregnancy care, several participants valued the option and safety that virtual consultations offered during the pandemic. Comfort associated with virtual pregnancy care, however, was greater for women who had received in-person care prior to COVID-19, demonstrating the value of clinic-based services during pregnancy. Monica explained: *"The other day I had one on the phone. They asked me some questions. The*

truth is for me, yes, it was good. But I have had almost all of them in person, so I don't have any complaints." (age 26, work permit holder, 4 years in Canada). The value of virtual pregnancy care was also deeply shaped by young women's personal circumstances, including experiences of domestic violence and coercion. Katrina described their experience after temporarily returning to their home country at the beginning of the pandemic due to the unaffordable cost of living in BC, and being met with BC's mandatory self-isolation period upon arrival: *"It [domestic violence] was really impacted by COVID-19 – during the self-isolation period... I also got pregnant again. He wasn't supportive and was forcing me to get an abortion."* (age 29, permanent resident, 4 years in BC). In simultaneously experiencing reproductive coercion, pregnancy, and domestic violence, Katrina expressed that using virtual midwifery care, legal aid, and social support protected their time and money, and supported their reproductive safety, mental health, and safety from COVID-19 transmission:

I didn't have to expose myself or feel anxious being on transit and commuting, so I was saving time. I also didn't have to find somebody to look after my daughter. The fact that I could just, in the same morning, call a legal advisor, a support worker and a midwife made it easier and way faster and less stressful. I felt more empowered too.

Katrina explained, however, that their experience would have been more challenging for a young woman who arrived more recently to Canada or faced language barriers. They highlighted the role of access to technology, time spent in Canada, and English language ability in accessing virtual pregnancy care and escaping violence during the COVID-19 pandemic.

4.3.2. Impacts of restricted in-person SRH services on young im/migrant women's access to pregnancy and contraception services during COVID-19

Young im/migrant women provided nuanced accounts of their experiences accessing in-person SRH services at a time when these services were temporarily restricted. Participants expressed feeling like clinic closures or limited hours of operation early in the COVID-19 pandemic neglected their service delivery needs for contraception and pregnancy care. Those who needed a consultation for tubal ligation, for example, described feeling forced to choose between losing a day of income or neglecting their

SRH needs. Indeed, the combination of restricted in-person services and unsupportive work environments not only impeded meeting their own contraception needs and choices, but that of their partners. Lucia explained:

I would like to go with my partner in case the [contraception] method is for him and not for me. But because he has been working and we cannot go at a time that the doctor's office is open, we have not concluded anything. We already said if it [pregnancy] happens, it happens. (age 30, permanent resident, 2.4 years in BC).

Lucia's experience demonstrated the ways in which reproductive lives were negatively impacted by shifts in health service delivery and work environments that do not support medical time off. This pushed some to pit their reproductive needs against their financial needs.

Shifts within clinic-based pregnancy care related to COVID-19 safety protocols also interacted with unsupportive employers to negatively shape participants' SRH care experiences. For example, although the protocol that patients attend appointments alone offered safety in reduced virus transmission, participants felt that they neglected the critical role that family, friends and community members played in providing young im/migrant women with social support in healthcare settings. Alessandra explained how this contributed to feelings of fear and isolation for first-time mothers:

When our baby was born, we could not receive visitors in the hospital. It was just my husband, and he had to go to work. We asked if a friend could please come, so I wouldn't be left alone, they said 'no, if it's not your husband then you have to be alone' (age 29, work permit holder, 1.4 years in BC).

Alessandra described the apathetic ways in which protocols were sometimes communicated by health personnel, and highlighted that young im/migrants' unjust work environments may not allow unpaid time off. This experience demonstrated a disproportionate impact of COVID-19 safety protocols in health service delivery for young im/migrants who often hold precarious occupations. Having less people present in healthcare settings supported safety from COVID-19 transmission, but occurred alongside unsupportive work environments that impeded young im/migrants' access to SRH well-being and social support.

As participants often attended clinic-based pregnancy care without accompaniment in accordance with COVID-19 safety protocols, having doctors who practiced patient-centered SRH care was especially important; however, young im/migrant women noted that this was often lacking. While challenges related to unaccommodated requests for female health providers, for example, existed prior to COVID-19, participants expressed that being placed in compromising positions while clinic-based SRH care was already restricted contributed to heightened stress alongside the uncertainty of the pandemic. Fatima explained:

There are a lot of pregnancy tests you need to do, but I was not feeling very comfortable with a male doctor. Whenever I had an appointment, the only focus that I had was that I wanted a female doctor. Even in ultrasounds (age 26, permanent resident, 2 years in BC).

Fatima demonstrated how their ongoing concern about potentially being attended by a male doctor, particularly as they often attended appointments alone, may have prevented them from fully focusing on their pregnancy, which was especially concerning as a first-time mother. Similar experiences of neglected SRH service delivery needs were described across interviews, where young im/migrant women often described feeling that their SRH was pushed aside and treated as secondary to COVID-19. At a time where in-person healthcare was limited and virtual care was often insufficient, participants expected greater attention to SRH care. Instead, many shared a mistrust in BC's health system's ability to provide appropriate SRH care during the pandemic.

4.3.3. Impacts of immigration status and health insurance processing delays on young im/migrant women's access to pregnancy services during COVID-19

Participants' narratives of SRH care experiences demonstrate how being a young woman navigating the immigration system during the COVID-19 pandemic led to often specific and challenging experiences. Delays in processing im/migration status changes and health insurance coverage driven by the pandemic, for example, often prevented young im/migrant women's access to ultrasounds and consultations required at certain stages of pregnancy. Women whose im/migration documents expired during the COVID-19 pandemic, including Monica, were often left without health insurance for

extended periods of time, and paid out-of-pocket for needed ultrasounds and pregnancy consultations:

When I had to get the ultrasound, I was waiting for a new MSP card [because it expired], so I had to pay. They did not tell me anything, they just gave me the invoice and that was it. It was \$250, plus the medical consultation, \$80. (age 27, no official im/migration status, 5 years in BC).

Participants often expressed that the financial consequences of these systemic delays were not appropriately communicated prior to using healthcare, which resulted in costs that were unexpected and that exacerbated their mistrust of Canada's health and im/migration systems. Monica also explained that being unable to use pregnancy care for these reasons left them uncertain about their child's health: *"When you apply, the wait is too long for the card to arrive... Not being able to go to the doctor for not having a work permit has affected me. I can't know anything about my baby."* These experiences demonstrated how unjust ties between im/migration status and health insurance created by Canada's immigration and health systems denied young women's access to SRH care, with impacts made more severe by systemic delays brought by the COVID-19 pandemic.

For some participants, im/migration status and health insurance processing delays during the COVID-19 pandemic symbolized a neglect of young im/migrant women's SRH concerns and decisions, which contributed to stress and fear. Nahomi explained:

We are still waiting for a response [to be seen by a clinic] due to COVID... right now it seems that for them it is not so important, a pregnancy right? In my case it is very important, because right now I am starting to feel unwell... I am very afraid, being pregnant and not being able to even have a medical check-up (age 24, im/migration status not disclosed, 2 years in BC).

On the other hand, the few participants who experienced timely, positive changes in im/migration or health insurance status during the pandemic explained how this facilitated their access to pregnancy and postpartum care by way of improved access to family doctors and midwives. Alessandra received a work permit during the pandemic

after previously having no documentation, and compared their access to postpartum support after experiencing pregnancy and childbirth without im/migration status:

Now I have a family doctor. Previously, well no, I didn't know who to ask, where to go, I didn't know any of that. Now it is different... there have been changes, and I feel it was after the MSP. (age 29, work permit holder, 1.4 years in BC).

Several participants, however, explicitly noted that young women who may have not received a more secure im/migration status during the pandemic were as deserving of SRH care. These experiences highlighted the control that Canada's immigration system has in shaping im/migrants' access to SRH care by way of im/migration status, where improvements were significant even for those whose more secure status was temporary.

4.4. Discussion

Im/migrant experiences are missing from evidence of young women's choices in and access to SRH care early during the COVID-19 pandemic, and our findings demonstrate why intersectional im/migration perspectives are needed. Research on young women's SRH access during COVID-19 has found virtual services to be helpful, for example,^{2,20,21} however, these studies have not described the SRH care experiences of young im/migrant women, including the role of time spent in Canada, English language ability, and employment. Our study demonstrates how participants who spent more time in Canada, were connected to a doctor prior to the pandemic, had greater English language fluency, and held less precarious employment had more positive experiences accessing virtual pregnancy care, for example. These were also the same participants who often held permanent residency or citizenship. Young women's social locations heavily influenced how im/migration factors shaped access to SRH care – a human right that is unjustly determined by time spent in Canada, English language fluency, workplace environments, and im/migration status. Our research also builds on recent quantitative research evaluating young people's engagement with virtual healthcare during the COVID-19 pandemic in Canada. Whereas one study found that young people faced no disparities in virtual healthcare access,⁴² our research found that experiences with virtual SRH care varied based on access to technology, connection to a family doctor, time spent in Canada, and English language ability. This may be

explained by our emphasis on the ways in which intersecting social locations and structural forces shape young im/migrant women's experiences with SRH care.

Our findings also outline the ways in which im/migration and employment status shapes young women's access to health insurance, moving them in and out of precarious situations determined by Canada's im/migration system. The unjust coupling of im/migration status, employment status and health insurance denied young im/migrant women's right to SRH care and information by way of processing delays and exacerbated workplace environments during the COVID-19 pandemic, and left many without the ability to make informed SRH decisions or freely access SRH services for extended periods of time. These findings are supported by a report by Canada's Auditor General that young im/migrants' access to workplace protections have worsened.⁵² Unsupportive work environments impeded young im/migrants' access to SRH well-being and social support – aspects of health service delivery that are evidently critical to positive healthcare experiences among young im/migrant women. Our findings build on prior evidence in Canada which has found that young people with precarious im/migration status and employment are often treated as undeserving of care,^{17,45} and demonstrate that this pattern continues to hold during COVID-19.

Young im/migrant women in this study contributed new evidence regarding how im/migration, social and health contexts inform benefits and drawbacks of virtual SRH care during COVID-19. For example, our findings provided novel evidence of the role that pregnancy stage and prior access to clinic-based care played in shaping virtual consultation experiences; those who were later in their pregnancy and received clinic-based care prior to the pandemic reported better virtual pregnancy care experiences, while those who were earlier in their pregnancy felt less confident about decisions regarding their child's health with virtual care alone. Connections to a doctor prior to COVID-19 as a facilitator to virtual pregnancy care access echoed previous research,⁴ highlighting the critical role of system navigation support in assisting young im/migrant women to access virtual SRH care during the pandemic. System navigation support, however, is insufficient without timely im/migration status and health insurance processing, where related delays left many unable to use timely contraception services, contributed to unplanned pregnancies and out-of-pocket payments, and deepened mistrust in Canada's health and immigration systems. Although close follow-up has been an essential component of virtual SRH care for young women during COVID-19,² our

findings also articulated how a lack of ongoing support for contraception was especially challenging while clinic-based services were restricted and for young im/migrant women who had limited social support. These experiences, however, took place alongside those of timely im/migration status changes, which facilitated access to health insurance, family doctors, and midwifery services for some women. While these findings are comparable to those found in commentaries and viewpoints published early during the COVID-19 pandemic,^{2,4} participants in this study enhance this work by highlighting the unique role of im/migration status and social support in young im/migrant women's SRH care access. The findings speak to how health and immigration systems shaped virtual and clinic-based SRH services and disproportionately impacted young im/migrant women.

While some contraception and pregnancy services can only be accessed in clinics, there has been limited published research about young im/migrant women's experiences of in-person SRH access during temporary restrictions of these services that were put in place during the initial phase of the COVID-19 pandemic. In this study, participants' narratives of restricted clinic-based SRH care contributed new understandings of how a lack of consideration for young im/migrants' social locations in accessing healthcare. For example, virtual contraception consultations were less supportive for participants who used contraception for the first time during the pandemic or lived with parents amidst SRH stigma. These findings are different from recent observational and survey research that found that virtual contraception consultations were helpful for young women in the United States more broadly.^{20,21} This difference in findings may be attributed to the in-depth and nuanced nature of qualitative research, as well as our application of reproductive justice and intersectional frameworks to better understand complex SRH care experiences among young im/migrant women. In this study, challenges associated with temporary clinic closures and limited hours of operation, combined with inadequate workplace protection, impeded young im/migrant women's access to SRH care. Having no paid time off to attend medical appointments forced several women to choose between fulfilling financial or contraception needs, which previous research has shown to be especially important for many young im/migrants who hold temporary im/migration status and work precarious roles without rights to healthcare, workplace protection, or income support.^{46,47} Where articles have often focused on the economic and social impacts of the COVID-19 pandemic,

participant narratives highlighted unjust links between employment and im/migration status that intentionally form the structure of Canada's immigration system and reflect the value placed on the economy at the expense of im/migrant health, well-being and reproductive choices.⁴⁵

4.4.1. Strengths and Limitations

Recruitment of the study population conducted in collaboration with IRIS community partners included a high representation of women with precarious im/migration status. This is an important strength of our study given that women with precarious im/migration status have often been excluded from research. Our ability to learn from their experiences is attributed to the trusting relationships and rapport built between our partners, community-based research team, and local im/migrant communities. While qualitative research does not aim to be representative, our findings still fill a critical gap in understanding the impacts of shifts in health and im/migration service delivery made during the COVID-19 pandemic on young im/migrant women's SRH access in Canada. Future research, however, is needed to understand and expand evidence in this area as it pertains to the different experiences of all young im/migrants, including transgender women, non-binary persons, and members of the LGBTQA+ community, as well as SRH services beyond family planning and pregnancy care. A limitation of our study is that the findings reflect SRH care experiences within the first year of COVID-19, which may have evolved with changing protocols and policies, and may not represent the different experiences of young im/migrant women over the course of the pandemic. However, given little understandings of young im/migrant women's SRH care early in the COVID-19 pandemic, this research makes a critical contribution to the literature. Finally, the community-based and participatory nature of this study supported collaboration with young im/migrant women in all stages of the research, strengthening its validity, quality and rigor.

4.4.2. Recommendations

This study provides novel understandings of the impact of shifts in health and im/migration service delivery made during the COVID-19 pandemic on young im/migrant women's access to SRH care, and highlight the importance of considering determinants of young im/migrant health in SRH service delivery. Our findings suggest that the

different experiences of young women cannot be reduced to a single one; while advocating for systemic change, and as both virtual and clinic-based healthcare are here to stay, healthcare personnel must provide both forms of SRH services in ways that are specific, accessible to all young women regardless of im/migration status, and that attend to the links between employment, health insurance, and im/migration status in SRH care access. Our findings also suggest that BC's health system decouple im/migration status from health insurance eligibility, and rightfully recognize access to healthcare as a human right. Within both virtual and in-person SRH care, our findings demonstrate the need to consider the type of SRH service needed, and accommodate preferences for female providers to avoid exacerbated discomfort during COVID-19.⁴⁸ In providing virtual SRH services, our findings highlight the need for health personnel to - provide close follow-up and intentionally consider social, economic, and im/migration needs in conducting health assessments.⁴⁹ For example, closed-questions may be asked for patients who live in unsafe home environments⁴⁸; phone appointments may be conducted with people who have limited access to Internet⁴⁹; and appropriate use of translation services may be used for those without English language fluency. These recommendations should accompany financial support for im/migrant-serving organizations to support young im/migrant women's access to formal and informal social networks that may more effectively support their well-being.⁵⁰

Our findings also suggest that all im/migrants in Canada be provided with full im/migration status⁵¹ to support reduced barriers to SRH care, safe home and workplace environments, and exercising their rights. In the short term, however, there is a need for better workplaces protections for young im/migrants in temporary and precarious roles, including authorized time off work to access health services, appropriate transportation to medical clinics.¹⁷ In addition to advocating for additional and accessible parental leave for all workers, we support Ontario-based advocacy that has called for 10-14 permanent sick days⁵² that are available, accessible, paid by employers, and appropriately enforced by the government during and beyond the COVID-19 pandemic. Awareness and enforcement must take place in collaboration with im/migrant networks, including Migrant Workers Alliance for Change for example, who better understand the context of im/migrant labour, to avoid poorly conducted workplace inspections that support continued exploitation by employers⁵³ – an occurrence that highlights Canada's

unwillingness to protect im/migrant workers, and the urgent need for full im/migration status for all.

4.5. Conclusion

Our study provided a nuanced understanding of young im/migrant women's access to and experiences with virtual and clinic-based SRH care early during the COVID-19 pandemic. Through intersectionality theory, the findings demonstrate that there is no one-size-fits-all protocol to addressing young im/migrant women's SRH access, and that complex experiences require complex solutions. Participant narratives demonstrated that young im/migrant women's healthcare access experiences varied according to time spent in destination settings, language ability, employment, and im/migration status. Our findings highlight the need for virtual and clinic-based SRH services that are specific, accessible to all young women regardless of im/migration status, and that attend to the links between SRH care, employment, and im/migration status. A reproductive lens helped highlight the role of these factors in shaping choices in and access to SRH care, and suggest changes to help young im/migrant women and their families thrive.

Importantly, this study presented various SRH care experiences of young im/migrant women, with and without precarious im/migration status and employment, that have not been represented in research to date. Learning about these experiences in such depth was a direct result of the community-based study design and trusting relationships built between our partners, community-based research team, and local im/migrant communities. Despite the remote nature of many research studies during COVID-19, we recommend that im/migrant health researchers adopt more creative, community-based approaches to better understand young women's experiences in ways that are honest, respectful, and collaborative.

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Chapter 5. Conclusion

5.1. Key contributions

5.1.1. Theoretical and methodological contributions

In this dissertation, I developed and applied a novel conceptual framework that combines aspects of a migratory process framework,¹ the structural determinants of health,² intersectionality theory,³ and a framework for patient-centered healthcare access.⁴ Previously, these frameworks have examined more limited dimensions of im/migrant health and have been used individually or in combination with one other theory. While these frameworks have shown promise in exploring im/migrant health and healthcare access, the framework that I used in this dissertation is more expansive and extends prior conceptualizations of health and healthcare access to account for a wider spectrum of im/migrant experiences, particularly those of women with precarious im/migration status and younger im/migrant women.⁵ The research in this dissertation is the first to draw on this combination of frameworks to attend to the different ways in which im/migration, health, and employment structures interact with processes of marginalization to shape im/migrant women's health and healthcare access.^{4,5,8,9} The overall findings demonstrate the complex nature of women's im/migration and healthcare experiences, which necessarily involve the interaction of factors related to migration experiences, health insurance policies, and precarious workplace environments. This is important; had this dissertation only focused on healthcare and im/migration, for example, I would have neglected the ways in which exploitative workplace environments common among young women with precarious im/migration status shape health and access to healthcare. It is my hope that this dissertation demonstrates how this novel conceptual framework can be applied in future research, policies, and practices to support im/migrant communities in ways that honour their full lives, meet their needs, and allow them to thrive with optimal well-being.

The methodological contributions of this research primarily come from my application of a qualitative and CBR approach, including a framework for community engagement developed by the IRIS project team that supported collaboration, leadership, and participation among im/migrant participants, team members, and

community partners at all stages of the research.¹⁰ This included participation on the development of research materials, data collection, analyses, and the co-creation of dissemination products. The research process that I used in this dissertation expand that used in a few studies conducted with im/migrant communities in Alberta and Ontario, Canada, which incorporated community-engaged approaches to collaboratively shape the research direction and relevance, share research tasks and responsibilities, and support participant-led dissemination activities.^{11,12} Using the IRIS community engagement backbone grounded this research and its processes in collaboration, respect, and relationship building, which played a significant role in supporting nuanced and impactful interpretations described as important by im/migrant women themselves. It also played a critical role in veering from individualistic research approaches to support a collaborative process that involved sharing power and resources. The detailed research process provided in Chapter 1 was written intentionally to offer support to other researchers working with im/migrant communities and encourage them to explore relevant issues in ways that center community relationships.

Finally, drawing on components of reflexive TA within a community-based project and participatory analysis demonstrates the importance and value of being a researcher that is subjective, situated, aware, and questioning.¹³ As I hold both im/migrant woman and researcher identities, a reflexive TA approach is aligned with CBR and the epistemological and ontological stance that I adopted in this dissertation, which centers the co-creation of knowledge and meaning, personal and contextual experience, and interpretation through im/migrant women's participation. Reflexive TA is an approach that is new to me and that I am continuing to learn about. However, its theoretical flexibility, values-based guidelines, and emphasis on subjectivity as a resource in qualitative research spoke to me and was helpful in understanding my research process.¹³ By embracing and interrogating subjectivity using reflexivity, I feel that I conducted this research in ways that supported the alignment of my assumptions and the research process.¹³ This means that I actively questioned my positions, power, and expectations in ways that contextualized research decisions and shaped each analysis. This contributed to nuanced findings that are necessary when exploring complex and dynamic im/migrant health issues. Learning more about reflexive TA encourages me to explore im/migrant well-being more critically and holistically.

5.1.2. Contributions as an im/migrant woman and researcher

My contributions to this research are based on my identities and experiences as a researcher, im/migrant, and woman. As a qualitative researcher, I had prior knowledge in and curiosities about methods of participant recruitment, qualitative data collection, and qualitative data analysis and interpretation. However, being an im/migrant woman and qualitative researcher *together* added greater value to the research process. In recruiting younger im/migrant women, for example, I, as a young im/migrant woman myself, related to participants on a deeper level and created a space that fostered safe and honest conversation. When facilitating qualitative interviews, I spoke as an im/migrant woman with shared understanding of the issues at hand and shared some of my own experiences as well. This contributed to a sense of humanness, comfort, and openness that supported reciprocal vulnerability and transparency. I also understood the issues shared by participants as many were similar to my own and/or those of my loved ones. This facilitated my analysis and interpretation of data and helped me understand and write about im/migrant women's experiences in ways that felt true to them.

While my identity and experiences helped me better relate to, understand, and interpret im/migrant women's experiences, I also recognize that the participants are the only people who fully understand their own lives. For example, it would have been wrong for me to assume that issues that felt important to me as an im/migrant woman were the same issues that felt important to all the im/migrant women who participated in this research. The CBR approach, therefore, helped support thoughtful engagement processes that considered a variety of community perspectives in understanding women's experiences. Aside from leading to more nuanced and accurate understandings of im/migrant women's experiences, using CBR processes created a space for im/migrant women to tell their own stories in ways that felt right to them while being supported financially, professionally, and personally through employment, research training, and referrals to community organizations, for example. By actively working with other im/migrant women on the research presented in this dissertation, I also had commitments to participants and community advisory board members, im/migrant co-authors, im/migrant team members, and community partners. As I continue to fulfill these commitments, I already see how they have contributed to the quality and value of the research and the well-being of im/migrant women. These commitments center around collaboration, relationships, communication, and action.

Collaboration: One of my primary commitments was to conduct this research collaboratively. This looked like discussing each research topic and question with other im/migrant women prior to conducting any analysis to assess its importance and relevance to community members other than myself. It looked like inviting other im/migrant women to then participate in the analysis, resulting in rich findings built on multiple and different perspectives. It also involved co-writing and co-reviewing research products and collaborating on ideas around ways to share findings to support the potential for action – action that was identified as important to im/migrant advisory board members, team members, and participants.

Relationships: Another commitment of mine was to build meaningful relationships with the im/migrant women that I collaborated with on this research. This means that working together involved regular conversations and actions that centered upon care and respect, and often went beyond the research itself. Meetings to co-analyze data, for example, involved respectfully sharing and listening to each other's perspectives to collaboratively make meaning of participants' experiences, even when these perspectives were misaligned. It also involved regular check ins with im/migrant women working on different stages of the research to ensure that their capacity was supported, that this work was still of interest and benefit to them, and that their needs related to research training, leadership opportunities, and income were met.

Communication: Central to any collaboration or relationship was my commitment to honest, respectful, and transparent communication. This means that in any type of collaboration, I attempted to create a safe space to share experiences as im/migrant women, as well as reflect on the different ways that these experiences informed the research analysis and products. I was committed to clearly and transparently communicating the purpose behind each analysis and my dissertation, how different people (including myself) benefitted from participation, as well as the types of change or action the findings may or may not contribute to.

Action: Finally, despite the limitations of research as a sole avenue for change, I am committed to working with im/migrant women to share these findings with people and places where action is possible. This stage is still in progress and involves having collaborative discussions around where and with whom we want the findings to be shared and what kind of change we want to see, even when we have different ideas of

what that looks like. It also involves transforming these discussions into the development of a realistic and feasible plan to share this research, transparently sharing this plan with im/migrant women, and inviting those interested to participate in implementation.

5.2. Key research contributions

In this section, I describe the key research contributions of this dissertation. The research presented in Chapters 2, 3, and 4 describe im/migrant women's experiences that have been insufficiently discussed in previous research and received little attention in public discourse around im/migrant health. While this dissertation was partly focused on SRH (Chapter 3 and 4), im/migrant women also described experiences related to mental health (Chapters 2 and 3) and chronic conditions (Chapter 2). The research describes how structural determinants of health and processes of marginalization work together to shape im/migrant women's health and healthcare access, as well as how these experiences and its impacts changed during the COVID-19 pandemic. I used a CBR approach to address the following objectives:

1. To use an intersectional and structural framing in examining im/migrant women's access to healthcare;
2. To explore the specific im/migration and health experiences of young im/migrant women;
3. To investigate how young im/migrant women's healthcare access experiences may have changed, if at all, during the COVID-19 pandemic.

Below I explain how the three empirical chapters in this dissertation addressed these objectives.

5.2.1. Objective 1: To use an intersectional and structural framing in examining im/migrant women's healthcare access

I addressed Objective 1 through the following research questions: (i) how do migration experiences shape women's access to healthcare? (ii) how does im/migration shape young women's experiences of pregnancy, motherhood, and marriage? and (iii) what are the impacts of shifts in health service delivery early during the COVID-19 pandemic on young im/migrant women's access to SRH care?

In **Chapter 2**, I highlighted the ways in which movement within precarious and secure spaces, shaped by im/migration system processes, impacted im/migrant women's access to healthcare. By situating women's experiences within structures of im/migration and health, I demonstrated how spatial and temporal processes within these domains worked with processes of xenophobia to inform healthcare access. Traumatic experiences faced by women who migrated alone, health and im/migration policies that excluded women with precarious im/migration status, and unmet healthcare expectations shaped by insufficient health system information and language barriers pointed to the ways in which structural factors worked with women's intersecting social locations to shape healthcare access.

In **Chapter 3**, I demonstrated the different ways in which being an im/migrant shaped young women's experiences of pregnancy, motherhood, and marriage, including how these experiences were shaped by recent migration, age at marriage, pregnancy timing, or instances of violence. By framing young im/migrant women's experiences using an intersectional and structural lens, I stressed how experiences of unequal power dynamics, barriers to health insurance, unaffordable childcare, and harmful occupational environments associated with precarious im/migration status, age, and gender identity shaped young women's experiences of pregnancy, motherhood, and marriage. Contextualizing these experiences within structures of im/migration, health and employment offered relevant recommendations necessary to support young im/migrant women.

Finally, in **Chapter 4**, I adopted an intersectional and structural framing by demonstrating how shifts in health service delivery made early during the COVID-19 pandemic shaped young im/migrant women's access to SRH care through factors like English language fluency, workplace environments, and im/migration status. By focusing on structures of health, im/migration, and employment, I demonstrated how the transition to virtual SRH services saved travel and childcare costs but offered little privacy and follow-up; unjust links between im/migration status, employment, and health insurance contributed to unplanned pregnancies; and connections to a doctor prior to the pandemic shaped positive healthcare experiences. Situating young women's SRH care experiences within intersectional and structural contexts helped attend to the different identities of young im/migrant women and highlight opportunities for them to thrive.

5.2.2. Objective 2: To explore the specific im/migration and health experiences of young im/migrant women

I addressed Objective 2 through the following research questions: (i) how does im/migration shape young women's experiences of pregnancy, motherhood, and marriage? and (ii) what are the impacts of shifts in health service delivery early during the COVID-19 pandemic on young im/migrant women's access to SRH care? In Chapters 3 and 4, I highlight novel experiences of im/migration, SRH, and healthcare among young im/migrant women aged 15-30 prior to and early during the COVID-19 pandemic – a population that has been underrepresented in research of im/migrant women's healthcare access.

In **Chapter 3**, I provide important insights around how being an im/migrant shapes experiences of pregnancy, motherhood, and marriage for young women. As most young women included in this study were temporary im/migrants, I highlighted the layers of precarity related to age, im/migration status, and employment that have insufficiently been considered in research conducted with young im/migrants. While young people experience a variety of formative experiences important to consider in understanding well-being, women described experiences of pregnancy, motherhood, and marriage as key events that shaped their lives as im/migrants. Building on this foundational understanding of young im/migrant women's SRH, in **Chapter 4** I expanded understandings of young women's im/migration and healthcare experiences by examining how shifts in health service delivery made early during the COVID-19 pandemic shaped im/migrant women's access to SRH care. Considering the essential and frontline roles that young im/migrants occupy, as well as the long-lasting impacts of the pandemic on im/migration and health services, this context was important to support understandings of young im/migrant women's well-being during and beyond this time.

5.2.3. Objective 3: To investigate how im/migrant women's healthcare access experiences may have changed, if at all, during the COVID-19 pandemic

Finally, I addressed Objective 3 through the following research question: (i) what are the impacts of shifts in health service delivery early during the COVID-19 pandemic on young im/migrant women's access to SRH care? In Chapter 4, I extend previous evidence of how im/migrant women's access to healthcare was impacted by the COVID-

19 pandemic by focusing on the experiences of young im/migrant women aged 15-30. By exploring how im/migration shapes experiences of SRH and healthcare access, Chapters 2 and 3 provide the background necessary to understand **Chapter 4**, which articulates the complex ways in which shifts in health service delivery made early during the COVID-19 pandemic shaped young im/migrant women's access to SRH care. In this analysis, I demonstrated how the transition to virtual services and restricted in-person care shaped young im/migrant women's access to SRH care differently based on their access to social support and im/migration and socioeconomic status. I spoke to the specific impacts of young im/migrants' overrepresentation in frontline jobs and precarious occupational environments, experiences of exploitation and violence, and context-specific barriers to healthcare during the pandemic – experiences that are supported by the operations of Canada's im/migration system identified in Chapter 1.

5.3. Im/migration, health, and employment recommendations

In Chapters 2, 3 and 4, I present a variety of recommendations for research, policy and practice rooted in the experiences of im/migrant women. In this section, I present a summary of these recommendations for policy and practice as they pertain to Canada and BC's im/migration, health, and employment structures. I focus on local recommendations as the findings in this dissertation have shown the importance of context. These recommendations may be applied in other settings; however, given the heterogeneity in im/migrant lives, a nuanced understanding of im/migrant women's experiences and the setting in which they occur is required to support context-specific interventions.

5.3.1. Recommendations for Canada's im/migration system

In Chapters 3 and 4, im/migrant women's experiences support the need for Canada's im/migration officials to fund community-based organizations and programs sustainably and equitably. In Chapter 3, I demonstrate how this effort could contribute to dismantling patriarchal structures by way of funded, community-led discussions around shared unpaid labour, for example, to increase participation in caregiving work in marriages and partnerships.¹⁵ These discussions could also help address the sacrificed educational and career goals that im/migrant women experienced as a result of unequal

gender roles. Additionally, in Chapter 4, I highlight the ways in which appropriately funded im/migrant-serving community organizations could have supported young im/migrant women's access to formal and informal social networks at a time of increased isolation early during the COVID-19 pandemic. Finally, in Chapter 2, I emphasize the need for sustainable funding to expand service and program eligibility to include all im/migrant women, regardless of im/migration status. Today, these efforts could help build social support among young im/migrants to support their well-being.¹⁶

Across studies, but especially in Chapters 3 and 4, participants highlight the need for all im/migrants to be provided with full and permanent im/migration status to fully exercise their rights.¹⁷ Young im/migrant women's accounts of how im/migration shaped their experiences of pregnancy, motherhood, and marriage demonstrate how structural interventions are needed to address issues related to accessing maternity benefits and affordable childcare while having temporary or no official im/migration status. I recognize, however, that the issue of unaffordable childcare goes beyond im/migration; in Chapter 3, therefore, I suggest that government leadership and financial support in Canada are also needed to build public systems of childcare in each province, including BC.¹⁸ Young im/migrant women's experiences of SRH care access early during the COVID-19 pandemic also demonstrate how full and permanent im/migration status is needed to support access to healthcare and exist in safe home and workplace environments during and beyond this time.¹⁷

5.3.2. Recommendations for British Columbia's health system

My health system recommendations center around the need to provide healthcare that is equitable – that is, care that is provided based on people's needs. In Chapter 4, I build on the concept of equitable healthcare by suggesting that health providers offer SRH care that is accessible to all young women regardless of im/migration status, and that they intentionally consider social, economic and im/migration needs.²⁴ This includes accommodating preferences for women health providers,²⁵ asking closed-questions for patients who live in unsafe home environments, conducting telephone appointments for people with limited Internet access,²⁴ and using appropriate translation services for those uncomfortable speaking in English. Integrating and appropriately funding community health centres into BC's health system could also allow for equitable healthcare that centers the needs of marginalized communities.

Finally, in both Chapters 3 and 4, I suggest the need for BC's health system to decouple im/migration status from health insurance eligibility, which would recognize access to healthcare as a human right for all people. The need for this is clear, especially given the recent policy that contraceptives will be free for all BC residents beginning in April 2023; however, as per government guidelines, residents only include people with health insurance. This policy will, therefore, exclude many im/migrants who are ineligible for health insurance while having precarious im/migration status. This aligns with my recommendation for all im/migrants to be provided with full and permanent im/migration status given its role in supporting people's ability to exercise their rights.

5.3.3. Recommendations for Canada's employment system

Finally, given the links between im/migration and employment described in Chapter 1 and across the analyses presented in Chapters 2-4, I outline important recommendations around employment based on the research in this dissertation. Within workplaces, I demonstrate the need for protections for im/migrants in temporary and precarious roles. This looks like offering authorized time off work for people to access health services, appropriate transportation to medical clinics,²⁶ and permanent sick days that are available, accessible, paid by employers and appropriately enforced by the government in collaboration with community organizations and advocates.²⁷ Due to im/migrant women's experiences of being denied work, I also suggest that all people be provided with paid time off work regardless of previous employment contributions, including the number of hours worked.

5.3.4. Collaboration as a recommendation

Outside of my PhD research, I am working with im/migrant-serving organizations and im/migrant community members to build a community-based model for social service planning. Ultimately, we are working to develop a model that can show us what it looks like for im/migrants to plan and lead the services offered to them. While planning social services often take place through top-down approaches, we do not have many examples of what this could look like using bottom-up, community-led approaches. I say this because across Chapters 2, 3, and 4, I recommend collaboration between health and im/migration officials, employers, im/migrant communities, and advocates. While the previous sections outline specific im/migration, health, and employment

recommendations based on previous research, we do not have similar examples around what collaboration could look like in action within policy and practice. For example, as government-led workplace inspections have been poorly conducted in the past,²⁸ I recommended that these occur in collaboration with im/migrant networks and advocates such as Migrant Workers Alliance for Change, who better understand the context of precarious employment among im/migrant communities. However, to my knowledge, we do not currently have examples of what these collaborative or community-led workplace inspections could look like. In this dissertation, I provide valuable lessons and examples around ways to engage in more collaborative and community-engaged research on localized projects, but I am left questioning how collaboration can be scaled up to policies and programs.

On an international level, in Chapter 2, I demonstrate how women's experiences of migration and its impacts on healthcare access went against the principles outlined in the Global Compact for Migration. I suggested that Canada's im/migration system establish measurable goals to abide by these principles and hold relevant government agencies accountable to the health, safety, and rights of im/migrants across migration. I recommended that these goals be implemented collaboratively with im/migrant communities, and that a process be developed for monitoring goals through publicly accessible annual progress reports that support accountability and transparency.¹⁴ In Chapter 2, I also highlighted the need for collaboration between im/migration and health systems, im/migrant communities, and im/migrant-serving organizations to provide clear, language-specific health system information while im/migrant women are in origin and transit settings, as well as upon arrival in each Canadian province.¹⁴ Once again, however, to my knowledge there is no information about what this type of collaboration could look like in tangible steps.

Finally, in considering the migration experiences of im/migrant women in Chapter 2, I demonstrated the need for post-arrival health assessments created in collaboration with im/migrant communities and that center migration journeys, including prior experiences related to health, violence, and family separation.¹⁹⁻²¹ I note that the collaborative nature of this work is necessary to ensure that health system officials and providers understand what it means to provide trauma-informed and culturally humble care that attends to unequal power dynamics and supports safety, especially after women may have experienced harmful interactions throughout their migration

journeys.^{19,22,23} However, a key takeaway from this dissertation is that im/migrant lives are dynamic, and efforts must be context-specific. There is no singular protocol or guideline that will work for all im/migrants, but we could implement approaches that incorporate this diversity. For example, at local and global levels, we must advocate for approaches that understand that im/migrant experiences are heterogenous and have various im/migration, employment, and health impacts, and then respond appropriately.

5.4. Limitations

The research in this dissertation has several limitations. Participants were im/migrants aged 15-49 who self-identified as women. However, despite intentional efforts to learn from the experiences of young im/migrant women aged 15-30 (e.g., developing a youth-specific arm of the IRIS project), few women below the age of 20 participated in this research. Additionally, while we indicated the term “self-identified women” in recruitment materials, we did not ask participants about their gender identity, pronouns, or sexual orientation. This means that it is unclear whether participants identified as cisgender women, transgender women, or a member of the LGBTQIA+ community, which may have shaped how im/migration shaped health and healthcare experiences. A limitation of this research, therefore, is that it elicits limited information about the specific im/migration and healthcare experiences of transgender im/migrant women and women in the LGBTQIA+ community. The focus on self-identified women also limits understanding of SRH, marriage, and caregiving experiences of cisgender and transgender men and non-binary persons.

I conducted this research within the larger IRIS project using research materials that centered around IRIS objectives. This means that we did not create interview guides with the specific research objectives of this dissertation. For example, we asked participants about their migration journeys to Canada and healthcare experiences in origin and destination settings, but an interview guide created with the intention of specifically conducting the analysis in Chapter 2 may have included more specific questions and probes regarding travel and transit experiences and its impacts on health. We also recruited participants through community partner organizations, meaning that we often limited inclusion to im/migrant women served by these organizations. This means that I do not speak to the variety of experiences of im/migrant women in BC in this dissertation, who may face additional challenges related to being isolated from these

organizations. Finally, given the community-based and time-sensitive nature of this research, as well as my primary language being English, I worked closely on analysis and writing with im/migrant women who speak English fluently only. This limited the opportunity to learn from additional perspectives offered by participants who speak other languages and who would have undoubtedly added valuable insights on this research.

5.5. Concluding thoughts

In this dissertation, I use CBR to explore im/migrant women's access to healthcare. Through analyses of women's migration journeys, the health experiences of young im/migrant women and women with precarious im/migration status, and experiences of healthcare access during the COVID-19 pandemic, I examine im/migrant women's experiences from an intersectional and structural perspective; expand existing information on the specific health experiences of young im/migrant women; and investigate how young im/migrant women's healthcare access changed early during the COVID-19 pandemic. Together, using a novel conceptual framework, I provide nuanced accounts of the ways in which im/migration, health, and employment structures interact with processes of marginalization to shape im/migrant women's health and healthcare access.

Using principles of CBR, the research in this dissertation is built upon respectful relationships, honest conversations, and collaboration with im/migrant women to support understandings of im/migration, health, and healthcare access that have not been previously explored in such detail. The findings importantly attend to personal experience, interpretation, and knowledge of im/migrant women who led and participated in the development of research materials, data collection, and analyses; the co-creation of clear, accurate dissemination products; and knowledge translation and exchange. The lead authors of each analysis, including myself, are self-identified immigrant women with research lenses informed by migration, health, and healthcare experiences both similar to and different from those shared by participants. I recognize my privilege and power as a researcher and community member as I worked closely with other im/migrant women to co-create findings, practicing reflexivity and centering the voices of participants. Adopting a CBR approach was important to both the research findings, as well as my commitments to this work, participants, and myself.

Through Chapters 2, 3 and 4, this dissertation tells an important narrative. Beginning with migration journeys, I demonstrate how im/migrant women's healthcare experiences take shape through origin, travel, transit and destination settings. I then focus on the unique experiences of young im/migrant women and temporary workers, a population that has been underrepresented in research. Finally, I present how structures of im/migration, health, and employment interacted to shape healthcare access early during the COVID-19 pandemic. The findings demonstrate the complex ways that im/migrant women's health and healthcare access is shaped by migration journeys and im/migration status, health insurance policies, and workplace environments, which work together to exacerbate or support well-being. Im/migrant women's access to healthcare is unjustly impacted by movement through precarious and secure spaces shaped by health and im/migration policies that exclude women with precarious or no im/migration status, and unmet healthcare expectations shaped by insufficient health system information and language barriers. Young im/migrant women's experiences of pregnancy, motherhood, and marriage are shaped by unequal power dynamics, unaffordable childcare, and harmful occupational environments. Finally unjust links between im/migration status, employment status, and health insurance that existed prior to the COVID-19 pandemic became especially prominent during this time and have contributed to unintended health outcomes and unmet healthcare needs. Together, these findings present important understandings of im/migrant women's lives and critical areas for action within Canada's im/migration, health, and employment systems.

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Chapter 6. Reflexivity

6.1. A reflection on my PhD experience

*This section is informed by reflections on conversations that I have had over the past years with mentors, family members, friends, and my therapist. It is also shaped by discussions led by women that I have been privileged to listen to and read, including podcasts such as *Seen by Nic & Lala* and the *Roxane Gay Agenda* by Dr. Roxane Gay; as well as thought-provoking essays by Dr. Tressie McMillan Cottom. These resources have helped me understand what it means to be a woman of colour and navigate colonial spaces with an imbalance of power, including academic settings.*

I entered the PhD program with a series of questions based on my experiences, those of friends and family members, and those of im/migrant participants in previous research. I had a desire to expand public understandings of im/migrant women's health and well-being and hoped that these understandings would inform health professionals, im/migration officials, and im/migrant communities to improve our access to healthcare. Ultimately, I hoped that these understandings would lead to action that would improve healthcare experiences for all im/migrant women, but I was unclear about how this could happen through research.

"I want to make change" is a desire that I have often heard people express, including myself, but I haven't been a part of many conversations that articulated what change could look like or the different ways through which change could happen through research. During my public health training, I most often heard about the goal for policy change through research, which led me to believe that research was *the* way to change or eliminate harmful policies. I was excited by the idea that my PhD research could contribute to positive change for im/migrant communities, but I was unclear about what this meant exactly. How was this research going to improve im/migrant lives and well-being? I spent lots of time prior to and in the early stages of this degree thinking that changing policy was the best (and often the only) avenue to improve im/migrant health and well-being. However, understanding how difficult it is for research to translate into policy action facilitated an important mindset shift for me.

In pursuit of policy changes and following what I understood to be an academic expectation of PhD students, I worked throughout my doctorate to publish research papers in academic journals and share findings at conferences so that they might reach “the right people”. However, I questioned what happened to research papers after they lived in academic journals. Which people can and do access them? How do we know that conferences attendees are “the right people” or if they care about what we have to share? At one conference I presented at, someone walked by my research poster and expressed to their colleague that they didn’t want to look at it because it was about im/migrants. So, who are the “right people”? Who really are the people who can and want to support im/migrant well-being? What does change look like, and to whom? Most importantly, what do we value in sharing research? Is it self-interest, as publications and presentations help build academic CVs and make people more competitive for funding and awards? This was certainly an outcome for me. Yet, I am left wondering whether we, perhaps unintentionally, diverge from alternative and more effective pathways to advance im/migrant well-being as they may not further our academic success in the same way. Much of what I learned during my PhD has resulted in me reflecting, unlearning, and exploring these questions and ideas.

Expectations to publish research, present at conferences, and apply for scholarships often competed with my own research priorities. For example, I wanted to explore different and meaningful ways to share and use this research in collaboration with participants. During each analysis, I worked with im/migrant team members and co-authors. We co-developed plans to share the research findings in collaboration with im/migrant participants and community advisory board members. However, conducting these analyses and fulfilling these plans in a timely manner and in a way that allowed for space to process the findings as a person with lived im/migration experience proved to be challenging when simultaneously fulfilling academic expectations and requirements as a doctorate student. If I hadn’t pursued a PhD, I wondered whether I could have engaged in similar research activities without being restricted by the requirements of an academic program. I wondered whether I would have fewer experiences of people telling me to choose between my academic or immigrant identity. Early into the PhD program, I quickly learned that I either had to do things differently from traditional academic research or change myself. While I chose the former, my experiences and questions

often contributed to confusion, stress, and self-doubt. These feelings, however, also raised an important question for me: How does academia value my research?

PhD programs require students to demonstrate independence and leadership in research to graduate, but it was early in the program that I learned that this could be discounted by collaboration. I find that the emphasis on independence can contribute to overwhelming pressure and isolation among students and speaks to the individualistic values centered in academia. The celebration of individualism often crowded out space for what I felt was most important in my PhD experience – the opportunity to collaborate with other im/migrant women, build on critical community knowledge and experiences, and enhance the quality of research. Expecting PhD students to singlehandedly conduct meaningful research fails to recognize the efforts of people who have explored and continue to explore similar topic areas. What do we try to achieve by working alone? Is it power? I am proud of being interdependent in this work and giving credit where it is due. The expectation to produce information alone is directly related to individualism and power sustained by institutional processes and must be interrogated. What makes my PhD research most unique is that I did not conduct this research alone, but in collaboration with other im/migrant women. Together, we built on the research and knowledge of people who have previously explored and continue to explore im/migrant women's health. Conducting this work in this way also meant supporting shared knowledge and skills, providing employment opportunities, promoting inclusion, and offering social support. Working collaboratively was not always easy and often involved me pushing back on traditional academic research processes. If my collectivist values found a place in academia, PhD programs would emphasize interdependence and the collaborative advancement of information that recognized different knowledge holders.

6.2. A reflection on my research process

A critical focus for me in conducting my doctorate research was ensuring that its processes were rooted in care, respect, and collaboration; not only did this feel ethically important, but I believed that it would strengthen the research. However, in my opinion, classes did not sufficiently address these values in my academic learning or public health training. Aligned with this, I found conducting CBR to be difficult within the constraints of academia and often felt like I was never doing enough. Through different experiences, I learned that it was less my fault and more that PhD programs are not

designed for community engagement. With limited funding, most students complete doctorate requirements while working multiple jobs and attending to personal lives all within a short academic timeline, making it difficult to build and nurture relationships with im/migrant communities that are essential components to CBR. Sometimes I feel like this is intentional and another way that systems perpetuate harm and neglect for marginalized im/migrant communities. My team members and I deeply felt the impacts of this, where we often felt frustrated and unfortunately sometimes took this frustration out on each other, mistakenly blaming one another because it is less exhausting than fighting academic and research structures. In reflecting on these experiences and as I approach the end of my doctorate, I feel that I did the best I could with the resources that I had at the time.

To conduct CBR within the constraints of an academic program, I chose to use the funding from my doctoral award to extend my PhD timeline to give this research, my relationships with community members, and myself the time that they deserved. Extending my timeline was needed for me to rest, take more breaks, and reduce burnout, which ultimately helped me engage more meaningfully with community. I was able to show up for myself, participants, and community researchers in ways that went beyond any academic expectations. I worked slowly and imperfectly with others and stayed true to my values, as opposed to working quickly and in isolation within a perfectionist mindset that academia often encourages and rewards. Still, however, I found it challenging to conduct this work at a pace that met the needs of everyone involved, while simultaneously learning new research skills, publishing research papers, and presenting at and attending conferences. I am reminded of my question about how the academy values my research and experiences, and I wish it placed greater value on community relationships and the well-being of student researchers, particularly those who are marginalized.

Whether or not it is valued in academia, community relationships played a central role in my research process. My relationships with participants and community researchers were built in different ways and had different impacts on myself and on the research. Interviewing participants, for example, always made me feel most like myself and like my immigrant identity was most embraced. I wasn't perceived as just a researcher, as I often was in academic settings. I was privileged to listen to stories that women so honestly and vulnerably shared, after which they often expressed feeling like

they were speaking to a friend. In some of my academic training, I learned that it was wrong to show emotions or share information about myself during qualitative interviews; however, taking this advice with caution was valuable in building these relationships. While centering participants, approaching interviews as myself and treating them as a social exchange as opposed to being more closed off contributed to a greater sense of trust and care. Many of my community relationships also went beyond the research. For example, when accompanying newer community interviewers in the field, participants sometimes asked if I could play with their children while they attended the interviews as there was no available childcare. The process taught me so much about what it means to conduct research that centered around relationships and community.

While I was not prepared for the individualistic nature of the PhD program, I tried to make the process as community engaged as I could with the knowledge, skills, and resources I had at the time. Outside of interviews, I built relationships with participants and community researchers while co-developing research priorities, analyzing data, writing papers, and sharing findings. For example, before going through training in qualitative methods and analysis with community co-authors, we worked together to analyze data and write up different sections of research papers in ways that felt more natural and that used our inherent skills. This process worked well for us. We were more focused on creating a space to reciprocally share tools and skills, as opposed to following a rigid structure to research analysis or writing. Beyond the research findings, doing this work in a community-based way also had real benefits for participants and community researchers in the form of employment experience, financial support, research skills, and relationships. I also did my best to talk about participants' experiences in ways that were true and honest by actively working with im/migrant women on all stages of the research and practicing ongoing reflexivity with community co-authors. For example, there were moments where we had conflicting feelings about the importance of a particular quote and whether to include it in a research paper. Together, reflecting about why we felt a certain way about a participant's experience often involved thinking and talking about how we were personally connected to it. We often identified an experience of our own that was related to that of the participant, and which was informing our research decisions. In this way, creating a safe space to recognize and talk about our experiences helped us understand how they informed our perspectives and contributed to collaborative decision-making. Such meaningful

relationships were built on care, respect, transparency, and trust – values that aren't aligned with the hierarchies and regulations embedded in academic programs. I attribute these relationships to CBR approaches and our shared identities as immigrant women. During these processes, however, I often only worked with one or two people at a time. I often felt bad about this, but it was all I could do while only being fluent in English and needing to complete this research within my PhD timeline. I tried my best to ensure that the research wasn't rushed by regularly checking in about the time, needs, and capacity of co-authors, which enhanced a sense of comfort, transparency, and regular communication. These values supported our personal connections and allowed for a smooth workflow that helped break down individualistic academic processes.

I am proud of how my doctorate research involved collaboration where possible, and I am grateful to the IRIS team members for these opportunities. The data was provided by many participants, collected by multiple multilingual interviewers, and organized by various researchers. The research questions, analyses, and plans for dissemination were contributed to by academics, participants, community advisory board members, and community researchers. These activities were intentionally collaborative and demonstrate how this work is not solely mine. However, privilege and choice inform why I am obtaining a PhD at the end of this process and others are not. When I think about how much research and experiences are valued in academia, I often think that privilege is what is most valued. For example, I don't think that my PhD research needed the completion of an undergraduate and postgraduate degree, but this was an academic requirement. I don't think that the research required fluency in English, but this was an academic requirement. I don't think that the research needed tuition fees, but this was an academic requirement. The reality is that my PhD research is shaped by the contributions of multiple people, some of whom do not have an undergraduate and/or postgraduate degree, speak English fluently, or have the financial means to pay exorbitant tuition fees. Is privilege, then, what academia truly values and rewards?

While team members, participants, and community researchers expressed happiness and excitement about my pursuing a PhD, I often felt guilty that I was getting a degree based on work that I did not complete alone and that this would enhance my privilege moving forward. I wasn't sure if that was okay. I felt so uncomfortable that I often contemplated leaving the program. My therapist was quick to remind me that my leaving the program would not put a PhD in the hands of anyone else and would simply

be a reaction based on guilt. Participants and community researchers often expressed excitement that that this degree would support me, as an im/migrant woman, to be employed in higher leadership positions, which they felt was important for other im/migrant women to see. I didn't know how to tell them that I often wanted nothing more than to be immersed in community and use my skills to help people on the ground. But I hold these sentiments closely, because when I'm unsure about what to do next or why I pursued a PhD at all, I think about the encouraging words of team members, participants, and community researchers. I think about the ways in which they experienced the research and described benefitting from it. The more they felt this work was important, the more I believed it was too.