

**EXPLORING HOW MIGRATION TRAJECTORY CONDITIONS INTERSECT TO  
INFLUENCE THE HEALTH AND WELL-BEING OF AFRICAN IMMIGRANTS  
WITH PRECARIOUS IMMIGRATION STATUS IN SOUTHERN ALBERTA**

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## Dedication

To the loving memory of my late mother, Mrs. Ellen Araba Desbordes, whose unwavering support, guidance, and love inspired me to pursue my academic journey. Although you are not physically here to witness the completion of this thesis, I know you are spiritually present and watching over me, as your legacy lives on through me. This work stands as a testament to your enduring influence and the values you instilled in me. I miss you dearly, but I know you are proud of me and smiling down from above. Thank you for being my rock and forever heroine. With all my love and gratitude, I dedicate this thesis to you.

*“Eternal rest grant unto her, O Lord, and let perpetual light shine upon her. May your soul and the souls of all the faithful departed through the mercy of God, Requiescat in Pace. Amen”*

## Abstract

There has been a significant increase in the number of precarious status migrants in Canada, mainly due to inadequate processes for granting citizenship or permanent residency, as well as the constantly changing immigration policies within the shifting political landscape (Gagnon et al., 2022). Although the study aimed to capture a wide range of experiences among the diverse group of African immigrants with precarious status in southern Alberta, there was a greater representation of international students and temporary foreign workers. The study's findings indicated that participants' migration trajectory conditions intersected to influence their health and well-being. Precarious migration status played a significant role because it intersected with other social determinants of health, including age, gender, racism and discrimination, health knowledge, employment, income, religious and cultural beliefs, and social support networks to influence the health outcomes and well-being of the participants. In Southern Alberta, African immigrants with precarious migration status experience challenges such as limited access to health and social services, which adversely impact their sense of belonging, security, stability, and mental and physical health.

This exploratory descriptive qualitative research was informed by intersectionality theory as a theoretical framework to analyze the data. Semi-structured, in-depth interviews served as the primary data collection method. Braun and Clarke's (2006, 2019) reflexive thematic analysis was used to examine the data and identify themes.

The study's findings enhanced understanding of the challenges experienced by African immigrants with precarious migration status in Southern Alberta, emphasizing the role of precarious migration status as a social determinant of health and its intersection with other social determinants that significantly influence their health and well-being. Additionally, it could help

inform the development of comprehensive policies aimed at improving the health and well-being of African immigrants with precarious migration status and supporting their integration into Canadian society.

## **Ethics Statement**

The work described in this thesis received research ethics approval from the University of Alberta Ethics Board 1 under the following applications:

**Title:** Exploring how migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious immigration status in Southern Alberta.

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*“May the LORD bless you and protect you; may the LORD smile on you and be gracious to you; may the LORD show you his favor and give you peace.” Amen. (Numbers 6:24-26)*

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## Executive Summary

This study explored the migration trajectory conditions that intersect to influence the health and well-being of African immigrants with precarious migration status in Lethbridge, Southern Alberta, Canada. The term “migration trajectory conditions” is often used in migration studies to describe the full continuum of experiences and factors that shape migrants’ lives before migration, during migration, and after migration. Although the study aimed to capture a wide range of experiences among the diverse group of African immigrants with precarious status in southern Alberta, there was a greater representation of international students and temporary foreign workers. Therefore, these findings are especially relevant for these groups and may not fully represent the experience of all African immigrants with precarious status because there is significant intersectional diversity within this umbrella title of precarious status.

The findings were generated through reflexive thematic analysis of interviews, which explored participants’ perceptions and perspectives of the phenomenon under study. This research captured the diverse realities and perceptions of participants, helping to close the existing knowledge gap surrounding this vulnerable population and the role that intersecting migration trajectory conditions play in their experiences. Much previous research on migrants has focused primarily on immigrants' post-migration conditions; therefore, this study’s unique approach of exploring the intersection of migration trajectory conditions across transnational spaces illustrates the complexity of these intersections at an individual level that shape these precarious migrants' experiences and their ability to achieve health, well-being, and success in their new environment.

Recruiting participants faced challenges, such as some potential participants feeling reluctant to participate in the research due to fears of being identified as African immigrants with

precarious migration status and the associated stigma. However, with support from immigrant community leaders (like a Pastor and an Imam) and immigrant associations, the study successfully recruited 18 eligible participants from Ghana, Nigeria, the Democratic Republic of Congo, Kenya, Uganda, Egypt, Cameroon, South Africa, Botswana, and Zimbabwe.

Applying Braun and Clarke's (2006, 2017, 2019) reflexive thematic analysis and Crenshaw's (1989) theoretical lens of intersectionality, these data were rigorously analyzed, coded, categorized, and themes were generated. Study findings are presented and discussed across six chapters, each reflecting different aspects of the participants' experiences: Chapter 4 (In Search of Stability), Chapter 5 (Great Expectations), Chapter 6 (The Evolving Experiences of Health), Chapter 7 (Persisting Precarity), Chapter 8 (Navigating Challenges), and Chapter 9 (Potential Policy Pathways). The findings indicate that multiple migration social and health determinants intersect to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta. The overarching theme, "In search of Stability," captured participants' desire for a more stable life characterized by better health and well-being, which was often elusive due to intersecting conditions. The sub-themes: Great Expectations, The Evolving Experiences of Health, Persisting Precarity, Navigating Challenges, and Potential Policy Pathways, illustrated various facets of this search for stability (detailed in Table 2), and documented the many intersecting migration trajectory conditions that influenced the participants' health and well-being, the coping strategies participants adopted to navigate these challenges, and their recommendations for improved policy to enhance health and well-being in this population.

In Canada, stricter immigration policies aimed at regulating migrant entry and legal status have resulted in a significant increase in migrants with precarious statuses due to limited

pathways to citizenship or permanent residency. It is important to recognize that the evolving and complex immigration policies are likely to increase the number of migrants with precarious status and occupying a space of semi-legality. Although participants experienced stress related to their precarious migration status in various ways, the study demonstrated that this migration status played a significant role when intersecting with other social determinants of health, such as age, gender, racism and discrimination, health literacy, employment, income, religious and cultural beliefs, and social support networks, thereby impacting their health and well-being. A woman participant shared that her pre-migration challenges motivated her and helped her to navigate post-migration challenges: *“I endure challenges. I guess because I'm African, that's why. Because sometimes in Africa, life is difficult, not easy, right? Um, yes, it's very difficult to survive sometimes. And sometimes you can't, yeah.”* This quote highlights the culture of endurance or resilience that many participants possessed. However, despite drawing on this resilience and cultural strength, the stress associated with precarious migration status still adversely impacted their health and well-being because it limited their access to conditions that support health and potentially to health and social services that could help address health issues.

Although not an a priori articulated theoretical framework, considering these participants' experiences from the perspective of the life course also supported understanding how the complex collision of intersectional factors influenced their individual experiences of these conditions. Using a life course lens was particularly helpful when examining the experiences of some older participants, who had held well-paid jobs and stable employment in their countries of origin, but were experiencing unstable employment, poor living conditions, and uncertainty about the future due to their precarious migration status. Despite migrating to Canada in search of a better life, these participants experienced a form of life course backsliding because their

precarious migration status influenced their ability to access and utilize health and social services. Since these participants never lacked access to health and social services in their countries of origin due to their relative privilege, age, social status, financial standing, and social networks, migration to Canada was seen as a step backwards in meeting life course markers. Conversely, for younger participants who were unemployed or students in their countries of origin and had migrated to Canada to continue their education, their post-migration experiences could be viewed as a new phase in their life course because they were in school, continuing their education (their main reason for migrating), and often financially supported by their social networks (e.g., parents and siblings).

Despite their challenging migration status, participants demonstrated strength and resilience rooted in their religious and cultural beliefs. Participants adopted several coping strategies, including maintaining open communication and finding emotional support, seeking guidance and peace from a higher power, pursuing self-care, and remaining hopeful and resilient for a better future. As part of their holistic approach to wellness, some participants highlighted the importance of integrating traditional practices into their daily routines.

Understanding these complex intersectional factors and their impact on the health and well-being of African migrants with precarious migration status could generate discussions about the health and social needs of this vulnerable group. This may also assist policymakers in developing and implementing comprehensive, culturally sensitive health policies that enhance the overall health and well-being of African immigrants with precarious migration status in Southern Alberta or across Canada. Indeed, participants suggested solutions to improve the health and well-being of migrants with precarious status in Southern Alberta or Canada, including the implementation of fair immigration policies, the elimination of employment

barriers, the improvement in living conditions for precarious status migrants, and investment in alternative medicine and healthcare professional education.

## Chapter 1: Introduction

Over the past few decades, there has been a significant increase in the number of international migrants, fueled by factors such as economic opportunities, conflicts, terrorism, environmental changes, and family reunification (International Organization for Migration, 2024). According to the International Organization for Migration (IOM), approximately 281 million international migrants were recorded worldwide in 2020, constituting 3.6% of the global population (International Organization for Migration, 2024).

The term “migration trajectory conditions” is often used in migration studies to describe the full continuum of experiences and factors that shape migrants’ lives before migration, during migration, and after migration. Canada has become an increasingly attractive destination for immigrants, including temporary foreign workers, refugee claimants, and international students from African countries (Statistics Canada, 2024). While many African immigrants have historically settled in major cities like Toronto, Calgary, and Edmonton, the number of African immigrants has increased significantly over the past decade in smaller urban areas such as Lethbridge, Southern Alberta (Statistics Canada, 2024). However, many in this group hold precarious migration statuses, including individuals awaiting refugee decisions, workers with precarious permits, international students whose visas have expired, or those who have lost their status due to complex immigration procedures (Gagnon et al., 2022; Goldring & Landolt, 2013; Hari & Liew, 2018).

Goldring et al. (2009) introduced the terms "precarious immigration status" or "precarious status" to challenge the simplistic binary between status and non-status. This terminology more accurately reflects the fluid nature of how Canada's immigration laws create illegality and exclusion. Precarious migration status relates to lacking characteristics typically

associated with citizenship and permanent residence in Canada, such as the inability to obtain employment authorization; failure to maintain permanent residence; dependence on a third party (like a spouse or employer) to secure immigration authorization; or inability to exercise social rights granted to permanent residents, such as public education and health coverage (Goldring et al., 2009). Consequently, immigrants without Canadian citizenship or permanent residency are considered to have a "precarious" migration status, which depends on their legal residency circumstances and access to health and social services (Goldring & Landolt, 2013). As a result, immigration status functions as a social determinant of health, influencing an individual's eligibility for and access to health and social services in Canada.

It is noteworthy that migrants with precarious status are a diverse group whose migration experiences vary considerably depending on factors such as current global events, the type of visa or migratory status they hold or have held, and the immigration laws and regulations of the receiving country (Brabant & Raynault, 2012). In Canada, precarious-status migrants have limited access to health and social services, which adversely impacts their sense of belongingness, security, stability, and overall mental and physical well-being (Castenada et al., 2015; Magalhaes et al., 2010). Precarious migration status alone does not determine their health, as these experiences are further influenced by the intersections of pre-migration conditions (such as unemployment and instability), migration conditions (such as lengthy visa processing time, medical screening tests, and uncertainty), and post-migration conditions (such as discrimination, unstable employment, and lack of institutional support). Despite these realities, African immigrants with precarious status remain largely invisible in research, policy, and public discourse, especially in smaller centers like Lethbridge, where available support is limited.

As a public health concern, providing precarious-status migrants with unrestricted access to health and social services that enhance their health and well-being is important because they do not exist in isolation. After all, what impacts their health and well-being can also impact the health and well-being of the wider population.

### ***Precarious Immigration Status Means Precarious Health Care Access***

Under the Canada Health Act (1985), an immigrant's access to healthcare and health service utilization depends on their immigration status (Odhiambo et al., 2022). The Canada Health Act defines people who are eligible for public health insurance as “a resident” of a province who is “lawfully entitled to be or to remain in Canada, who makes his home, and is ordinarily present in the province, but does not include a tourist, a transient, or a visitor to the province” (Canada Health Act, 1985). Therefore, under the Canada Health Act, Canadian residents who meet the conditions outlined in the federal and provincial legislative framework are eligible to access healthcare and health-related services.

Globally, the right to health, as recognized in several human rights treaties, obliges many countries, including Canada, to adhere to this principle (United Nations General Assembly [UNGA], 1948). Under Article 12 of the International Covenant on Economic, Social and Cultural Rights, member states of the UN are required to support and ensure the right to health and basic healthcare access for all, regardless of where an individual lives (ICESCR, 2000). There is a common belief that Canada's universal healthcare coverage includes every resident in the country (Grassby et al., 2021; Odhiambo et al., 2022). Unfortunately, migrants with precarious status often have limited access to health services (Magalhaes et al., 2010; Odhiambo et al., 2022). This issue raises concerns because it breaches Article 25 (1) of the United Nations Declaration of Human Rights (1948), which states that “everyone has the right to a standard of

living adequate for the health and wellbeing of himself and his family, including medical care and social services, and the right to security in the event of sickness” (UNGA, 1948).

Although lacking empirical support, the primary reason for restricting precarious-status migrants’ access to healthcare is the cost. Portes et al. (2009) argue that one way to oppose granting unlimited healthcare to uninsured immigrants is by claiming there is no problem. In a Canadian study, opponents of unrestricted access for uninsured immigrants pointed out that this issue primarily concerns "illegal" immigrants. Justifications for denying healthcare to illegal migrants include: (a) the government had valid reasons to deny them legal status initially; (b) they entered Canada illegally and disrespected immigration laws and procedures; or (c) after their legal status expired, they voluntarily left the country and did not pay income taxes that support Canadian health and social services. They contend that uninsured individuals are "illegals" who do not deserve access to Canadian healthcare because providing unrestricted access burdens scarce healthcare resources and can lead to system abuse.

Justifications for providing healthcare to all, regardless of migration status, involve a mix of the prevalent "health ethics" and "preventive fiscal" frameworks. Gottlieb et al. (2012) and Willen (2011, 2012) note that arguments based on health ethics often rely on humanitarian, human rights, social justice, or public health principles, while those based on the preventive fiscal framework focus on the higher financial costs of restricting or denying access to healthcare for the host society. Using the humanitarian framework, they argue that migrants with precarious status are "vulnerable subjects" who should receive consistent support when needed, since standing up for the disadvantaged helps build a morally and humanely strong Canadian society. Regarding social justice, they believe that, regardless of insurance coverage, healthcare is an economic resource that should be shared freely. Furthermore, they emphasize that healthy

individuals contribute to a healthy society, highlighting the dangers of discrimination and exclusion towards migrants with precarious status and viewing them as aspirants for full integration into Canadian culture. According to the Public Health Agency of Canada (2018a), this view frames health as a social determinant of well-being, considering the socioeconomic factors influencing a person's ability to achieve positive health outcomes. Advocates of the "preventive fiscal" approach argue that undocumented immigrants should have unlimited access to healthcare services because it is an economic resource that should never be withheld. They believe that universal healthcare coverage for uninsured immigrants would be more cost-effective than limiting care to emergencies, as the expenses of not providing preventive care tend to be higher. A study across several European countries found that expanding access to primary care leads to significant reductions in both direct medical and non-medical costs (Ursula et al., 2016). In essence, preventive care reduces the risk of minor, inexpensive health issues escalating into more serious and costly illnesses. Public health concerns form the backbone of the historical case for offering treatment to uninsured immigrants. Although the host population is rarely at risk from diseases migrants may carry, denying care poses potential risks (Williams et al., 2016). A German study compared the costs of mass vaccination with those of controlling a measles outbreak in an asylum seeker shelter, revealing that 50% of the expenses associated with controlling the outbreak could have been avoided if migrants had received measles vaccinations upon arrival, reducing the need for serological testing (Takla et al., 2012).

Therefore, it is important for us as a society to understand the emerging patterns and respond with appropriate policies and interventions to prevent wider dire consequences. Exploring these intersections would help gain a deeper understanding of health outcomes and show how regional healthcare systems influence immigrant health. This could lead to the

development and implementation of targeted interventions to reduce long-term health disparities in the population.

### **Problem Statement**

Precarious immigration status often translates to health precarity and poor health outcomes due to the social and epidemiological impacts of marginalization, as well as the relative invisibility of this vulnerable and legally unrecognized population in the eyes of policymakers and healthcare systems. Precarious status fosters a cycle of vulnerability that is not well understood in smaller Canadian cities, like Lethbridge. Despite growing diversity in the region, there is limited empirical research specifically focusing on African migrants with precarious status in Southern Alberta. As a result, policymakers, service providers, and community stakeholders lack the necessary data to develop targeted, culturally responsive programs for this vulnerable group. The absence of data on African immigrants with precarious migration status in Lethbridge continues to render this population invisible and sustains ongoing inequalities. Therefore, this research helps to close this knowledge gap by exploring how African immigrants with precarious migration status experience life in Lethbridge, the challenges they face, and the supports they deem necessary for their well-being.

Furthermore, by exploring the impact of precarious migration status on mental health, this research also documents an important and often under-addressed aspect of immigrant health. Studies indicate that precarious status migrants experience higher rates of mental health illnesses and psychological disorders (Li et al., 2016), poorer general health and well-being (Cebulla et al., 2010), and lower levels of life satisfaction (Noh et al., 2018) compared to those with permanent residency and citizenship. For example, precarious-status migrants in Canada may experience migration-related stress due to fear of arrest and deportation. This hampers their sense

of security and safety, making it difficult to engage in behaviours and practices that support their health and well-being (Hanley & Wen, 2017). When navigating Canadian cities, some precarious-status migrants feel less entitled to enjoy city life for fear of being forced to justify their presence, potentially leading to arrest and deportation (Villegas, 2015). Many also feel embarrassed and frustrated by being denied access to public healthcare, affordable housing, and education (Brabant & Raynault, 2012). Furthermore, precarious-status migrant workers may worry more about losing their jobs or sustaining long-term injuries at work, knowing that without employment, their lives in the city could become impoverished and they would have nowhere to turn for support (Villegas, 2015).

Migration-related stress often strains family bonds and causes mental health issues. However, returning to their home countries may not be a feasible option for many precarious-status migrants in Canada, especially those from war-torn nations (Hanley & Wen, 2017). Many precarious-status migrants believe there are fewer opportunities for work, healthcare, and education back home, which means that despite the challenges they experience in Canada, the idea of going back is even less appealing and would shatter their dreams of a better life through migration (Hanley & Wen, 2017). Despite their precarious circumstances, many precarious-status migrants may choose to stay in Canada because they financially support their immediate families here and in their countries of origin, holding onto the hope that their children will one day access much better opportunities.

My conversations with some migrants in Western countries, including Italy, the US, and Canada, who have precarious legal status, inspired this research topic. During these discussions, I learned about their precarious living and working conditions, which adversely impact their overall health and well-being. I often feel helpless when hearing about the stories and

experiences of many precarious-status migrants. As an emerging researcher in migrant health, I feel compelled to engage in scholarship that may inform efforts to mitigate the challenges they face.

### **Why Study African Immigrants with Precarious Migration Status in Southern Alberta?**

There is a significant increase in the number of African immigrants with precarious migration status, such as temporary foreign workers, refugee claimants, and students transitioning to uncertain immigration pathways in Lethbridge, Southern Alberta (Statistics Canada, 2024). However, there is limited data and scholarship on this vulnerable group, which creates knowledge gaps that may impede policy development, settlement planning, healthcare planning, and community programming. Unlike Calgary or Edmonton, Lethbridge has fewer immigrant-serving agencies, limited culturally specific supports, fewer legal resources for migration status issues, and fewer African-led organizations. These limited resources may potentiate the influence of precarious migration status on the health and well-being of African immigrants in Lethbridge and worsen service gaps. While African immigrants with precarious status may experience challenges, such as limited access to health and social services, these challenges may be experienced differently based on variations in their migration histories, backgrounds, and needs. Therefore, this study provides much-needed evidence to potentially support policies or programs, such as public health initiatives, housing strategies, and funding allocations, to better address the diverse needs of this vulnerable African population.

African immigrants in Canada are regarded as a minority group and often considered homogeneous, categorized as “Blacks” of African origin on Canadian Census documents. This categorization makes it challenging to determine the exact number of immigrants from specific African countries residing in Canada (Soudien & Ladhari, 2011). Soudien and Ladhari (2011)

and Mensah (2014) contend that it is misleading to view African immigrants as a single group because they are highly diverse in terms of their cultural backgrounds, values, and behavioural norms. Mensah (2005) further explains that while many immigrants from Western African countries, like Ghana and Nigeria are typically identified as Black Africans, this does not apply to those from Northern, Southern, or Eastern Africa. For example, immigrants from North African countries such as Morocco, Libya, Algeria, Tunisia, and Egypt are often classified as Arabs or Maghrebi; South African immigrants may be classified as Whites, Indians, or Coloured (African); and East African immigrants are frequently described as Europeans, Arabs, or Asians (Mensah, 2005). Despite the ethnic, national, and regional diversity among African immigrants, they share certain commonalities rooted in history, culture, and social structure, which highlight key features across these different groups (Okeke-Ihejirika & Salami, 2018; Mensah, 2005). For instance, many African nations are former colonies of Britain or France, and their immigrants often speak French or English alongside their native languages or dialects (Okeke-Ihejirika & Salami, 2018). This background underscores my decision to study African immigrants with precarious migration status in Southern Alberta.

### **Purpose of the Study**

The number of precarious-status immigrants is increasing everywhere, including Southern Alberta in response to shifting migration/immigration patterns in Canada (increased number of temporary foreign workers, international students, working holidaymakers, and seasonal workers) and in the world (increased number of migrants escaping poverty, climate change consequences, violence, war, and demographic realities related to overpopulation in some areas without opportunity). Interestingly, few empirical studies have explored how the migration

trajectory conditions intersect to influence the health and well-being of precarious-status migrants in Southern Alberta.

Precarious-status migrants, including Africans, are a diverse, vulnerable, and hard-to-reach population for research and intervention purposes (Ingleby, 2009). As a result, this vulnerable group is underrepresented in studies (Khan et al., 2016) because researchers encounter numerous challenges when trying to identify, access, recruit, and collect data from them (Bonevski et al., 2014). For example, mistrust of the research process, language and cultural barriers, and the difficulty of maintaining communication with people who move frequently all pose challenges for researchers (Raymond-Flesch et al., 2016). These challenges contribute to the limited information available on precarious-status migrants' migration trajectory conditions, including their living and working situations, how they can effectively support their children in the shadows of society with limited access to legal, health, and social services, and the effects on their overall health and well-being in Canada (Cloos et al., 2020; Magalhaes et al., 2010).

This study aims to: 1) explore how migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious immigration status in Southern Alberta, Canada; and 2) address the existing knowledge gaps surrounding the complex intersectional migration trajectory conditions of African immigrants with precarious immigration status in southern Alberta, and the impact on their health and well-being.

The objectives of this study are fourfold: 1) to explore how African immigrants with precarious immigration status define health and well-being; 2) to explore what migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious immigration status in Southern Alberta; 3) to explore what coping strategies African

immigrants with precarious immigration status in Southern Alberta use to navigate their precarious circumstances and; 4) to communicate the findings with relevant stakeholders to facilitate the development of effective policy interventions.

This research study will be guided by the following three primary research questions to achieve the purposes and objectives.

### **Research Questions**

1. How do African immigrants with precarious immigration status perceive and define health and well-being?
2. What migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious immigration status in Southern Alberta?
3. What coping strategies do African immigrants with precarious immigration status in Southern Alberta use to navigate their precarious circumstances?

To achieve these research objectives, I sought assistance from immigrant religious leaders (a Pastor and an Imam), leaders and members of immigration organizations (such as the Southern Alberta Afro-Canadian Association and Ghanaian-Canadian Association in Lethbridge), an immigrant entrepreneur, and used snowball sampling to gain credibility. I successfully acquired a diverse sample of qualitative respondents for this research after obtaining approval from the University of Alberta Human Participant Research Committee (Pro00144998).

### **Summary**

In this chapter, I define precarious migration status as a social determinant of health, present the problem statement, outline the purpose of the study, and state the research questions. In the following chapter, I review the existing literature on the overlapping migration trajectory

conditions and challenges that influence the health and well-being of African immigrants with precarious immigration status.

## **Chapter 2: Literature Review**

The literature search strategy was structured around broad topics, including international migration, migration laws and policies, precarious migration status, pre-migration conditions, migration conditions, post-migration conditions, documented and undocumented migrants, regular and irregular migrants, legal and illegal migrants, and immigration status. The literature search consisted of three phases: searching online databases, using a breadcrumb strategy by reviewing references from retrieved articles, and examining articles that cited the selected studies as additional sources. Electronic databases accessed included SocIndex, JSTOR, PsycINFO, and Google Scholar. The search terms and keywords were grouped into relevant categories such as international migration, precarious-status migrants in Canada, pre-migration challenges, migration challenges, post-migration challenges, and immigration laws and policies in Canada.

The results of this literature search and synthesis are presented in the forthcoming sections of this chapter to frame the backdrop of the current research project and to establish the current scope of knowledge related to this area of study. Despite the increasing number of African immigrants with precarious status settling in southern Alberta, the literature review affirms the limited amount of research related to this population and socio-geographical context. Based on the literature review, I observed that little research has been conducted on this topic in Southern Alberta, despite the increasing number of African immigrants, including those with precarious status in Southern Alberta. Therefore, this study could expand our knowledge and understanding of how migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta.

## **Pattern of Increasing Immigration**

Canada's population has increased significantly, surpassing 41 million in the first quarter of 2024, mainly due to an increase in international migrants (Statistics Canada, 2024).

Considering Canada's aging population and fertility rates below replacement level, immigration continues to be the primary driver of population growth (Statistics Canada, 2022). Statistics Canada (2022) projects that immigrants could make up about 29.1% to 34.0% of the Canadian population by 2041 if current trends persist. Historically, Europeans formed a large percentage of immigrants to Canada. However, over the past half-century, the proportion of immigrants from Europe has decreased, while the share from Asia, Africa, the Caribbean, and the Middle East has increased (Statistics Canada, 2022). To promote multiculturalism, Canada enacted the Multicultural Act in 1988, a policy that recognizes and respects diverse ethnic groups within the framework of equality. Additional laws, including the Immigration Act of 1967 and the Charter of Rights and Freedoms of 1982, were enacted to build an inclusive Canadian society. These laws largely account for the substantial number of immigrants making Canada their home. However, despite these policies and immigrants' significant economic contributions, migrants with precarious status experience many challenges, such as limited access to health and social services, which adversely impact their health and well-being. However, many host country governments often do not provide these individuals with the necessary psychosocial and financial support to prevent and address these health issues (Li et al., 2016; Hynie, 2018). This chapter on the literature review outlines the approach to the literature search, discusses the presence of precarious-status migrants in Canada, explains what precarious immigration status entails, and explores how migration trajectory conditions intersect to impact the health and well-being of these migrants.

## **The Presence of Precarious-Status Migrants in Canada**

The number of migrants in Canada with precarious status has steadily increased since the 2010s (Bhuyan et al., 2024). However, their precise numbers remain unclear due to limited reliable and comprehensive data, as well as the fluctuation of migrants' statuses between having status and being without status (Ellis, 2021; Mak et al., 2021). Statistics Canada (2024) estimates that over one million migrants in Canada hold precarious status, including work and study permit holders and asylum seekers, with many residing in urban centers such as Calgary, Edmonton, Toronto, Montreal, and Vancouver. Many precarious-status migrants receive work authorizations and apply for permanent residence from within Canada once they meet all the requirements. Because many migrants with precarious status experience long-term economic marginalization, inadequate housing, and food insecurity, several studies suggest that precarious migration status is linked to poor health outcomes (Goldring & Landolt, 2021; Braban & Raynault, 2012; Gagnon et al., 2022; Landolt, 2019).

Interestingly, in the hope of gaining full legal status, many precarious-status migrants enter Canada lawfully, follow Canadian laws and policies precisely, accept their employment conditions, and endure mistreatment and exploitation by employers (Ellis, 2015). Studies in Canada indicate that many precarious-status migrants often arrive with temporary permits, such as work permits, student visas, tourist visas, or other forms of status that eventually expire or are withdrawn, leaving individuals without legal status (Bhuyan et al., 2016; Bonifacio, 2017). Statistics Canada (2024) estimated that around 9% of precarious-status migrants entered through the TFWP, while 42% were students, 44% held postgraduate work permits, and included spouses of students and exchange program migrants. The remaining 5% consists of individuals whose asylum or refugee claims were denied, students whose permits expired, tourists who overstayed

their visas, or temporary permit holders who changed employers (Alcaraz et al., 2021; Statistics Canada, 2024). Denied claimants are declared ineligible for status because of complex and ever-changing immigration laws and requirements. As a result, many precarious-status migrants may choose to stay in Canada and live and work in the shadows, despite being denied permission to stay. Due to their precarious migration status and the risk of deportation, some report living in constant fear of arrest, detention, and deportation, which makes it hard for them to access the limited rights and services available to them (Goldring & Landolt, 2013).

Precarious-status migrants remain invisible in mainstream Canadian society due to the lack of official data about them (Gagnon et al., 2022). It is important to recognize that some immigrants may fall through the cracks and become non-status migrants because of the constantly changing Canadian immigration laws and policies (Chen, 2017). Other precarious-status migrants continue to participate in place-specific relationships, employment, and activities in Canada even if their immigration status is revoked, believing that their ongoing presence might improve their chances of obtaining permanent residency and eventually citizenship in Canada (Dennler, 2020). These conditions contribute to the “production of illegality,” defined as the process by which social actors and immigration laws enable the (re)production of precarity into illegality (Goldring et al., 2009).

The following sections discuss precarious immigration status, pathways to precarity, pre-migration conditions, migration conditions, and post-migration conditions.

### **Precarious Immigration Status**

According to Goldring et al. (2009), the Canadian immigration system is complex, with migrants frequently changing their status and relying on external sources such as employers or spouses to obtain lawful immigration status. Precarious-status migrants have limited access to

health, social, and legal services, which adversely impact their overall health and well-being (Magalhães et al. 2010). Goldring and Landolt (2013) emphasize that precarious-status migrants in Canada can experience multiple different statuses over their lifetime, increasing their sense of precarity. The term "precarity" is often used in public discourse, especially in France, to refer to social inequality. It originates from the Latin word "precaria," derived from "precarius," meaning "obtained by prayer," "given as a favour," and from "precari," meaning "to ask, beg, or pray." More specifically, it describes the status of precarious-status migrants as unpredictable, revocable, and unstable regarding their ability to meet basic needs (Goldring & Landolt, 2013).

### ***Pathways to Precarity***

According to Goldring and Landolt (2021), many temporary-status immigrants in Canada experience prolonged precarity, limited access to public services, and an uncertain route to permanent residency or citizenship. Some scholars suggest that Canada's increasingly strict and ever-changing immigration laws contribute to the rising number of precarious-status migrants, who have restricted access to essential health, social, and legal services (Bergen & Abji, 2020; Dauvergne, 2016), which harms their health and well-being. Over recent decades, Canadian immigration policies have preferred highly skilled, self-reliant immigrants over refugees and family sponsorship (Goldring & Landolt, 2013). Certain precarious-status migrants who meet specific criteria can obtain permanent residency and citizenship. For example, international students or temporary workers in particular industries or sectors may apply for permanent residency after earning a tertiary degree from a Canadian university or working in Canada for a set period (Nakache & Dixon-Perera, 2016). Additionally, some precarious-status migrants also become permanent residents through family sponsorship, humanitarian applications, or refugee claims.

It is also important to note that legal migrants can lose their rights to live and/or work in Canada for various reasons, such as failing to meet the conditions required to extend their stay. Canadian immigration and humanitarian policies outline multiple routes to legal entry on a temporary or permanent basis. However, some pathways to legal admission often lead to individuals losing their status at some point (Goldring et al., 2009). Consequently, some migrants with precarious status may experience transitions between different migration statuses, which can result in losing or maintaining their immigration status. For example, if a migrant does not fulfill all the requirements for maintaining their legal immigration status, they can lose it and become a non-status migrant, a situation known as "befallen irregularity" (González Enríquez, 2013; Vickstrom, 2014). While a refugee claimant can be granted legal status if their application is approved (Triandafyllidou et al., 2019), a permanent resident can lose their status if found guilty of an indictable crime, if they fail to meet residency requirements for the period they have lived in Canada, or, in some cases, if an intimate relationship ends during the family sponsorship process (Goldring & Landolt, 2013). Therefore, it is accurate to state that obtaining permanent residency in Canada does not completely prevent an individual from transitioning into a precarious status.

Notably, the pathway to legal permanent residency does not always follow a straight or unbroken line from non-status to status. Immigrants admitted to Canada as permanent residents have secure status and a clear path to citizenship, whereas categories of temporary residents do not have a clear, articulated path to permanent residency or citizenship, except for those admitted under the Live-In Caregiver Program (Goldring et al., 2009). There are only three ways that precarious-status migrants in Canada can regularize their status: (a) marry a Canadian; (b) enroll as an international student; or (c) find employment that will sponsor them (Ellis & Bhatia, 2019).

Therefore, the phrase "precarious migration status" or "precarious status" is useful in capturing the inherent flexibility of mobility between different immigration statuses (Goldring & Landolt, 2013).

### **Pre-migration Conditions**

This is the initial stage of the migration process, where the migrant prepares to leave their country of origin for the host or destination country, in this case, Canada (Wessels, 2014). The pre-migration conditions include the disruption of social roles and networks as migrants depart for their destination countries. Reasons for migration are diverse: "push" factors such as wars, displacements, unemployment, low income, and limited employment opportunities, as well as the anticipated economic prospects in destination countries, may drive migration (Adhikari, 2013); "pull" factors such as immigration policies and the welcoming attitude of the host country (e.g., Prime Minister Justin Trudeau's #WelcomeToCanada tweet in January 2017) (Toshkov, 2012); and "enabling" factors like the proximity or location of the destination country and the ease of travel to it (Monsutti, 2010), the ability to obtain visas and travel documents, proximity to established migrant networks such as family members and friends (McAuliffe, 2017), the presence of immigrant communities in the host country and the support they offer to newcomers (Doraï, 2011), the migrant's financial situation (de Haas, 2010), and advancements in communication technology (e.g., blogs, social media, and news reporting) that provide migrants and human smugglers with valuable information for making migration decisions (McAuliffe, 2017). It is important to recognize that none of these migration drivers are fixed; they can change and influence migration plans, making migration a complex phenomenon (McAuliffe, 2017).

Regardless of the reasons for migration, many migrants with precarious status often experience abuse, exploitation, stigmatization, and marginalization (Alcaraz et al., 2021). For

refugees and asylum seekers who may have endured violence, persecution, war, torture, and land displacement and dispossession in their home countries, these experiences can significantly and permanently influence their health and well-being. Consequently, these pre-migration circumstances put precarious-status immigrants at risk for mental health issues such as stress, anxiety, and depression (Birman & Tran, 2008). However, these health risks impact different migrant groups differently due to variations in migration histories, vulnerabilities, and needs (Kamperman et al., 2007). Compared to the general population, precarious-status migrants are more likely to experience negative health outcomes because of their pre-migration backgrounds, histories, and multiple needs (Omenka et al., 2020).

### **Migration Conditions**

Migration conditions relate to the middle stage of the migration process. They represent the experiences and conditions at the start of the migration journey from the country of origin to the destination countries. This stage may include lengthy visa application processing times and medical screening tests in migrant's home countries, living in refugee camps in a safer third country, or being detained in immigration detention centers in destination countries (De Haas, 2021). Immigrants in transit, such as refugees, may experience violence, exploitation, abuse, detention, starvation, dehydration, family separation (including children being separated from parents upon arrival, or children lost or left behind during migration), uncertainty, fear, and social isolation, which adversely impact their health and well-being (Wessels, 2014).

### **Post-migration Conditions**

This is the final stage of the migration process, where migrants arrive or remain in the host or destination country (Canada) and apply for migration status (Wessels, 2014). At this stage, migrants with precarious status experience multiple intersecting challenges related to

social and economic determinants of health, including acculturation stress, social isolation or exclusion, limited healthcare access and utilization, lack of social support, a discrepancy between pre-migration expectations and post-migration realities, economic challenges, racial discrimination, inadequate housing, language barriers, non-recognition of foreign qualifications, poor access to culturally competent healthcare professionals, and potentially loss of religious practices (Beiser, 2006; Hadgkiss & Renzaho, 2014; Hynie, 2018; Kirmayer et al., 2011; Wessels, 2014). It is important to note that post-migration conditions can contribute to low self-esteem, difficulty adjusting, and poor mental and physical health among migrants with precarious status (Beiser, 2006; Hadgkiss & Renzaho, 2014; Kirmayer et al., 2011; Wessels, 2014).

### **Migration Trajectory Conditions Intersect to Influence the Health and Well-being of Those with Precarious Migration Status**

Precarious-status migrants may experience many complex health-related challenges due to the intersections of their migration trajectory conditions. Despite the unique challenges related to these phases, some potential challenges overlap. Precarious-status migrants may encounter unique pre-migration and migration challenges, such as land displacement and dispossession, living in refugee camps, and visa restrictions. Unique post-migration challenges include communication barriers, a lack of culturally competent healthcare professionals, precarious migration status, shifting societal gender roles and acculturation stress, the hospitality of the host country, and exclusionary social and health policies. However, they may also experience overlapping migration trajectory conditions challenges, such as geographic location, gender, age, cultural and religious beliefs, income, unemployment, low socioeconomic status, racism, discrimination, lengthy visa or immigration processes, social isolation, social networks, family

separation, and lack of health literacy or knowledge, all of which are social determinants of health that influence their overall health and well-being. For example, in Canada, temporary or precarious-status migrants are often employed in low-skilled and precarious jobs and are more likely to experience poverty and adverse physical and mental health outcomes (Kaushik & Drolet, 2018; Liu, 2019; Premji & Shakya, 2017). This may partly stem from a lack of recognition of foreign credentials, racism, and discrimination, which collectively impact the health status of precarious-status migrants in Canada (Gagnon et al., 2022; Liu, 2019; Premji & Shakya, 2017).

The following sections explore land displacement and dispossession as distinct pre-migration challenges, as well as overlapping migration trajectory conditions such as geographic location, gender, age, racism and discrimination, employment, income, cultural and religious beliefs, limited access to culturally competent healthcare professionals, immigration laws and policies, challenges within the Canadian health system, inadequate health knowledge, communication barriers, social isolation, social networks, family separation, and acculturation stress, all of which intersect to influence the health and well-being of precarious-status migrants in Southern Alberta.

### **Land Displacement and Dispossession**

Land displacement has disrupted many immigrants' ways of life and adversely impacted their health and well-being. According to the United Nations High Commissioner for Refugees [UNHCR] (June 2024) Global Trends Report, 120 million people have been forcibly displaced worldwide due to persecution, violence, human rights abuses, wars, and conflicts by May 2024. Many industrialized countries, including Canada, the United States, and the United Kingdom, host about 3 refugees per 1000 people (UNHCR, 2019). Because forced migration makes travel

planning difficult, some migrants with uncertain status, such as refugees, cannot plan trips (Crawley, 2010). They are often forced to give up their sources of income (e.g., businesses, properties, savings) and belongings, including proof of their professional qualifications. This can prevent them from pursuing their careers in the destination countries (Hynie, 2018), and they may experience stressful migration conditions like living in overcrowded refugee camps and being exposed to communicable diseases (UNHCR, 2019).

In the '80s, many people from South America, Asia, and Africa were displaced from their traditional lands and experienced unemployment due to economic restructuring through the Structural Adjustment Program [SAP] that included user-pay social services, privatization, and cuts to public spending tied to debt relief (McNevin, 2009). Since many people, especially men, worked in the public sector, the SAP caused widespread unemployment in these developing countries and a significant increase in international migration (Walia, 2013). Precarious migrants' pre-migration economic and social conditions (such as low income, unemployment, discrimination, and family separation), migration conditions (such as lengthy visa application processing time, medical screening tests, and living in refugee camps), and post-migration social and economic conditions (such as low income, unemployment, discrimination, social isolation, language and cultural barriers, limited access to social and health services, and stigma related to their migration status) intersect to influence their health and well-being.

### **Geographic Location**

Research studies show that proximity to services influences access to health and social services (Cheung & Phillimore, 2014). Because of their low social status, precarious-status migrants often live in remote, impoverished, and isolated areas far from health and social service centers, which complicates access. Additionally, their geographic location and unpredictable

work schedules, such as shift work, can coincide with service hours, making access even more challenging (Berinstein et al., 2006).

In Canada, many detention centers housing precarious-status migrants are in remote and isolated areas, making access to health services and visits very challenging (Paquet & Schertzer, 2020). Furthermore, many detention centers are not properly equipped to address the health needs of these migrants due to limited funding resulting from budget disputes between provincial and federal governments (Paquet & Schertzer, 2020). These conditions at the detention centers can adversely impact precarious-status migrants' health, leading to issues like anxiety and depression caused by social isolation.

## **Gender**

Although biological differences between men and women exist, which may partly explain behavioural differences, social constructionists and scholars like Judith Butler agree that gender is socially constructed or performed, and may be best understood as performative. Gender is not necessarily defined by the biological sex assigned at birth, which assigns males and females to two separate groups (Butler, 2004; Crawford, 1995). Indeed, although presented as a clear dichotomy by many, sex also extends beyond two groups, with many variations of intersex conditions possible (Connell, 2009). Gender norms, such as behaviours or characteristics considered appropriate for men and women within a given social context, are deeply embedded in cultural and social structures, thus shaping and defining behaviour. As a result, men and women tend to think and act according to feminine or masculine norms they have acquired from their culture, which are usually passed down from parents to children, older siblings to younger siblings, and peers to peers (Hill & Lynch, 1983; Courtenay, 1999).

Social constructionists argue that people are not merely conditioned by their cultures to behave a certain way; rather, they actively contribute to shaping and reshaping the dominant norms of femininity and masculinity through their interactions with their environment (Butler, 1990; Crawford, 1998; Courtenay, 1999). Andersen (2010) further emphasizes that gender is a social construct existing in connection with other identities such as race and class. As a result, gender norms are not fixed but are constantly evolving because they are socially constructed and perpetuated through individuals' actions and interactions within their immediate surroundings (Courtenay, 1998a; Rwafa, 2016).

Gender norms shape power dynamics at both interpersonal and systemic levels, which often disadvantage women and other marginalized gender identities. This leads to unequal access to socioeconomic resources, such as the gender pay gap and health disparities (Krieger, 2020). Depending on the host country's gender norms, gender roles can be challenged, maintained, or enforced after migration (Creese, 2012). Post-migration gender reversal roles often result in negative health outcomes, such as anxiety and depression, when they conflict with immigrants' pre-migration norms (Boyd & Pikkov, 2005). Despite progress toward gender equality and increased participation of women in the Canadian labour force, women still experience systemic barriers and challenges in the workplace, including the wage gap, limited advancement, and sexual harassment (Nangia & Arora, 2021). Pelletier et al. (2019) highlight that this widespread wage gap between men and women is due to women's higher participation in low-paying jobs, over-representation in part-time work, lack of work experience, and employer biases. Although several studies indicate that the wage gap has narrowed, women remain underpaid compared to men (Nangia & Arora, 2021). Consequently, the gender wage gap influences access to health and social services, as income is a social determinant of health. Notably, studies in Canada suggest

that immigrant women from traditional societies are more likely than their immigrant men to access and utilize healthcare services, partly due to the social construction of gender, which assumes that men are strong and women are weak (Turin et al., 2020).

### ***Gender and Health***

Although gender is a significant psychosocial predictor of health, immigrant men and women experience migration trajectory conditions differently (Mengesha et al., 2017; Tadiri et al., 2021). Since precarious-status migrant women generally have more gender-specific health needs, including childbirth, pregnancy, and menopause, which require regular visits to healthcare providers more than their men, their inability to fully access and utilize healthcare services due to their precarious migration status can impact them more profoundly (Gómez et al., 2020).

Additionally, a single mother may find it difficult to raise her children alone if her husband is arrested or deported, as this can adversely impact their health by causing long-term stress, anxiety, and depression. Some precarious-status migrant women, particularly from traditional patriarchal societies, enter Canada as dependents of their spouses because they do not meet the labour or family requirements (Bhuyan et al., 2016). Consequently, some of these women may be forced to stay in an abusive relationship or marriage out of fear of deportation if they leave, because their legal status is tied to that of their abusive sponsors or partners (Bhuyan et al., 2016). This often results in negative health outcomes such as chronic stress, anxiety, and depression.

### ***Gender and Migration***

In many traditional patriarchal societies, the decision to migrate often involves sacrifices such as leaving spouses and children behind. Migration has a significant gender aspect due to the interplay of various independent factors, such as family traditions (e.g., who makes family

decisions), provider roles, social status, cultural practices, and religious beliefs (McAuliffe et al., 2017). For example, in many traditional patriarchal societies, a woman's choice to migrate could be driven by household needs rather than her personal development (Monsutti, 2007). As a result, men from traditional patriarchal societies are generally more likely to migrate than their women, making gender a stronger dimension of migration.

Interestingly, recent studies show that half of all immigrants and refugees are women due to an increase in sex trafficking and employment needs in professions or services that have traditionally been dominated by women, such as caregivers, nurses, and nurses' aides (UNHCR, 2018). According to studies, many women with precarious migration status, particularly those from Mexico and Central America, often escape gender-based violence to seek humanitarian asylum in Canada for themselves and their children (Bhuyan et al., 2016). Gender-based violence against women occurs in both public and private settings and manifests in many forms, including rape, sexual assault, sexual harassment, stalking, physical abuse, psychological abuse, and murder (WHO, 2013).

### ***Migration, Masculinity, and Rites of Passage***

In many traditional patriarchal societies, a man's worth is measured by his ability to provide shelter and financial support to his spouse, children, parents, and sometimes his in-laws (Babou, 2008). Therefore, migration in these societies is deeply rooted in cultural norms and is often linked to social status, adulthood, rites of passage, and masculinity (Conrad Suso, 2020; Prothmann, 2018). As a result, some men with precarious migration status may even risk taking illegal and dangerous routes to reach their destination countries when legal options are unavailable, to fulfill societal expectations of what it means to be a man (Carling & Hernandez-Carretero, 2008).

It is worth noting that migration as a rite of passage is considered complete after the migrant returns home, achieves financial success, can support their non-immigrant families, and becomes a hero and role model for the youth in their communities (Conrad Suso, 2020; Prothmann, 2018; Sinatti, 2014). The failure of a young man to migrate and provide for his family is often seen as a challenge to masculinity in many traditional patriarchal societies (Ceesay, 2020). Able-bodied young men who stay in their home country are often viewed by their peers as lazy, unambitious, cowardly, and undesirable (Conrad Suso, 2020; Sinatti, 2014). Additionally, able-bodied young men wishing to relocate but unable to do so due to financial constraints may experience stigma, frustration, and depression (Conrad Suso, 2020). Therefore, a young man's inability to complete the migration rites of passage because of involuntary immobility could lead to "nerve syndrome," a condition that impacts well-being and is marked by prolonged feelings of hopelessness and persistent desires or aspirations to migrate (Gaibazzi, 2015), or "Babylon syndrome," a phenomenon characterized by daydreaming and wishful planning of trips to Europe or North America (Conrad Suso, 2019), or a combination of both. Nonetheless, migrants who are deported from the host country or return home without achieving economic success often experience shame and stigmatization, which can cause them to withdraw from their peers (Conrad Suso, 2019).

Although gender is a social determinant of health, it is not an isolated factor because it intersects with other factors such as age, race, ethnicity, socioeconomic status, immigration status, and cultural or religious beliefs to influence the health and well-being of migrants with precarious status (Hankivsky, 2012; Straiton et al., 2017; Williams et al., 2016).

## Age

Canada's strict immigration policies, such as the point system, attract younger and skilled immigrants (with strong language proficiency, higher education, and job offers) who meet Canada's economic needs, while discouraging older and unskilled immigrants, often viewed as a burden on the economy (Liu, 2019). Age functions as a social indicator of health because the age at which a person migrates to Canada influences their acculturation, social integration, health, and overall well-being (Guo et al., 2019). According to Citizenship and Immigration Canada [CIC] (2011), many immigrants arrive in Canada during their prime working years (between 25 and 64).

Many global studies show that age influences employment decisions in the labour market (Ahmed et al., 2012). Research indicates that older migrant applicants experience discrimination because employers often see them as slower, less healthy, less tech-savvy, demanding higher wages, and unsuitable for their jobs (Lahey, 2005). Consequently, some older migrants with precarious status encounter psychological, physical, and social challenges that intersect to impact their mental and physical health (MacCourt et al., 2008; Mental Health Commission of Canada [MHCC], 2013). Furthermore, many older immigrants perform most household work and carry heavy family responsibilities, which can lead to stress and stress-related illnesses (Beiser & Hou, 2006; Guruge et al., 2008). Interestingly, Guruge et al. (2015) note that some older immigrants experience mental health issues because of overlapping stigmas, such as being older, having a mental illness, and being an immigrant. As a result, older migrants are more likely to seek help from health professionals than younger migrants, due to multiple intersecting factors.

Additionally, studies show that older migrants are more inclined to reconnect with their home

countries through access and utilization of healthcare services, driven by a sense of belonging, entitlement, and the need for both "affective" and "effective" medical care (Sun, 2014).

Therefore, it is reasonable to state that the age at arrival in the host country is not a standalone factor but interacts with immigrants' length of residency, family responsibilities, attachment to their home countries, and discrimination in the labour market to heighten their risk of mental health issues and the need for mental health services. However, some immigration scholars argue that an immigrant's age at arrival in the host country may have an inverse relationship with their mental health risk because younger immigrants from traditional patriarchal societies often experience strict and disciplinary parenting practices and cultural conflicts, which can elevate their mental health risks (Suarez-Orozco et al., 2011).

### **Racism and Discrimination**

Paradies et al. (2015) define racism as an institutionalized system within nations that causes avoidable and unjust disparities in the access to opportunities, resources, and power for racial or ethnic groups. Berman and Paradies (2010) state that racism can manifest in various forms, including interpersonal racism (interactions between individuals), internalized racism (the adoption of racist attitudes, beliefs, or ideologies into one's worldview), and systemic racism (e.g., control of and access to labour, material, and symbolic resources within systems). Several research studies indicate a link between racism and discrimination and adverse health outcomes (Khanlou & Vazquez, 2018), making racism and discrimination social determinants of health. According to Esses et al. (2021), racism and discrimination related to negative perceptions of immigrants can influence their health and well-being by leading to an unequal distribution of resources between groups and contributing to social and health disparities.

Social and health disparities continue to persist among racialized and marginalized groups, such as precarious-status migrants, due to limited access to quality health services (e.g., health insurance coverage) and disproportionate exposure to environmental hazards (Paradies et al., 2015; Willey et al., 2022). As social determinants of health, racism and discrimination contribute to a higher risk of morbidity (e.g., poor mental health outcomes, low birth weight of infants, and increased risk of hypertension) and mortality among marginalized groups like precarious-status migrants (Paradies et al., 2015; Williams & Etkins, 2021). Additionally, racism and discrimination often lead to delays in diagnosis, prescriptions, and medical tests, which can drive some precarious-status migrants to seek alternative healthcare options that may be harmful to their health (Nápoles-Springer et al., 2005). Furthermore, racism and discrimination can foster mistrust in the healthcare system, reduce patient satisfaction, impair patient-provider communication, result in biased treatment recommendations, and compromise the quality of care. They also lower patients' perceptions of the medical encounter quality, including nonverbal behaviour of providers (Ben et al., 2017; Cooper et al., 2012; van Ryn et al., 2011).

Despite their economic contributions, there have been numerous public debates and outcries about the unprecedented increase in the number of immigrants in Canada. Some of these debates have fostered anti-immigration sentiments because immigrants are portrayed as criminals, unwanted, illegals, outcasts, and aliens, particularly after 9/11 (Mogahed & Mahmood, 2019), which adversely impacts their health and well-being. Racism and discrimination reinforce feelings of "othering" and (non)belonging in political, social, and professional settings, creating barriers to accessing health and social services (Caxaj & Cohen, 2021). Depending on how long they stay in the host country, migrants with precarious status' experiences of racism and discrimination can significantly impact their health and well-being (Torres & Young, 2016).

Some scholars argue that restrictive immigration laws and policies fuel anti-migration sentiments, social marginalization, and increased prejudice, all of which adversely impact immigrant health (Perreira & Pedroza, 2019). For example, some politicians and media outlets propagate normative messages that depict migrants with precarious status as lawless individuals (Chavez, 2013; Massey & Sánchez, 2010). Unfortunately, some precarious-status migrants in Canada internalize these negative stereotypes about themselves, leading to feelings of alienation, which harm their ability to manage post-migration stressors, as well as their overall health, well-being, and integration into Canadian society (Brabant & Raynault, 2012; González Enríquez, 2013). Moreover, such anti-migration rhetoric can promote the development and enforcement of federal and provincial laws that often prevent some precarious-status migrants (e.g., certain refugee claimants) from accessing health and social services, creating disparities and increasing their risk of arrest, detention, and deportation (Golash-Boza & Hondagneu-Sotelo, 2013; Valdez et al., 2013).

It is worth noting that racism is not a stand-alone factor but may intersect with religion, ethnicity, stereotypes, media, exclusionary laws and policies, country of origin, length of stay, and immigration status to influence the health and well-being of precarious-status migrants in Canada. Systemic racism adversely impacts the health and well-being of racialized and marginalized groups, such as precarious-status migrants, in several ways, including: a) limited opportunities for work, housing, and education; b) negative cognitive and emotional processes and related psychopathology; c) allostatic load and related pathophysiological processes; d) reduced engagement in healthy behaviours (like exercise and sleep) and increased engagement in unhealthy behaviours (like alcohol consumption), either directly as a stress coping strategy or indirectly, through reduced self-regulation; and e) physical harm resulting from racially

motivated violence (Harrell et al., 2011; Priest et al., 2013; Public Health Agency of Canada, 2018a).

## **Employment**

Employment is considered a social determinant of health (Craig-Neil et al., 2023; Marmot & Wilkinson, 2006; World Health Organization, 2007). This is because unemployment or underemployment can result in negative health outcomes, such as premature death, depression, distress, anxiety, stress-related illnesses (e.g., high blood pressure and other cardiovascular conditions), and musculoskeletal problems (O'Campo et al., 2004), as well as the adoption of unhealthy behaviours like increased alcohol and tobacco use, and poor lifestyle choices related to nutrition and exercise (Marmot & Wilkinson, 2006). Precarious-status migrants are often employed in low-skilled, low-paying jobs with less job security and an increased risk of exploitation (Basok et al., 2014), which contributes to higher poverty levels and poorer health outcomes (Liu, 2019).

In Canada, the Employment Equity Act (1995) was enacted to promote equality and address the workplace disadvantages experienced by marginalized groups such as Aboriginal peoples, people of colour, immigrants, and those with disabilities. Despite this legislation, the Minister of Employment, Workforce Development, and Labour noted in the 2018 Annual Report that these groups, especially women, Aboriginal peoples, immigrants, and persons with disabilities, continue to experience challenges and remain underrepresented in certain occupational sectors (Employment and Social Development Canada, 2019). For example, immigrants are often disadvantaged and underrepresented in the labour market due to issues like the lack of recognition of foreign credentials, language barriers, and racial and ethnic discrimination, all of which adversely impact their economic well-being (Picot et al., 2019;

Statistics Canada, 2022). Chen (2017) argues that, to maintain a flexible labour force and reduce government spending on benefits such as healthcare, an increasing proportion of immigrants are granted only temporary legal status.

Historically, immigrants have significantly contributed to the growth of the Canadian labor and caring economy and the administration and maintenance of the universal healthcare system through taxation (Alcaraz et al., 2021). Studies reveal that the significant changes in labor market regulations, politics, and the economy in recent decades have increased precarious employment in many industrialized countries, including Canada (Rönblad et al., 2019). Vosko (2010) defined precarious employment as work for remuneration characterized by uncertainty, low income, limited social benefits, and statutory entitlements. However, the impact of precarious employment on health can vary significantly depending on how this social determinant of health manifests in individuals' daily lives (Gagnon et al., 2022). This is because precarious employment intersect with multiple factors such as age, gender, ethnicity, low income, access to healthcare, work stress, health behaviors, poor living conditions (e.g., substandard, unsanitary, and overcrowded housing), health-related debts, and poor and dangerous working conditions to influence the health and well-being of precarious status migrants, which in turn creates social and health disparities (Gagnon et al., 2022). Favorable working conditions create an environment where employees experience positive health outcomes (e.g., better physical well-being, happiness, self-confidence, life satisfaction, self-esteem, and improved mental health), a phenomenon known as the “*healthy worker effect*” (Frankish et al., 2007). Many precarious-status migrants in Canada are hired on temporary work visas tied to specific employers, are exploited by being paid less than the minimum wage, and frequently work ‘4D’ jobs (dirty, dangerous, demeaning, and demanding), particularly in sectors such as construction, agriculture,

catering, and cleaning (Durand et al., 2016; Gorina et al., 2018; Maher & Cawley, 2016). Unfortunately, these sectors are associated with labor malpractices, such as working overtime without pay, having little job security, and having no opportunity for career advancement (Durand et al., 2016; Gorina et al., 2018; Maher & Cawley, 2016). These jobs are in what are known as "*fluid zones of precarity*," which describes a condition where a precarious status immigrant transitions to another equally precarious immigration status, particularly when their migration status is tied to employment (Basok et al., 2012a). Several disciplinary procedures by the employers, such as the threat of deportation or the forcible removal of migrants from the host nation, guarantee their adherence to the unfavorable working conditions since their migration status is tied to their employment. Many precarious-status migrant workers are not entitled to workers' compensation and disability payments in the event of illness or occupational injuries, which makes it practically impossible for them to sue their employers (Ellis, 2015; Marks, 2013; Villegas, 2017). Consequently, many precarious-status migrant workers refrain from even seeking medical assistance for work-related injuries out of fear of being reported to the authorities, detained, and deported (Burnett & Whyte, 2010). Unfortunately, only a few employers in Canada have been prosecuted for hiring and abusing precarious-status migrants (Ellis, 2015). Therefore, it makes sense to state that precarious-status migrant workers are more susceptible to exploitation by employers since their immigration status is tied to employment, which adversely impacts their health and well-being. This is consistent with the recent UN Special Representative's findings on Canada's temporary worker program as a "breeding ground for contemporary forms of slavery" because of reports of worker abuse and exploitation (e.g., wage theft, excessive work hours, limited breaks, and physical abuse) (CBC News, August 2024), which the government refuted, but the program was consequently ended in September

2024, before its official end date in February 28th, 2025. Although many immigrants view the workplace as a venue and opportunity for socializing with other members of the community, precarious employment could lead to feelings of alienation, frustration, stress, and depression due to precarious-status migrants' desire to remain in Canada (Alcaraz et al., 2021; Maher & Cawley, 2016; Shen & Kogan, 2020). Despite being pushed into hiding, many precarious-status migrants make significant contributions to Canada's economic growth by working mostly in the informal sectors of the economy (Chen, 2017).

### **Income**

Income is considered a social determinant of health because a lack of income resulting from unemployment adversely impacts an individual's health and well-being by limiting their ability to meet basic needs (Marmot & Wilkinson, 2006; Patel et al., 2018; Tibber et al., 2022; World Health Organization, 2007). Additionally, low- or no-income limits immigrants' access to primary healthcare and other resources that support health, leading to health disparities (O'Mahony et al., 2013). Unfortunately, many immigrants in Canada often experience a decline in financial status after migrating due to unemployment, underemployment, or low-wage jobs (O'Mahony et al., 2013). As a result, many migrants with precarious status become vulnerable to stress-related illnesses such as anxiety and depression, because of low or no income (Fleury, 2007; Gilmore, 2009). However, some research suggests that immigrants may experience the psychological effects of low or no income differently, depending on factors like age, gender, family responsibilities, marital status, migration background, and financial circumstances (Shen & Kogan, 2020). For instance, an immigrant couple with at least one unemployed member might experience severe psychological impacts from unemployment than a couple where both partners are employed (Clark, 2003).

Importantly, low or no income hinders precarious-status migrants' ability to achieve economic prosperity and meet their various needs in Canada (Shen & Kogan, 2020). Since one of the main reasons for migration is to attain economic success, many immigrants may perceive unemployment as more than just a loss of income.

### **Cultural/Religious Beliefs**

An immigrant's cultural and religious norms and beliefs about health and well-being influence their attitudes and behaviours towards accessing and utilizing healthcare, including the decision to seek medical help, follow treatment, cope, and determine appropriate interventions within their communities (Gopalakrishnan, 2018; Taylor & Haintz, 2018; Wang et al., 2019). For example, in many cultures, mental illnesses or disorders are stigmatized because they are seen as incurable, shameful, and embarrassing for family members; consequently, these issues are often hidden and not properly addressed (Lai & Surood, 2013). Notably, many immigrants in Canada originate from cultures where religion and spirituality significantly influence health and healing, shaping their views and actions related to healthcare access and utilization (Thomson et al., 2015; Yohani et al., 2020). Studies in Canada suggest that religious centers or communities play a significant role in promoting immigrants' health and well-being (Agyekum & Newbold, 2016). They offer members a sense of meaning and purpose amid difficult times, such as illness, by accepting suffering as a normal aspect of life (Koenig, 2009). Additionally, they serve as a place for connections among diverse ethnic groups, which has long-term positive effects on migrants' health and social integration into the community (Tegene, 2018). For instance, research indicates that regular participation in religious activities, including prayer and meditation, can reduce the negative effects of post-migration issues like unemployment on immigrants' health and well-being (Joly & Reitz, 2018; Vang et al., 2019), and decrease the risk of emotional or mental health

issues later in life (Yu, 2021). Interestingly, studies show that immigrant women are more likely than men to regularly engage in religious activities (Greenfeld et al., 2009), which influences health disparities between genders among immigrants (Yu, 2021). Moreover, many younger migrants depend on older immigrants for valuable knowledge about language, culture, religion, and history, fostering positive health and well-being (Dong et al., 2015; Kim et al., 2002). As a result, many turn to religion to cope with the multiple stressors of migration (Wessels, 2014). However, government regulations on religious practices and cultural norms can impact an individual's level of religiosity and overall well-being (Doane & Elliott, 2016).

A holistic approach to health promotion recognizes the influence of spiritual and mental well-being on physical health, and vice versa. Consequently, many immigrants from traditional societies believe that optimal health requires balancing physical, mental, and spiritual aspects (Martin, 2009). Many immigrants address their health issues by applying their beliefs and knowledge in complementary and alternative medicine or traditional healing practices (Stewart et al., 2011). Additionally, their belief in the healing power of non-medical interventions, such as seeking God's help and protection, shapes some immigrants' attitudes and behaviours toward healthcare access and service utilization (Whitley et al., 2006). For example, prayer-based spiritual healing and self-talk can offer immigrants comfort, hope, and strength, enhancing their overall health and well-being (Donnelly et al., 2011). Unfortunately, the biomedically-focused Canadian healthcare system does not fully acknowledge the role of spirituality in health and healing, which can prevent some immigrants from seeking medical care or using healthcare services (Collins & Guruge, 2008; Koenig, 2009, 2012). As a result, some immigrants continue to use herbal or traditional medicine because it is culturally acceptable and safe when used with a healthcare provider's knowledge (Kirmayer et al., 2011). While not a common practice within the

Canadian healthcare context, many countries endorse the use of acupuncture for pain management in cancer patients (Deng et al., 2018). Research shows that Chinese herbal therapy can be an effective alternative treatment for cardiovascular disease (Luo et al., 2013). Therefore, in societies where healthcare systems are based on Western concepts of health and illness, some immigrants turn to their traditional or cultural views, which may hinder them from seeking medical attention or utilizing healthcare services.

### **Inadequate Access to Culturally Competent Healthcare Professionals**

Betancourt et al. (2002) define healthcare cultural competency as "the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs." Health professionals encounter numerous challenges in providing care for migrants due to immigrants' differing perspectives on health, illness, and healthcare (Burchill & Pevalin, 2014). Additionally, healthcare workers must address the complex health and social needs of racialized and marginalized populations, often through cross-cultural interactions, within health systems that may not be politically or structurally designed to serve them (O'Donnell et al., 2016). Aside from the scarcity of health resources, policy restrictions prevent doctors from treating some precarious-status migrants because of their migration status. Due to these restrictions, community-based organizations often deny services to some precarious-status immigrants because of the burdensome bureaucratic process involved in processing their information (Berinstein et al., 2006). As a result, these obstacles hinder healthcare practitioners' ability to deliver the same standards of care to racialized and marginalized groups, such as precarious-status migrants, leading to healthcare disparities (O'Donnell et al., 2016).

Notably, some immigrants prefer physicians who are fluent in their native language and familiar with their culture (Lum et al., 2016). Considering that cultural differences exist both between and within different racial and ethnic groups, a lack of culturally competent healthcare practitioners and culturally sensitive policies to meet the diverse healthcare needs of immigrants influences their attitudes and behaviors toward healthcare accessibility and utilization, fostering mistrust of the healthcare system (Donnelly et al., 2011). For instance, many Muslim and Asian immigrant women prefer physicians from their own ethnic groups, who are more familiar with their customs and religious beliefs (Lee et al., 2014). Even when a woman doctor is performing the physical examination, some of these women feel shy and uneasy about exposing their bodies (Brotto et al., 2008). Since some South Asian immigrant women prefer women doctors, especially for physical exams and reproductive health, the gender of a doctor can also serve as a cultural barrier to their access and utilization of healthcare (George et al., 2014). Additionally, many Chinese immigrant women prefer an obstetrician over a midwife for maternal care because they see midwives and nurses as inferior to doctors (Lee et al., 2014). To address this misconception, nurses and midwives spend extra time explaining their roles to their immigrant patients before starting maternal care (Ng & Newbold, 2011). As a result, some immigrants either underuse or avoid health services altogether due to skepticism and mistrust of Western medicine and a lack of access to culturally sensitive healthcare and competent professionals, which negatively impacts their health and well-being (Majumder et al., 2015).

### **Immigration Laws and Policies**

The concept of immigration status first appeared in the 19th century when nation-states established legal frameworks to distinguish between legal and illegal migration (Ngai, 2005). Immigration status refers to an immigrant's social position concerning society's rights and

obligations within the laws and procedures that govern various groups and social circumstances (Stuart et al., 2015). Immigration status is a complex and fluid condition because it can be obtained through employment, family sponsorship, or humanitarian reasons, or lost if an immigrant cannot meet the requirements to renew or extend their stay. Many precarious-status migrants in Canada are more likely to receive low-quality medical care because they lack health insurance coverage, which can lead to adverse physical and mental health outcomes (Crooks et al., 2011). Therefore, it makes sense to state that immigration status is a structural determinant of the health of precarious-status migrants because it limits their legal, social, and health rights and exposes them to a higher risk of abuse and exploitation (Alcaraz et al., 2021; Caulford & D'Andrade, 2012; Gostin, 2021; Li, 2017; Martinez et al., 2015; Philbin et al., 2017).

Canada's current immigration laws and policies promote the creation and maintenance of several temporary statuses, such as foreign workers, asylum seekers, international students, and those classified as unlawful (e.g., those who overstay their visas, border crossers, and stateless persons) (Hari & Liew, 2018). Furthermore, many immigrants are granted temporary legal status to limit government intervention and keep a flexible labour force in Canada (Chen, 2017). Although many migrants with precarious status do not achieve permanent residency in Canada, they often choose to stay illegally when their permits expire instead of returning to their countries of origin. This choice is driven by various reasons, including the pressure to continue working to fulfill financial obligations to relatives back home and a strong desire to remain in places where they have established roots (Macklin, 2015).

### ***Immigration Laws and Surveillance***

Although surveillance is an important security component in today's world, it is considered risky for many precarious-status migrants and those without legal immigration status.

A country's internal boundaries are reinforced by surveillance methods, which often lead to the expulsion of some precarious-status migrants (Villegas, 2015). While it is common practice for immigration authorities to target some precarious-status migrants with removal orders through known addresses, workplaces, and other networks, other institutions, such as banks and medical facilities, also assist law enforcement agencies in tracking, policing, and potentially deporting some precarious-status migrants (Villegas, 2015).

Three interconnected elements comprise surveillance practices: ways of knowing, actors, and institutions (Villegas, 2015). Knowledge about precarious-status migrants is generated through policy, discourse, news reports, and surveillance data. Actors include politicians, social care providers, private sector employees, immigration officers, and non-immigrants. Institutions are places where relevant actors engage actively, such as banks, employment agencies, the police, the immigration department, and the medical field. Additionally, actors and institutions can gather data on migrants using surveillance and profiling tools (like databases and fingerprinting) and by identifying physical markers linked to precarious-status migrants, including accents, attire, surroundings, physical inscriptions, friends, identity documents, or individuals who 'look unlawful' during interactions with the police, in the media, at community gatherings, and in casual settings (Villegas, 2015).

### ***Immigration Laws and Detention Centers***

Immigrants must obtain permission from their host country (Canada) to enter and stay on its territory, as there is no inherent right to immigration (Gill et al, 2014). Countries regulate who can enter their territories through various restrictions or control mechanisms, such as detention centres, which vary depending on the type of migration (Gill et al., 2014). The main purpose of detention centres is administrative, to prepare migrants with precarious status for deportation,

rather than punitive, which would involve serving a jail sentence for their unauthorized presence in the host country (Broeders, 2010). Detention centres act as facilities for surveillance, confinement, and control of migrants with precarious status, who are often portrayed as dangerous criminals and threats to national security. When a migrant with precarious status is detained, specific standards are applied to decide whether they should be released to remain in the country while their application is processed or deported back to their country of origin. It is important to note that deporting migrants with precarious status often presents many challenges, including precarious-status migrants destroying their identity documents, remaining silent about their identities, deliberately lying about their origins, refusing to cooperate with immigration authorities, and facing resistance from the embassies of their (presumed) countries of origin, which may refuse to cooperate with the host country (Broeders, 2010; Grimm, 2004).

Like many industrialized countries, detention facilities in Canada function as restrictive measures to maintain the state's integrity, safety, and security (Molnar & Silverman, 2017), as well as to prevent illegal migration (Winterdyk & Dhungel, 2018). Since 2000, at least 16 documented deaths have occurred in Canadian immigration detention centers (Molnar & Silverman, 2017). Regardless of how long precarious-status migrants are detained, many studies indicate that a significant number experience mental health issues due to overcrowding, poor hygiene, limited access to water and sanitation, verbal, physical, and sexual abuse (Alvarado et al., 2019), neglect, delayed medical care, violence, racism, discrimination, and social degradation, conditions that may include handcuffing, constant monitoring, searches, and other severe restrictions on their freedom and dignity (Kronick et al., 2015, 2016, 2018). Unfortunately, some detention center guards often overlook the deteriorating mental and physical health of detained precarious-status migrants because they are seen as deceitful, criminal, or

merely acting (Razack, 2017). All these conditions contribute to adverse health outcomes for precarious-status migrants, including stress, anxiety, and depression. It is important to note that delayed care leads to delayed diagnosis, worsening health conditions, and, in some cases, the development of viral resistance, such as HIV/AIDS (Access Alliance, 2005).

For many migrants with precarious status in detention, their pre-migration challenges (e.g., poverty, wars, torture, conflict, persecution, and violence), migration challenges (e.g., living in refugee camps) and post-migration challenges (e.g., limited access to healthcare services, and poverty) intersect to influence adverse health outcomes such as anxiety and depression (Harris & Pickles, 2018; von Werthern et al., 2018). For example, many detained migrants, especially men from traditional patriarchal societies, experience psychological distress due to their inability to fulfill the sole provider role and remit to their non-immigrant relatives in their home countries, which often accounts for a greater percentage of household income (Sampaio & Carvalhais, 2019).

Although there have been fewer reports of abuses or mistreatment in Canadian detention centers than in many other developed countries (Kronick et al, 2018), several immigration advocacy groups have questioned and condemned immigration detention facilities because the conditions there adversely impact the health and well-being of migrants with precarious status (Harris & Pickles, 2018; Juarez et al., 2019; McKenzie, 2019). In 2013, the Royal College of Psychiatrists published a policy statement about detaining individuals with mental illnesses, stating that such individuals should only be detained when necessary because, in most cases, detention centres cause a significant decline in mental health, increase suffering, and heighten the risks of suicide and self-harm (The Royal College of Psychiatrists, 2013).

## Canadian Health System

The Canada Health Act (1985) stipulates the conditions that all provinces and territories must fulfill to receive federal healthcare funding: (a) *portability*: which ensures coverage within Canada for all insured residents; (b) *universality*: which ensures that no insured resident receives preferential access based on their ability to pay privately; (c) *accessibility*: which ensures that no insured resident is charged for publicly insured services; (d) *comprehensiveness*: which ensures that publicly funded health insurance plans cover all insured health services provided by hospitals, physicians, or dentists (including surgical dental procedures requiring a hospital setting); and (e) *public administration*: which requires health insurance plans to be publicly regulated on a non-profit basis (Bobadilla et al., 2017; Martin et al., 2018). Although health delivery services are managed at the provincial and territorial levels, it remains the federal government's responsibility to provide healthcare coverage and services to veterans, federal prison inmates, Canadian Forces members, status Indians, and some refugee groups (Government of Canada, 2019). Additionally, hospitals, health authorities, and other healthcare institutions operate with separate budgets, allowing them to make decisions regarding healthcare service delivery (Government of Canada, 2019). This often disproportionately impacts marginalized groups, including migrants and individuals from certain ethnocultural communities.

Precarious-status migrants in Canada have filed multiple legal petitions against their limited public healthcare coverage to gain full healthcare access, but with little or no success (Canadian Doctors for Refugee Care v Canada [Attorney General], 2014). Their most common argument is that the restricted access to healthcare for these migrants violates the equality rights provision in the Canadian Charter of Rights and Freedoms compared to citizens and permanent residents, who have full access to healthcare (The Constitution Act, 1982, Canada Act, 1982).

However, Canadian courts have consistently rejected this argument, ruling that inequalities in healthcare benefits due to differences in immigration status do not fall under the protection of the Charter's equality rights. In their decisions, the courts made assumptions about how precarious-status migrants ended up in this situation and what they could do to change it. For example, Ontario's Divisional Court rejected a section 15 Charter challenge brought by a group of international students whose right to provincial health insurance was revoked following a policy change in 1994 in *Clarcken et al. v. Ontario Health Insurance Plan*. The Court concluded that their immigration status did not meet the criteria for being considered immutable and therefore could not be protected under the equality rights of the Charter. Justice Chilcott explained that obtaining permanent residence was necessary for international students to fully access and benefit from healthcare in Canada, which they did not qualify for. Nonetheless, some migration scholars argue that it is unreasonable to expect precarious-status migrants to obtain permanent residency to access full healthcare, especially considering the political benefits the government gains by keeping them in a state of precariousness. Notably, the Court paid no attention to the structural factors within the Canadian immigration system that encourage more temporary than permanent residency, a practice that continues today.

### **Lack of Health Literacy/Knowledge**

Previous studies suggest a strong relationship between health education/literacy and health (Price et al., 2011). Many precarious-status migrants lack knowledge of the Canadian healthcare system, including mental health services and preventative treatments like screening. These gaps influence their post-migration attitudes and behaviours towards healthcare access and utilization and health outcomes over time, potentially increasing the likelihood of missing medical appointments (Dastjerdi, 2012; Gele et al., 2016). Since health services and resources

are rarely publicized, precarious-status migrants' awareness of the accessibility and availability of health resources depends on the level of health knowledge of the individuals who form their networks in the host country (Goldring et al., 2009). Furthermore, studies show that immigrant women who are health literate are more likely to get tested for conditions such as cancer compared to less informed immigrant women and men (Hislop et al., 2004).

Therefore, providing health education to immigrants enhances their knowledge and understanding of how to access and utilize health resources in Canada, and promotes their overall health and well-being (Ahmed et al. 2016).

### **Communication Barriers**

Effective communication between healthcare professionals and patients is crucial to the quality of care, as poor communication lowers the likelihood of diagnosing illnesses and referring patients for additional treatment (Bischoff et al., 2003). Some medical professionals find it challenging to understand the complaints of immigrant patients due to cultural differences in medical terminology used to describe the same conditions, as well as the time and effort required to explain healthcare concepts, medical systems, and medical conditions to immigrant patients (Ali et al., 2021; Suurmond et al., 2013; Yelland et al., 2014). For example, among South Asians, emotional pain is often described using medical terms such as "heartache" or "sinking heart" (Lai & Surood, 2008). Studies indicate that using interpreters for communication can solve some problems associated with communication barriers (Mayo et al., 2016). However, questions are often raised concerning the availability and quality of interpreters. It is recommended that professional interpreters be engaged since they are trained in professional standards, medical terminology, and ethical considerations (Mayo et al., 2016). Although it may be necessary to use ad hoc interpreters, such as family or community members, in some

situations, it could compromise patient confidentiality and lower the quality of interpretation (Mayo et al., 2016). In addition, using family members who are children as interpreters due to a shortage of qualified interpreters can make it difficult for patients to understand their diagnosis, recommended course of treatment, and follow-up care plans (Grantmakers in Health Bulletin, 2003).

The inability of precarious-status migrants to communicate in English or French can hinder their access to and utilization of healthcare services in Canada. This often results in missed appointments, delays in diagnosis and treatment, increased anxiety, uncertainty about their health, higher healthcare costs, feelings of alienation, and mistrust towards the healthcare system. This is due to their difficulty understanding health information and medical terminology, as well as describing symptoms (Dastjerdi et al., 2012; Montesanti et al., 2017; Woodgate et al., 2017). Additionally, previous experiences with doctors in their home country may influence migrants' communication with healthcare providers in Canada (Poureslami et al., 2011). Many migrants come from developing countries where a power imbalance exists between physicians and patients, discouraging patients from initiating conversations until prompted by the doctor (Donnelly, 2008). These previous experiences of power dynamics between physicians and patients in their countries of origin can hinder open communication with doctors in the host country (Donnelly, 2008). Conversely, many Canadian healthcare providers expect patients to speak openly about their concerns without fear (Marshall et al., 2010). Therefore, communication gaps between patients and healthcare providers often stem from language barriers and preexisting power dynamics.

## **Social Isolation**

Social isolation is a persistent stressor and a well-established health risk factor that has been associated with depression, loneliness, and other mental health issues (Marcus et al., 2017; Taylor et al., 2018). Research shows that some migrants with precarious status are more likely to experience social isolation and loneliness than permanent residents, mainly due to fear of being reported to authorities, arrested, detained, or deported (De Jong Gierveld et al., 2015, 2018; Koehn et al., 2022; Smith & Victor, 2019). This fear adversely impacts their mental and physical health and overall well-being. Nonetheless, the experiences of social isolation among precarious-status migrants remain inadequately evaluated and addressed (Chow et al., 2017; Cruz et al., 2016; Holt-Lunstad, 2017).

Longitudinal studies have shown that age is a risk factor for social isolation and loneliness (Koehn et al., 2022). Older adults (80 years and above) are more likely to experience loneliness, especially after losing a spouse or partner (Koehn et al., 2022). This can lead to declines in mental health, functionality, mobility, and overall health. However, many cases of mental health issues related to social isolation and loneliness among older adults go unreported due to stigmatization (De Jong Gierveld et al., 2018). For example, studies in Canada indicate that about 43% of older adults experience social isolation and loneliness (National Seniors Council, 2017; The Federal/Provincial/Territorial Working Group on Social Isolation and Social Innovation, 2017). Older immigrants with precarious status are more likely to experience social isolation and loneliness due to structural risk factors such as higher poverty rates caused by racism and discrimination, and limited access to or awareness of health and social services (Cela & Fokkema, 2017; Comas-Diaz et al., 2019; The Federal/Provincial/Territorial Working Group on Social Isolation and Social Innovation, 2018). Nonetheless, experiences of social isolation

and loneliness can vary based on immigrants' immigration history, needs, and length of stay in Canada (De Jong Gierveld et al., 2015; Wu & Penning, 2015). Interestingly, some precarious-status migrants adopt self-imposed social isolation strategies to avoid arrest, detention, and deportation (Brabant & Raynault, 2012; Chen et al., 2015; Tenenbaum & Singer, 2018), either by living in the shadows (Miklavcic, 2011; Villegas, 2015) or by participating less in community activities (Villegas, 2014).

### **Social Support/Networks**

Previous studies indicate a strong positive relationship between social support and improved health and well-being of migrants globally (Lin et al., 2020). An immigrant's social support networks, including family, friends, acquaintances, and community in both their countries of origin and destination, play an important role in their lives. These networks influence their migration decisions by providing migration financial assistance, housing, job leads, emotional support, and resources that help reduce stress and foster trust and positive health outcomes (Gangamma, 2018; Lin et al., 2020). Therefore, when migrants lack their pre-migration social networks in the host country, it can adversely impact their health and well-being, making it harder to maintain family stability while navigating challenges in their new environment (Ryan, 2011). It can also lead to feelings of loss and shame, alienation, powerlessness, insecurity, diminished ambitions, withdrawal, diminished self-confidence (Cook, 2009; Pemberton et al., 2013), and high-risk health behaviours (Smit et al., 2012), all of which influence migrants' overall health and well-being. As a result, many immigrants may relocate to host countries with well-established immigrant communities that support immigrants and their successful integration.

## **Parent-Child/Family Separation**

Although children born in Canada to non-status migrants are not eligible for detention for immigration-related reasons, they may be permitted to accompany their parents in detention (Amnesty International and Canadian Council for Refugees, 2017). In this context, non-status migrant parents have the option to remain in the custody of their children while they are in detention, place them in the care of extended family, if available, or in the care of provincial youth protection agencies (Amnesty International and Canadian Council for Refugees, 2017).

According to findings from a long-term birth cohort study, non-status mothers' anxiety about deportation was linked to higher levels of maternal depression, which was connected to a decline in the cognitive development of preschoolers (Yoshikawa & Kalil, 2011). Like other adverse effects of childhood hardships, family separation caused by deportation can adversely influence children's physical and mental health outcomes (Garner et al., 2012). Family separation may lead to "toxic stress," which is defined as long-term exposure to stressors without the support of family or other resources to mitigate the effects of the exposure (Garner et al., 2012). In other words, toxic stress caused by family separation or other traumatic childhood experiences can negatively impact health through mechanisms of systemic inflammation, immune dysregulation, increased psychological reactivity, cellular aging, and DNA methylation (Fagundes et al., 2013; Lacey et al., 2013).

## **Acculturation Stress**

The discrepancies between premigration expectations of a better life in Canada (such as economic success) and postmigration realities (like unemployment) are major sources of stress for many immigrants (Okeke-Ihejirika et al., 2019). For example, the pre-migration perceptions of Canada as a land of opportunity, where skilled immigrants could easily find jobs that match

their educational background, often do not align with the realities experienced after migration due to reasons, including the devaluation of foreign credentials and lack of Canadian work experience (Berry & Hou, 2016; Okeke-Ihejirika et al., 2019). These discrepancies can lead to delusions, stress, anxiety, and frustration caused by an inability to achieve economic success (Berry & Hou, 2016; Okeke-Ihejirika et al., 2019). However, migrants with precarious status and permanent residents experience postmigration stress, anxiety, and desperation differently due to differences in migration history, needs, and backgrounds (Olukotun et al., 2019). For instance, while precarious-status migrants may experience stress and anxiety related to their migration status, such as constant fear of detention and deportation, permanent resident migrants might experience stress concerning their families' well-being, especially their children (Olukotun et al., 2019). Additionally, many precarious-status migrants experience stress from working low-wage jobs, particularly in sectors like construction, cleaning, care, agriculture, food service, hospitality, and the sex industry, as well as from family separation, discrimination, and xenophobia, all contributing to poor mental and physical health outcomes (Negi, 2013; Ojeda & Pina-Watson, 2013). Interestingly, research suggests that prolonged periods of stress adversely impact impulse control, cognitive function, and both short-term and long-term memory (Plessow et al., 2012).

### **Summary**

A review of the literature shows that precarious-status migrants experience many complex health-related challenges due to the intersections of their migration trajectory conditions. However, their experiences may vary due to the differences in migration history, needs, and financial status. Despite the growing number of precarious-status migrants in Canada, little is known about how their migration trajectory conditions intersect to influence their health and well-being. While all these factors are social determinants of health for precarious-status

migrants, many governments in host countries do not provide the psychosocial and financial support needed to help these individuals overcome health challenges (Hynie, 2018; Li et al., 2016). The review explored land displacement and dispossession as unique pre-migration and migration conditions, as well as overlapping pre- and post-migration conditions such as geographic location, gender, age, racism and discrimination, employment, income, cultural and religious beliefs, inadequate access to culturally competent healthcare providers, immigration laws and policies, issues within the Canadian health system, lack of health literacy, communication barriers, social isolation, social networks, parent-child and family separation, and acculturation stress, all of which intersect to influence the health and well-being of precarious-status migrants in Canada. Developing a deeper understanding of how these migration conditions intersect to impact health outcomes can help healthcare professionals and policymakers create more effective health and social policies that address the diverse needs of precarious-status migrants in Canada.

### **Theoretical/Conceptual Framework**

Qualitative researchers often benefit from adopting a theoretical framework to analyze qualitative data logically, perceptively, and with minimal bias or prejudice (Hesse-Biber & Leavy, 2010). Although qualitative researchers can use multiple theoretical frameworks, the one they choose should be relevant to their findings and support further generalization of their research (Punch, 2005; Rosman & Rallis, 2012). To help the audience and other researchers understand the study's contribution, researchers must thoroughly describe their chosen theoretical framework (Punch, 2005). The following sections discuss intersectionality theory as a key theoretical framework that informs the study's exploration of how migration trajectory

conditions intersect to influence the health and well-being of immigrants with precarious migration status in Southern Alberta.

### **Intersectionality Theory**

An intersectionality theoretical perspective guided the conceptualization and conduct of this research (Crenshaw, 1989, 2003). The intersectionality framework is recognized as a useful paradigm for normative and scholarly work, helping us to understand the complexity of health disparities (Bowleg, 2008; Hankivsky, 2011). According to Green et al. (2017), intersectionality theory challenges researchers to consider how upstream social determinants, such as racism, gender, classism, sexism, and disability, intersect to produce unique forms of privilege or oppression that influence people's experiences and opportunities in life due to their complex social identities. Racism and sexism are examples of contextual factors that interact to produce health disparities rather than acting independently. Intersectionality theory is increasingly applied in social epidemiology because it aligns with the discipline's focus on the underlying power structures that generate inequality, rather than disparities solely resulting from the accumulation of separate risk factors (Green et al., 2017). Consequently, as an alternative analytical framework, intersectionality can be applied to analyze health inequities from a structural level of power, race, class, gender, and immigration status.

Intersectionality theory can be traced back to the 19th century, during the Black American Freedom Movement (Eriksson-Zetterquist & Styhre, 2008). However, it was not until 1989 that Kimberlé Crenshaw coined the term 'intersectionality' to describe how multiple intersecting factors influence the lives of minorities, particularly among Black women. The theory of intersectionality posits that multiple independent social factors, including migration status, religion, power dynamics, age, geography, gender, class, sexual orientation, race/ethnicity, and

ability or disability, intersect to produce inequities (Crenshaw, 1989, 2003; Hankivsky, 2014). McCall (2005) highlighted that these independent social factors are dynamic and continuously intersect to generate inequality in society. Crenshaw (1989, 2003) emphasized that social identities are mutually constituted and experienced simultaneously. Racialized minority groups' experiences of inequalities and marginalization can be analyzed by examining these multiple overlapping social factors and locations linked to social systems of domination and power (Hankivsky et al., 2014). Although Crenshaw's original research mainly highlighted the socioeconomic disadvantages experienced by Black women in the U.S., intersectionality theory has developed into an important analytical tool for understanding health inequities experienced by socially disadvantaged marginalized groups, such as immigrants.

It is important to note that social groups are not homogeneous, and members within these groups are situated according to their social and economic status within the social hierarchy of dominance, privilege, and oppression (Stewart & McDermott, 2004). Intersectionality extends beyond single or commonly used categories of analysis, such as sex, gender, race, and class, to examine the effects of systems and processes of oppression and dominance, as well as the concurrent interactions among different aspects of social identity (Hankivsky & Cormier, 2009). Consequently, an individual's position within the social hierarchy of privilege, dominance, and oppression shapes their perspectives and experiences (Ritzer & Stepniski, 2013). These intersections occur within a framework of interconnected systems and structures of power, including laws, policies, state governments, political and economic organizations, religious institutions, and the media (Crenshaw, 1989, 2003; Hankivsky, 2014).

Although there are many tenets of intersectionality, some central theoretical tenets are clearly acknowledged. These include the belief that human lives cannot be reduced to just one

characteristic; that human experiences are not fully understood by focusing on only one factor or a limited set of factors; that social categories such as race/ethnicity, gender, class, sexuality, and ability are socially constructed, fluid, and flexible; and that social positions are interconnected and shaped by interacting social processes and structures influenced by time and place (Hankivsky, 2012). These tenets serve as the foundation for a new line of inquiry where specific distinctions are not always prioritized over others, and no form of oppression is automatically considered the most harmful (Hankivsky, 2012).

Intersectionality differs from other diversity analysis methods because it is not additive. Therefore, the combined impact of factors like gender, class, and race/ethnicity is not simply the sum of their individual effects, which are often measured as multiple straightforward binaries. Critics argue that this additive approach layers "several simultaneous oppressions" without considering their connections or mutually reinforcing mechanisms (King, 1988). Comparatively, intersectionality examines how social identities and structural forces interact to shape and influence human experiences. According to Andersen and Collins (2001), intersectionality recognizes and analyzes the hierarchies and systems of domination that permeate society and that systematically exploit and control people. Additionally, intersectionality aims to be a multi-level study, considering how power and social processes impact individual development at both macro and micro levels (Dhamoon & Hankivsky, 2011). It is also important to note that intersectionality describes how social organization influences every aspect of our lives, and it is not just a tool for expanding knowledge about marginalized or disadvantaged groups to promote social justice (Weldon, 2008). Furthermore, it challenges binary thinking, which often places groups against each other (e.g., women/men; black/white; Aboriginal/non-Aboriginal), by highlighting the possibility of experiencing privilege and oppression simultaneously (Hankivsky, 2011).

Intersectionality is a valuable framework to recognize the diversity included within the label of precarious migration status. While precarity is often utilized as an umbrella term to describe migrants with vulnerable, fluid, or absent legal migration status, there is significant intersectional variation present within this label, with very different experiences and consequences possible depending on a multitude of intersectional identities and social locations, such as: gender, immigrant class, racialized status, religion, language competency, and many others. Consequently, the intersectional social and legal location of members of the sample for this research is relevant to the analysis, findings, and implications arising from the research process.

As an analytical framework for this research, intersectionality theory guided the exploration and identification of the overlapping migration trajectory conditions that influenced the health and well-being of African immigrants with precarious migration status in Southern Alberta. This was achieved by: (a) recognizing and understanding that precarious-status migrants' circumstances are shaped by dynamic and ever-changing independent intersectional conditions and factors. Therefore, migration trajectory conditions and factors were subject to change and were identified and discussed during the research process; (b) recognizing that a variety of interconnected factors, rather than a single factor, influenced the health and well-being of African immigrants with precarious migration status; (c) understanding that, depending on circumstances, time, and place, African immigrants with precarious migration status could experience privilege and oppression simultaneously; (d) acknowledging that social policies and legislation, such as immigration laws at the macro, meso, and micro sociocultural levels, can intersect with precarious-status migrants' migration trajectory conditions to create social and health inequities; (e) minimizing bias that could have influenced the research findings through

conscious efforts to separate my beliefs, values, and standards of the phenomenon under study from those of the research participants; and (f) consciously addressing the power dynamics between the study participants and myself (the researcher), which could have impacted the research outcomes. This was achieved by recognizing and valuing the diversity of perspectives and fostering a sense of data ownership among participants.

Using intersectionality as a conceptual framework could assist policymakers in understanding the root causes of social and health disparities among immigrant groups, enabling them to develop and implement comprehensive policies that address the diverse health needs of African immigrants with precarious migration status in Southern Alberta or across Canada. This approach could enhance their overall health and well-being. Additionally, it could guide future research, both prospective and retrospective, on how migration trajectory conditions intersect to influence the health and well-being of precarious-status migrants in Southern Alberta over time, which is often overlooked in discussions of the social determinants of immigrants' health (Risman, 2004).

In summary, the intersectionality theoretical lens helped me address the research questions by capturing the various migration trajectory conditions, including individual, structural, and systemic factors, that intersected to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta. It assisted me in achieving the research aims and acknowledged participants' diverse perspectives on the subject during data collection, analysis, and presentation of findings. It helped me understand and recognize the unique and socially constructed nature of my participants' evolving experiences and how they interpreted these within their social contexts. Adopting this theoretical lens also challenged me as a qualitative researcher to recognize and explore the socially constructed nature of my own

assumptions, perspectives, and beliefs, and their role in analyzing and interpreting my participants' accounts. By considering these perspectives as part of my ongoing reflexive practice, adopting this theoretical lens also helped reduce potential bias in the study results.

### **Chapter 3: Research Methodology**

This chapter discusses my research philosophy for this study, the research design, research settings, participant recruitment, data collection, data management, data analysis, budget and timelines, trustworthiness or scientific rigour, ethical considerations, and potential risk assessment.

#### **Research Philosophy**

A researcher's worldview is shaped by their philosophical stance, which can influence their research study and findings. This stance clarifies their study design, research methodologies, and theoretical framework that could affect the quality of study results (Jackson, 2013). Therefore, my prior understanding of the phenomenon under study may influence the choice of study design and the interpretations of the findings. In this regard, I consciously worked to self-reflect on any biases, values, and views that could impact my choice of study design, research methodologies, and the interpretation of results.

#### **Research Design**

An exploratory descriptive qualitative research design incorporating semi-structured, in-depth interviews as the primary data collection technique was employed in this study. This approach was appropriate because there was limited documented knowledge in this topic area; therefore, this approach was a good fit for this research to explore and expand knowledge and understanding of the migration trajectory conditions that intersected to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta. In addition, a comprehensive strategy was used in the research study to identify and describe the phenomenon under study and to comprehend the meanings participants attached to reality.

This research gathered and analyzed qualitative data from the understudied vulnerable group of African immigrants with precarious migration status in Lethbridge, Southern Alberta. The study provided this marginalized population in Southern Alberta the space to share their experiences in their own words and perspectives, which could foster policy discussions and assist policymakers in developing comprehensive policies that meet their needs. Furthermore, the findings contributed valuable knowledge to the fields of health and migration studies within the Canadian context. Importantly, participants felt a sense of belonging, recognized the power of their voice to bring about positive change, and established a relationship with the researcher (me). Although reaching African immigrants with precarious migration status was challenging, I consistently employed strategies that improved my interactions with this vulnerable group, enabling their views to be heard and interpreted from their perspectives.

### **Research Setting**

The study was conducted within African immigrant communities in Lethbridge, Southern Alberta. Lethbridge is the fourth-largest city in Alberta by population, after Calgary, Edmonton, and Red Deer, and the third-largest city by area, after Calgary and Edmonton. It has become home to many recent migrants, including African immigrants from diverse backgrounds. According to the 2021 census, around four thousand African immigrants, mostly from Nigeria, Ghana, Cameroon, Sudan, Eritrea, Ethiopia, Somalia, Kenya, South Africa, and the Democratic Republic of Congo, reside in Lethbridge, including international students, TFWs, and refugees from African countries like South Sudan (Statistics Canada, 2022).

Conducting this research in Lethbridge, Southern Alberta, is unique for several reasons. First, Lethbridge is a smaller city that has seen more recent increases in immigrant settlement, and it has less infrastructure and support networks for new immigrants. Unlike Calgary or

Edmonton, Lethbridge has fewer immigrant-serving agencies, limited culturally specific supports, fewer legal resources for migration status issues, and fewer African-led organizations. These limited resources may influence the health and well-being of immigrants with precarious migration status in Lethbridge and highlight service gaps. This reflects a growing pattern of IRCC encouraging settlement outside larger urban centers like Calgary, Edmonton, and Toronto. Second, Lethbridge is a politically conservative and predominantly Christian community. Given the less supportive perspectives on immigration within conservative political discourse in Alberta and beyond, this may create greater challenges related to reception, support, and integration of immigrants into the community, especially if they hold precarious status. In addition, African migrants who follow Islam may also experience less acceptance and more discrimination, especially if they are clearly identified as Muslim by religious clothing such as hijab or niqab. Therefore, studying this phenomenon in southern Alberta may not only shed light on the unique experiences of Africans with precarious status settling in this geographic location but may also provide insights into the experiences of other precarious immigrants settling in similar smaller cities and less urban settings. Additionally, it can offer local policymakers evidence-based insights specific to Lethbridge and southern Alberta, supporting advocacy for funding, programs, or policy changes, and ensuring that immigration policies account for rural-urban differences.

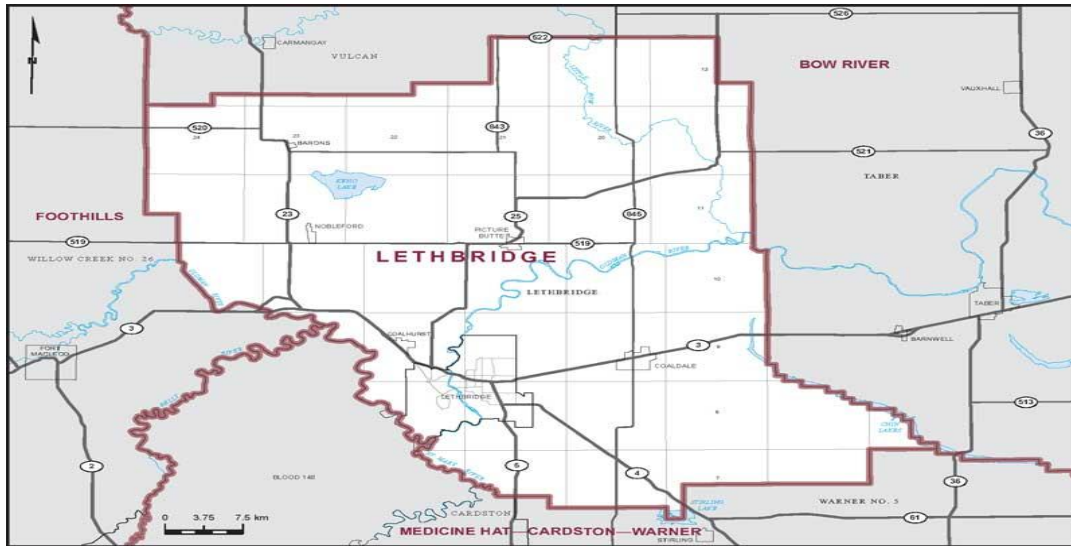


Figure 1: Map of Lethbridge, Southern Alberta, Canada

### Participant Recruitment

African immigrants with precarious migration status form a diverse and difficult-to-reach group, making this population particularly challenging to sample. One of the main challenges I encountered as a researcher during recruitment was identifying potential participants within this group, as their precarious migration status often caused some to feel reluctant to participate. In Southern Alberta, or Canada more broadly, African immigrants with precarious migration status remain understudied due to the many obstacles researchers must overcome to locate and recruit them and gather data.

According to Ellard-Gray et al. (2015), knowledge about precarious-status migrants is essential for effective and diverse sampling. Therefore, I acquired this knowledge through interactions with some immigrant religious leaders, immigrant entrepreneurs, and immigrant associations (such as the Ghanaian Canadian Association in Lethbridge and the Southern Alberta Afro-Canadian Association). These relationships enhanced the quality of my research and helped attract a diverse sample of qualitative respondents for this research. This was because these community leaders were well-connected with African immigrants with precarious migration

status in their communities. Additionally, it enabled me to establish trustworthy relationships with the initial study volunteers, who then connected me with other eligible participants and consequently minimized absenteeism and attrition.

I anticipated recruiting 20-25 eligible African immigrants with precarious migration status living in Southern Alberta, after the study received approval from the University of Alberta Human Participant Research Committee. However, I recruited 18 eligible participants because additional data collected did not reveal any new information. To maximize diversity and meet research goals, I used the nonprobability sampling method of purposive and snowball sampling methods to identify potential participants who met the inclusion criteria: (a) African immigrants currently residing in Southern Alberta (not in detention centres) with precarious statuses, such as those holding temporary visas (e.g., international students and temporary workers), individuals whose visas have expired or who are not complying with visa conditions, those who have applied for permanent residence, claimants of refugee status, border crossers, and stateless persons; (b) aged 18 or older; (c) able to communicate in English; (d) residing in Southern Alberta for at least one year; and (e) able to provide informed consent. Therefore, the purposive sampling technique assisted me in selecting specific precarious-status migrants who fit the eligibility criteria and whose qualities or experiences provided valuable information for a deeper understanding of the phenomenon in question. Snowball sampling method enabled me to find additional eligible participants through the social networks of initial volunteers, who would have been difficult to reach otherwise.

Following my migration to Lethbridge, I have been actively involved in the African immigrant community, especially the Southern Alberta Afro-Canadian Association and the Ghanaian Canadian Immigrant Association in Lethbridge. Recruitment of participants began by

sending official invitation letters (Appendix A) to leaders of these African immigrant groups and religious leaders (an Imam and a Pastor), requesting their support in recruiting voluntary participants. The invitation letter outlined the nature, purpose, potential risks, and benefits of the study to these leaders. With their assistance, eligible participants were asked to contact me via email or mobile phone. I also received help from an immigrant entrepreneur, members of the Southern Afro-Canadian Ethnic and the Ghanaian Canadian Association in Lethbridge, and through snowball sampling, to recruit voluntary participants who met the criteria. To maximize response rates, I ensured the information in the invitation letters addressed the specific concerns of precarious-status migrants and was free of stigmatizing language. A recruitment poster (Appendix B) was displayed on bulletin boards of immigrant churches, mosques, and grocery stores, and shared on social media platforms (e.g., WhatsApp) of immigrant associations, which also attracted eligible voluntary participation.

### ***Recruitment Challenges***

First, after a scheduled in-person meeting, some of the immigrant community leaders expressed skepticism about the research, believing it would not improve the lives of African immigrants with precarious migration status, and displayed protectiveness toward these vulnerable members, which prevented them from wanting to help me recruit eligible voluntary participants (Ellard-Gray et al., 2015). Second, some eligible participants did not attend the interview at the agreed-upon date and time and did not respond to my follow-up calls and texts regarding the interview. Third, some potential participants declined to participate due to mistrust and fear of having their information shared with authorities and stigmatization. Fourth, some eligible participants later refused to participate after an informed consent form was sent to them

via email or text. Finally, some potential participants found it difficult to understand the meaning of "precarious status," even though it was explained on the recruitment poster.

### ***Strategies to Mitigate Recruitment Challenges***

Although sampling and studying African immigrants with precarious migration status in Southern Alberta presented challenges, as mentioned earlier, I employed the following strategies to address these issues at various stages of the research. First, because migrants with precarious status are a hard-to-reach group, I received assistance from leaders within immigrant communities and churches, including leaders of churches attended by immigrants, the Imam of the Lethbridge Muslim community, an immigrant grocery store entrepreneur, members of the Southern Afro-Canadian Ethnic and Ghanaian-Canadian associations, and through snowball sampling to enhance credibility and gain access to this vulnerable population. This approach allowed me to successfully recruit a diverse set of qualitative respondents after receiving approval from the University of Alberta Human Participant Research Committee. Since these community leaders serve this vulnerable group, their involvement also helped me establish trusting relationships with participants who might otherwise have been hesitant to engage due to mistrust of the research process, without coercion. Second, to increase diversity and ensure effective sampling, I used purposive and snowball sampling techniques, set eligibility criteria during the research planning stage, and ensured the sample included all individuals meeting these criteria. All eligible participants were contacted by phone, which helped build trust and confidence between the interviewer and participants. I scheduled initial meetings at their convenience, explained the purpose and nature of the study, and addressed all their concerns. During recruitment, I reassured participants that their privacy and confidentiality would always be protected as these data were stored in a safe and secure filing cabinet, and saved and

encrypted as electronic files on a password-protected computer. I also asked newly recruited participants to inform their peers about voluntary participation in the study. Third, recognizing that what is considered stigmatizing in one community may not be obvious to outsiders, I made deliberate efforts to avoid stigmatizing language, such as "undocumented," "illegal," and "alien," in the interview guide, invitation letters, and recruitment posters to prevent bias and prejudice in analysis. Fourth, I fostered a sense of ownership among participants by acknowledging their valuable contributions during interviews and member-checking sessions to ensure that data interpretation reflected their perspectives. Fifth, to clarify the term "precarious status," I explicitly explained that it referred to migrants with temporary, unstable, or transient statuses. Finally, although some eligible participants did not respond after initial contact, I followed up by calling or texting reminders a few days before scheduled interviews and on the day itself to reduce attrition and absenteeism. I acknowledged that follow-up could be challenging for some participants due to their precarious migration status, financial constraints, or lack of fixed addresses or consistent email access. To address this, I maintained multiple contact methods, including phone, email, and physical addresses, to reach them if necessary. Moreover, to mitigate issues related to transportation and childcare, I informed participants that they would be reimbursed for related expenses and offered flexible scheduling to accommodate their practical needs. Fortunately, none of the participants incurred any costs for taking part in the study.

By adopting these measures to mitigate recruitment challenges, I positioned myself as a familiar and approachable researcher, which increased participants' trust and willingness to take part in the study. This approach also helped me identify and address participants' challenges related to the study.

## **Data Collection**

Demographic information (Appendix C) was collected from participants via email or text before data collection. This helped me understand how these demographics intersect with their migration trajectory conditions to influence their health and well-being. Eligible participants were interviewed using a semi-structured in-depth interview guide (Appendix D) after explaining the nature, purpose, and potential benefits and risks of the study, and after the informed consent form (Appendix E) had been read, understood, signed by the participants, and emailed back to me. Data were collected through Zoom virtual communication software. Interviews were scheduled at the participants' convenience. They were conducted separately in a natural setting that protected their confidentiality, such as their home (if they lived alone) or another comfortable location outside their homes, which provided them the safety, security, and privacy needed to engage in the research and share their experiences. Herzog (2012) emphasizes that the interview location is important in research to protect the privacy and confidentiality of participants. Therefore, I ensured the interview environment was private, which prevented others from observing or overhearing. Participants were informed of their right to turn off cameras if they did not feel comfortable on camera. Importantly, I informed participants that they possessed valuable information for this study, which established a trusting relationship with them and enhanced their sense of ownership of their data and experience. The in-depth interviews were conducted from September 2024 to February 2025, lasting between 35 and 70 minutes each. They were digitally recorded with the participants' permission. The Zoom recorder and digital audio recorders were tested beforehand to confirm they were functioning correctly. To capture the conversation clearly, I ensured there was no background noise. One of the advantages of digitally recording participants' responses over note-taking was that it ensured that the

participants' responses were captured in their own words without losing any phrases or language. To further protect their privacy, the interview recordings were stored on a password-protected computer, and a password-protected virtual waiting room was utilized during Zoom interviews, which enhanced security and confidentiality. However, despite all precautions, confidentiality could not be fully guaranteed when using Zoom, as the Internet was used as the medium of communication.

I established a trusting relationship with the participants at the start of the interview by engaging them in general topics (e.g., life experiences and daily routines), which helped them feel comfortable and engage in honest conversation. When responding to questions, participants were encouraged to speak freely and without interruption, with additional probing questions used when needed to clarify their perspectives. I took brief notes on each participant's responses and observed their body language, gestures, postures, and communication patterns during the interview. This helped me understand their subtle or censored responses. With their consent, I maintained temporary contact with the participants in case I needed to follow up after the interview for further clarification or member checking (Appendix F).

### ***Reflexivity***

Rice and Ezzy (1999) define reflexivity as “an acknowledgment of the role and influence of the researcher on the research project. The role of the researcher is subject to the same critical analysis and scrutiny as the research itself.” Therefore, reflexivity in qualitative research involves a researcher critically analyzing and scrutinizing their roles and how these impact data collection, data analysis, and findings. However, Yin (2016) emphasizes that reflexivity in qualitative research interviews can be bi-directional: that is, the researcher's influence on the participant, and the participant's influence on the researcher. To incorporate reflexivity in my

study, I used a reflexive journal to clarify my preconceived ideas about how migration trajectory conditions intersect to influence the health and well-being of precarious-status migrants. The following characteristics I possess created some recruitment challenges and may have directly or indirectly influenced my ability to conduct this research: (a) having temporary migration status (i.e., an international student); (b) being born and raised in Ghana, West Africa; (c) having a recognizable Ghanaian native middle name; (d) having a Ghanaian/African accent; (e) possessing knowledge of migration trajectory conditions; and (f) being in contact with people who have knowledge and experience of migration trajectory conditions that influence the health and well-being of precarious-status migrants. As a researcher with a temporary migration status and originally from Africa, all these reflexive elements may have directly or indirectly influenced my participants' selection, data collection, interpretation, analysis, results, and conclusions. Although it was not easy, I endeavoured to maintain a clear separation between my preconceived ideas about the phenomenon during interviews to minimize barriers to genuine communication and to keep a focused interpretation of the data collected. Although I sought to capture participants' experiences and opinions without undue bias, I acknowledge that my own social location as an African man, international student, and one who has experienced precarious immigration status, will have inevitably influenced the co-construction and perhaps the interpretation of these data during collection and analysis. However, occupying this adjacent social location also helped me to gain access to this vulnerable population, establish a trusting relationship with participants before data collection, and helped them to feel safe when sharing their experiences openly. To ensure that the study findings represented the experiences of the participants, I also randomly selected six participants for member-checking to ensure that their perspectives and views were accurately reflected in my data interpretations.

## **Data Management**

I ensured that participants' privacy and confidentiality were always protected. However, under Alberta law, everyone has a mandatory obligation to report any revelation of potential crimes, such as child abuse or elder/vulnerable adult abuse, to appropriate authorities. In this regard, each participant was made aware of the limits to confidentiality, as I am legally required to report any revelations of a potential crime, such as child abuse, during the study to appropriate authorities (e.g., the police or Children's Services), or disclosures of situations that place the safety of the participant or others at risk. I did not have additional reporting obligations, as I do not belong to any regulated profession with an extra code of conduct or ethics. The data collected from the field were shared only with my supervisor. I transferred each digital audio file after every interview to an encrypted folder on my password-protected computer. All hard copies of data, including handwritten notes, transcribed data, an external drive (USB) key, and other documents bearing participants' names, are stored securely in a filing cabinet and used only for this research. Additionally, these data were saved on a password-protected computer and in encrypted electronic files. I used pseudonyms to protect the identities of participants, especially during analysis and the write-up of findings. Informed consent forms are stored separately in a locked file from any study data. All raw data, both hard copies and digital files on the digital recorder and computer, will be deleted, shredded, and disposed of in the Faculty of Health Sciences' confidential shredding facility after five years.

## **Data Analysis**

These data were rigorously analyzed by transcribing all interviews verbatim, verifying accuracy against the original audio recordings, and reading the transcripts multiple times to gain a thorough understanding of the data before beginning the coding process. Braun and Clarke's

(2006, 2019, 2021) reflexive thematic analysis method was used in this study to inductively explore, analyze, and generate themes within and across the data related to participants' experiences, perspectives, behaviours, and practices. The reflexive thematic analysis approach highlights the researcher's subjectivity as a valuable resource (rather than a problem to be fixed) in the analytical process and stresses the importance of reflexive and recursive engagement with the data to produce a credible analysis (Braun & Clarke, 2013, 2019). As a result, I chose to use Braun and Clarke's (2006, 2019, 2021) reflexive thematic analysis, which supports a critical realist and contextual perspective in data analysis. Therefore, using NVivo 15 QSR software, the interview transcripts were imported, coded, categorized, and themes were generated. Themes are patterns of shared meaning supported by a central or overarching organizing theme that addresses the research question (Braun & Clarke, 2006; Braun et al., 2014).

Braun and Clarke's (2006, 2019, 2021) reflexive thematic analysis method involves six recursive phases: *(a) familiarization with the data and identification of items of interest*: All written transcripts were read line by line several times to gain an overall understanding of the data, and themes were identified before starting the coding process; *(b) generating initial codes*: Initial codes were identified to capture important phrases and statements about the data. Codes were manually generated and grouped into categories based on their similarities and differences. The coding process helped organize the data, identify, and document links within and between concepts and experiences. Important phrases or statements directly related to participants' experiences were extracted from each transcript; *(c) generating themes*: I organized the codes into potential themes, grouping similar codes. Relevant codes were gathered and reviewed, and potential themes were identified; *(d) reviewing potential themes*: I examined the nature and characteristics of the possible themes, considering the amount and quality of data supporting

each theme. I ensured that the themes were meaningful and connected to the codes and the dataset as a whole; (e) *defining and naming themes*: I named, described, and defined each theme to capture the overall story of the data analysis; and (f) *producing the final report*: I finalized the possible themes, articulated their organizational structure, and ensured they made sense in the context of both the literature review and research questions. The final report depicted a comprehensive description of the studied phenomenon, and the credibility of these findings was further validated by cross-checking the descriptions and themes with the participants.

Applying Braun and Clarke’s (2006, 2019, 2021) reflexive thematic analysis was ideal for this study due to the limited study timeline (Braun & Clarke, 2021). It also helped me identify, analyze, and report patterns (themes) in these data that address the research questions in a theoretically informed manner (Braun & Clarke, 2021). Figure 2 shows Braun & Clarke’s phases of reflexive thematic analysis.

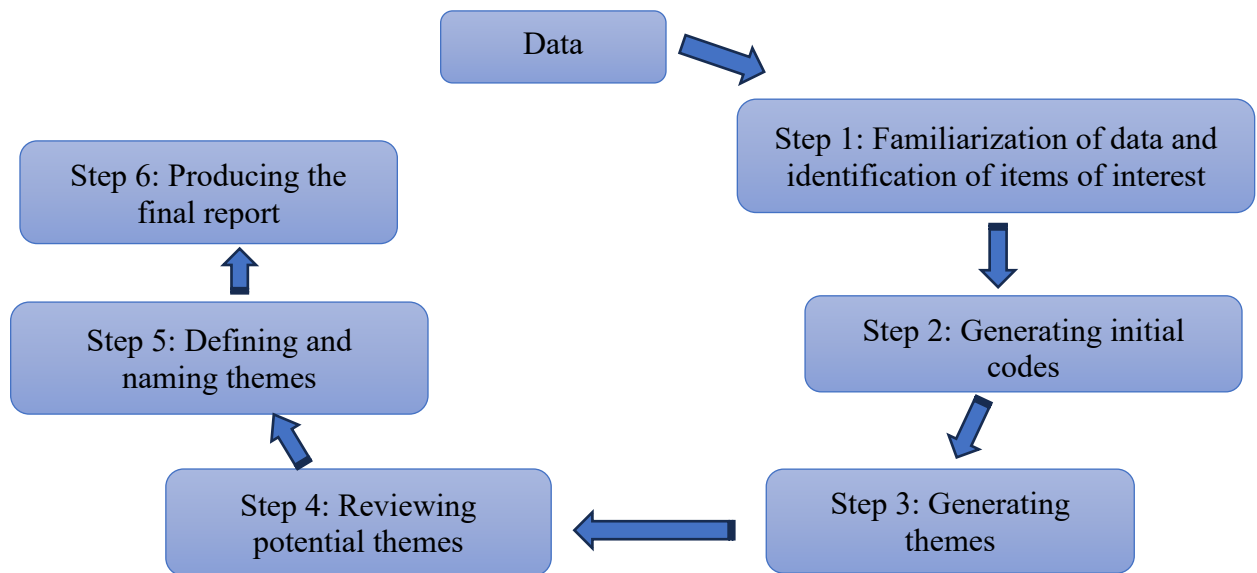


Figure 2: The six phases of reflexive thematic analysis (Braun & Clarke, 2006, 2019, 2021)

## **Budget and Timelines**

This study was funded through my monthly graduate student stipend. Appendix G outlines the budget, and Appendix H outlines the timeline for this study. As a show of appreciation and gratitude for participation, each participant received a \$20 gift through an e-transfer to thank them. No participant incurred any costs for participation, including transportation costs (such as bus tickets, taxi fares, or Uber fares) or childcare costs that needed reimbursement.

## **Trustworthiness or Scientific Rigor**

Qualitative researchers employ several assessment criteria to establish trustworthiness in research studies. Establishing rigor or trustworthiness is crucial in qualitative research because an accurate interpretation of the data that reflects the reality of the participants demonstrates the study's credibility and integrity (Liamputtong, 2013; Bryman, 2012). To establish trustworthiness in qualitative research, Lincoln and Guba (1985) suggested four widely known criteria used for the assessment of research of any kind: credibility, dependability, confirmability, and transferability. For these reasons, I applied Lincoln and Guba's (1985) four assessment criteria for a qualitative research study to establish trustworthiness for this study.

### ***Credibility***

Chilisa (2012) argues that the researcher's credibility depends on their ability to accurately and thoroughly represent the different realities of the participants. According to Johnson and Waterfield (2004), if participants can identify the researcher's descriptions and interpretations, then their portrayal of reality is considered accurate and adequate. To enhance the study's credibility, I carefully chose eligible participants who met the inclusion criteria, reviewed all written transcripts multiple times, conducted member checks with six participants, and tried

to set aside any preconceptions about the topic under study. The process of consistently verifying the researcher's data, analytical categories, interpretations, and findings with the participants is called member checking (Lincoln & Guba, 1985). Although member checking was time-consuming because it involved scheduling appointments and meeting participants again at their convenience, it was worthwhile because it established the study's credibility, given the significant time, patience, effort, and resources participants invested in the research. After collecting and analyzing the data, I followed up with six participants from diverse backgrounds who were available to ensure their views and interpretations were accurately represented.

### ***Dependability***

Lincoln and Guba (1985) define dependability as a situation in which another researcher can follow the decision trail used by the researcher in the study. Carpenter and Suto (2008) noted that the extent to which the study findings (description, interpretation, or theory) accurately and sufficiently reflect the data from which they were derived determines their dependability. Dependability was achieved through a thorough explanation of the study techniques, theories, rigorous data analysis, constant comparison, member checking, peer review, and coding and re-coding with the assistance of my supervisor. This process ensured that the research procedure was logical, traceable, and well-documented.

### ***Confirmability***

Confirmability, according to Lincoln and Guba (1985), is the extent to which the results are solely the product of the research's conditions and participants, rather than influenced by biases, motives, or viewpoints. Confirmability was achieved through reflexivity, detailed description, establishing an audit trail, and with the assistance of my committee and supervisor. According to Liamputtong (2013), creating an audit trail enhances the researcher's ability to

explain in detail the theoretical, methodological, and analytical decisions made, enabling readers and other researchers to understand the methodology used in the study, as well as how the researcher arrived at their conclusions and interpretations. In this regard, I kept a research journal that documented all aspects of the research process, including the methods used to gather and analyze data, any modifications to procedures, issues or challenges encountered, steps taken to address them, member checks to verify data accuracy, and documentation of the methods used to assess the research's limitations and findings. I also continuously updated the audit trail throughout the research. Additionally, I ensured confirmability by sharing preliminary findings with six randomly selected participants through member checking to confirm that the findings accurately reflected their experiences and were considered correct by them.

### ***Transferability***

According to Lincoln and Guba (1985), the degree of similarity should evaluate how well the findings apply to situations outside the study context. According to Liamputtong (2013), transferability forms the basis for the generalization and application of qualitative research results to similar individuals, groups, or circumstances. To support transferability, I relied on an adequate and purposeful sample size and provided a thorough description of the migration trajectory conditions that intersect to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta. In qualitative research, a rich or thick description is important because it offers readers and other researchers a comprehensive understanding of the sample of participants studied by providing a thorough description of the research setting, participant demographics, methods, and processes, all of which help in assessing transferability (Holloway & Wheeler, 2010).

## **Ethical Considerations**

Ethical conduct is an important aspect of research because it encompasses informed consent, avoidance of deception, privacy and confidentiality, and accuracy (Creswell & Poth, 2017). Before conducting any ethical research, Creswell (2013) emphasized the importance of obtaining ethical approval from an institutional review board and following all ethical research guidelines throughout the study. In this context, ethical approval was obtained from the University of Alberta Human Participant Research Committee before the study began, and the study adhered to all the ethical guidelines outlined in the Tri-Council Policy Statement (2018), including, but not limited to, concerns for welfare, justice, and respect for persons.

### ***Concern for Welfare***

I ensured that participants completed and signed a consent form after they read and understood the purpose and nature of the study, procedures, time commitment, responsibilities of both the researcher and participants, potential risks and benefits, privacy and confidentiality, and their right to continue or withdraw from the study at any point in time, for any reason, without penalty or consequences. Each participant received a copy of the informed consent form for their reference and to contact my supervisor or me if they had questions or wished to withdraw from the study. The interviews were recorded with participants' consent. The collected data were shared only with my supervisor and were used solely for this research. I protected participants' privacy and confidentiality by using pseudonyms, storing data in a safe and secure filing cabinet in a locked office, and encrypting electronic files on a password-protected computer immediately after the interview. All files from the digital recorder, my computer, hard copies, and raw data will be deleted and digitally shredded after five years.

### ***Justice***

I ensured that all participants were treated with equity and fairness. I did not exploit participants by forcing or inducing them to participate in the study. I ensured that the burdens and benefits of this study did not unfairly weigh on any one individual. I took conscious efforts to establish an equal power dynamic with the participants and created a free and honest environment where they felt safe to share their experiences openly.

### ***Respect for Persons***

I ensured that participants exercised their judgments and participated freely without coercion or influence. I did not pursue consent or interviews with those who were impaired or had diminished autonomy. I ensured that participants understood the nature and purpose of the study, which allowed them to make meaningful and informed choices. I also ensured that participants' views are accurately represented, which could potentially influence positive policy change. I addressed issues of psychological, physical, economic, or social discomfort appropriately. There were no conflicts of interest, as this study was not funded by any organization. I maintained the dignity and welfare of both the researcher and the participants by avoiding any humiliating, dangerous, offensive, or degrading language.

### **Potential Risks Assessment**

The risk in this study was minimal, meaning it was within an acceptable level of daily risk. I applied the principle of "non-maleficence" in my research to ensure that participants' health and well-being were protected and that their involvement did not negatively impact them (Liamputtong, 2013). Therefore, I ensured that the study posed no social, psychological, or physical risks to participants, such as damage to their reputation, loss of social status, or invasion of their privacy. Although none of the participants experienced psychological or emotional

distress (e.g., anxiety and shame) or social stigma (e.g., loss of social standing and discrimination) while sharing some of their difficult, embarrassing, or painful migration experiences and challenges, I informed them about the availability of counselling services in Southern Alberta (Appendix I) in case they experienced emotional or psychological distress during the interview. To minimize the risk of breaching privacy and confidentiality, interviews were conducted in a more private and secure setting, including outside their homes. Additionally, pseudonyms were used to protect their identities. Furthermore, confidentiality and anonymity become more challenging to maintain when using the snowball sampling technique since some participants were referred by others and thus identifiable. It is important to note that, despite my efforts to ensure the safety of my participants, I also remained conscious of my own safety when recruiting participants and collecting data. This was facilitated by regularly updating my supervisor on the progress of the research.

Importantly, to minimize study risk and achieve the study's goal of addressing the literature gap by exploring migration trajectory conditions that intersect to impact the health and well-being of African immigrants with precarious migration status in Southern Alberta, I established a trusting relationship with the participants and engaged them in all aspects of the study, including member checking of transcripts and analysis. While I maintained a friendly relationship with the participants, I experienced no difficulty ending the relationship, as my interactions were brief and limited to the initial interviews and a follow-up for member-checking results. Nonetheless, I kept an "open door policy" for participants if they had further questions or concerns, or if they chose to withdraw their consent at any time during the study.

## **Chapter 4: In Search of Stability**

The study findings are presented and discussed across six chapters, each reflecting different aspects of the participants' experience: Chapter 4 (In Search of Stability), Chapter 5 (Great Expectations), Chapter 6 (Evolving Experiences of Health), Chapter 7 (Persisting Precarity), Chapter 8 (Navigating Challenges), and Chapter 9 (Potential Policy Pathways).

The study findings revealed how migration trajectory conditions intersected to influence the health, well-being, and enduring experiences of instability among African immigrants with precarious migration status in Southern Alberta, Canada. Data were collected from participants in two formats: a demographic information questionnaire (Appendix C) and an in-depth semi-structured interview (Appendix D), to capture the migration trajectory conditions that intersect to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta. These interviews were audio-recorded and transcribed using Microsoft Word Transcribe, with durations ranging from 35 to 70 minutes. Data saturation was reached after collecting data from 18 eligible participants, enabling the study's conclusions to be drawn. The data were then imported into NVivo 15 QSR software and thoroughly analyzed using Braun and Clarke's (2006, 2019, 2021) reflexive thematic analysis. Transcripts were checked for accuracy, and any identifiable information was removed or altered to protect the participants' identities and ensure data confidentiality.

Although there were unique challenges evident in both pre-migration conditions, migration conditions, and post-migration conditions, this study identified and explored the overlapping migration trajectory conditions or challenges experienced by the participants, including: evolving health status, evolving health knowledge, healthcare system challenges, participant-healthcare professional relationships, the intersection of religious/cultural beliefs and

healthcare, environmental impact, migration uncertainty, semi-legality, age and agency, gendered health experiences, transnational experiences of discrimination, employment opportunities, money matters, life course backsliding, and it takes a village to survive that intersect to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta.

This chapter summarizes the demographics of the research participants, discusses the central overarching theme (In Search of Stability) that emerges from the thematic analysis of the participant interviews, and introduces the sub-themes and their elements, which will be analyzed in the following chapters. Each theme is explained in detail, and quotes from the participants are included to support each respective theme. Because the themes are interconnected, some quotes are occasionally repeated to support different themes.

### **Demographic Characteristics of Participants**

Demographic information (Appendix C) about the participants was obtained via a questionnaire during the interview. Eighteen adult African immigrants with precarious migration status, who resided in Lethbridge, Southern Alberta, for a year or more, were interviewed for the study. Participants originated from all 5 African regions: 5 from South Africa (South Africa, Botswana, and Zimbabwe); 5 from West Africa (Ghana and Nigeria); 3 from central Africa (Cameroon and the Democratic Republic of Congo); 3 from East Africa (Kenya and Uganda); and 2 from North Africa (Egypt). The participants' ages at the time of migration ranged from 13 to 50 years, while their ages at the time of the interviews ranged from 19 to 52 years old. Many of the participants were between the ages of 19 and 35 years. One young woman participant migrated at age 13 to Strathmore, Alberta, where she completed her elementary and high school education in a private boarding school. Another woman participant migrated with her family to

Canada at the age of 15. All participants had temporary status: eight were international students, seven were temporary workers, and three were asylum seekers. Participants' religious affiliations varied: 15 participants identified as Christians, and three participants identified as Muslims. Eleven participants were single, and seven were married. Twelve participants didn't have children, and six participants had children. Four participants had children and spouses living with them; 1 participant had a spouse and children in their country of origin; two participants had spouses in their country of origin; one participant had a child in their country of origin; one participant lived with a child. Regarding the participants' levels of education, many had at least a high school diploma or a bachelor's degree, and some had work experience prior to migrating to Canada. It is worth noting that despite the diversity noted among these African immigrants with precarious migration status in Southern Alberta, they shared some commonalities in terms of cultural values, beliefs, norms, and language, which contributed to the co-construction of themes that captured their collective experiences. Table 1 presents the participants' demographic information.

Table 1: Demographic Characteristics of the Study Participants

<b>Participants</b>	<b>Number</b>	<b>Percentage</b>
<b>African Regions of Origin:</b>		
West Africa:	5	27.8%
East Africa:	3	16.7%
Central Africa:	3	16.7%
South Africa:	5	27.8%
North Africa:	2	11.1%
<b>Age Range</b>		
18-25	8	44.4%
26-35	7	38.9%
36-45	2	11.1%
46-55	1	5.6%
<b>Immigration Status</b>		
Students	8	44.4%
Temporary Worker	7	38.9%
Asylum	3	16.7%
<b>Length of Stay</b>		
1-3	16	88.9%
4-6	2	11.1%
<b>Level of Completed Education</b>		
Diploma		
Undergraduate	3	16.7%
Graduates	4	22.2%
Postgraduates	8	44.4%
	3	16.7%
<b>Marital Status</b>		
Single	11	61.1%
Married	7	38.9%
<b>Has Children</b>		
Yes	6	33.3%
No	12	66.7%
<b>Employment Status</b>		
Part-Time	10	55.6%
Full-Time	5	27.8%
Unemployed	3	16.7%
<b>Income Per Month</b>		
Less than \$1,000	7	38.9%
Between \$1,000-\$2,000	3	16.7%
Between \$2,000-\$3,000	6	33.3%
Over \$3,000	2	11.1%
<b>Religious Affiliation</b>		
Christian	15	83.3%
Islam	3	16.7%

## **Description of Themes**

Braun and Clarke's (2006, 2017, 2019) reflexive thematic analysis was applied rigorously to analyze these data and identify their thematic structure. The overarching central theme was "In Search of Stability." The participants migrated to Canada due to a variety of unstable conditions in their countries of origin, and continued searching for stability in Canada, which was often elusive because of their precarious migration status and intersecting challenges in their migration experiences.

### **In Search of Stability**

Participants pursued migration to Canada with great expectations of a better life, with greater stability, safety, success, health, and well-being. However, although their post-migration reality in southern Alberta brought many positive changes, it also came with numerous intersecting and colliding challenges. The result was often an experience of persistent precarity characterized by legal and daily uncertainty, structural barriers to obtaining stability and success, and often a perception of life course back-sliding compared to their sense of achievement and status in their countries of origin. Unlike simplistic narratives that present migration experiences as being consistently positive or negative, the participants' words illustrated the complexity of their experience in both locations. Each location brought with it positive aspects and challenging aspects, and these conditions frequently interacted with each other across transnational space. While the current study sought to explore the experiences of African migrants to Canada possessing precarious legal status, these findings illustrated that this precarity infused many aspects of participants' life and experience, and that the shifting landscape of Canadian immigration policy cast a shadow over their hopes for greater stability and threatened to throw

some participants into greater legal, social, economic, and psychological precarity. This experienced reality frequently resulted in stress, frustration, anxiety, and depression.

*I think we are just always having changes, and having changes. I don't know what the new rules are, and it's only coming out on the 30th of September when I can read to know. I spent weeks studying the whole website to know exactly which category I'm supposed to be in and which documents I need, so when my six months are over, I'm ready. Now I have to start, I don't know if they gonna say Oh, you need to wait for one year before you can apply or 2 years. And then you only have a Postgraduate Work Permit (PGWP) for so long, and then the process of application and getting back also takes a long time. Mentally, it's really stressful. It's like something that hangs on your head 24/7. Even though you try to go about your day and focus on the things that you can control, it's there all the time, and it's stressful. Everyone who's in a similar position as I am is stressed because you don't know right now what if the system keeps changing, the rules keep changing, we don't know, and you're basically just living by the grace of God every day. You just hope that it goes well (Sunshine).*

*The only pressure, like I have said already, is this high level of uncertainty that is right before us. Apart from that, apart from a high level of uncertainty in terms of the pathway, because it impacts your physical and mental health as well. Yes, you're thinking, you're thinking, you're thinking; what's next, what if, what if there is, there are so many things that go around your brain that ordinarily shouldn't be (Samon).*

Different aspects of these participants' experiences were captured by each of the sub-themes and their elements, which will be explored further in the coming chapters.

### **Sub-themes supporting the Central Theme**

Five key sub-themes contributed to the overarching theme: (a) *Great Expectations*; (b) *The Evolving Experiences of Health*; (c) *Persisting Precarity*; (d) *Navigating Challenges*; and (e) *Potential Policy Pathways*. Table 2 presents the central theme of these data, the sub-themes, and their elements.

Table 2: Central Theme, Sub-Themes, and Sub-Theme Elements

**Central Theme: In Search of Stability**

<i>Sub-Themes</i>	<i>Great Expectations</i>	<i>The Evolving Experiences of Health</i>	<i>Persisting Precarity</i>	<i>Navigating Challenges</i>	<i>Potential Policy Pathways</i>
<i>Sub-theme elements</i>	It Takes a Village to Migrate	Mental Health is for the West	Migration Uncertainty Semi-Legality	Maintaining Open Communication and Finding Emotional Support	Implementation of Fair Immigration Policies
	Culture of Migration	Evolving Health Status	Age and Agency	Seeking Guidance and Peace from a Higher Power	Elimination of Employment Barriers
	Moral Reciprocity	Evolving Health Knowledge	Gendered Health Experience	Pursuing Self-Care	Improvement in the Living Conditions of Precarious Status Migrants
	Sentimental Giving Back to Society	Healthcare System Challenges	Transnational Experiences of Discrimination	Remaining Hopeful and Resilient	Investment in Alternative Medicine
		The intersection of Religious/Cultural Beliefs and Healthcare	Employment Opportunities		Investment in Healthcare Professional Education
		Environmental Impact	Money Matters		
			Life Course Backsliding It takes a Village to Survive		

## Chapter 5: Great Expectations

This sub-theme captured participants' pre-migration expectations of Canada, which were ultimately unmet. Many participants expressed their disappointment about Canada because their pre-migration expectations of a better life in Canada (e.g., achieving economic success) did not align with their post-migration realities (e.g., unemployment). Participants came to Canada for many reasons, including work, education, and asylum-seeking. Before migrating, participants hoped to overcome the challenges they were experiencing in their countries of origin. They expected Canada to offer easy integration, safer and more peaceful conditions, fewer crimes, less gun violence, the best educational system, a welcoming and multicultural environment, social support networks, and better economic opportunities.

*I came to Canada because it has one of the best educational systems, it is multicultural, and integration is easier (Aaric).*

*My reason for migration is generally for a better life for, um, myself and my children. And again, uh, very importantly too, because of the way insecurity was building up gradually in Nigeria with the terrorist activities of Boko Haram, looking at the world and the way the insecurity can spread, the way it's spreading to West Africa, specifically in Nigeria (Samon).*

*I came here because I needed to get a job so I could work and earn money. So, I can better myself and my family, and yeah (Johannes).*

These diverse reasons for migration were influenced by participants' pre-migration expectations of Canada. Additionally, these participant quotes highlighted the role of relationships (migration chains) in migration decisions, the culture of migration in many sending countries, migrants' moral and financial obligations towards family members who did not migrate, and their hopes of giving back to society. Many participants expressed their disappointment about Canada because their pre-migration expectations did not align with their

post-migration realities, especially due to the uncertainty surrounding their precarious migration status, which often led to stress, frustration, and depression.

*So, coming from Africa, you know you hit Canada, you're going to work because I came at a time when there was no decision. You could work more than 40 hours even though you were a student. So, you come, you think you get to work easily, and you are going to pay your school fees, and all those things, all that luxury stuff you're going to get them. But when you reach you, you live the reality, yeah (Caesar)*

*What was advertised was very different from what we saw when we got here. Then we saw that there were a lot of jobs you could have once you get to Canada, you get immediately a job in your field, and the like, but it's not the same. It's just an invitation to treat. It's just like playing in the gallery, you know, coming here and it's way different from what you see outside (Marcus).*

*My pre-migration expectations of Canada were high. I wouldn't have been here in the first place if I didn't have that. I thought it would be very easy; when you just come here, you will get a job, but before you know it, you start sending money home. But it is just the opposite of that. When I got here, it was difficult during my first semester. But it wasn't what I was expecting; it was far from it (Timon).*

Interestingly, Timon's reason for applying for admission to Canada as a student was different from his actual migration goal, which was employment. This mismatch adversely impacted his mental health because of his inability to achieve his actual migration objective.

*I didn't want to go to school here. I just wanted to work. So, I am only prepared to work. I tried for several months, but I didn't get the job, so that led to a lot of things. The plan was not for me to go to school, but when I got here, I found that like I really had to go because that was the only way I could get my permanent residence (PR). So, because I didn't plan for it, everything went south. I didn't plan for not getting a job in the summer, and suffering, and then it affected me mentally, and I just have to be strong. So, it really does affect me and the experience has not been, has not been awesome at all (Timon).*

Many participants commonly experienced uncertainty surrounding their precarious migration status, devaluation of their foreign credentials, and reduced opportunities because they lacked Canadian job experience, which led to an inability to meet family expectations and achieve economic success. This inertia surrounding achieving economic success fueled stress, frustration, and depression, and adversely impacted their health and well-being.

### *It Takes a Village to Migrate*

This theme captured the role of participants' wider social networks in influencing their migration decisions. Thus, participants' migration decisions were influenced by friends, family, personal aspirations, and external influences. While some participants encountered challenges due to insufficient information, others found support from relatives and friends, underscoring the significant role of social networks in migration decisions.

*It was completely just us coming up with it. So, we didn't have any external friends or family. Like, we don't have any family here. While it was my husband's initial idea, and then it became our idea [laughing], to migrate to Canada. So, my husband was part of the decision-making to come here (Sunshine).*

*I was too comfortable back home with the community that I have, and you know, just knowing how to move around the country and how to do things, I didn't want to move somewhere else and have to learn new things. My girlfriend's influence was the major thing that made me apply for my student visa because, without her, I was not into Canada at all. She had tried to bring up the idea before, and I downplayed it because I was not interested, to be honest. But once I got the admission letter from the school, I saw it like as a real thing and I decided to, you know, be on board 100% with the idea. Once I got the letter from the school, I think that's when my brain snapped, and I was like, oh! It's a real thing, so maybe I can try and do it, and that's how I got to apply for my visa (Kamon).*

*I can say I had a lot of people influencing my migration decision. Personally, I always wanted to come to Canada from a very young age. I always dreamt of coming to Canada someday, and so when I got to the time where I had to pick a post-secondary education, I had cousins here already, some from Halifax, others in Edmonton, and they did tell me good things about Canada and everything. They helped me with the application process. So yeah, they were the ones that mostly influenced my decision to come to Canada (Talitha).*

To facilitate their travel to Canada, participants either relied on their savings, sold their properties, received financial support from their families (both nuclear and extended) and friends, or borrowed money from financial institutions in their countries of origin.

*So, we had a house, and we sold it, and that basically paid for the whole thing. Um, yeah, so we funded it ourselves. So, no family involvement and no external involvement with money (Sunshine).*

*Yeah, I had financial support from some friends. No, no, not friends, some relatives. And I also borrowed some money from some financial institutions and stuff like that to facilitate my migration to Canada (Johannes).*

*I had financial help from my family, my girlfriend, and my savings to facilitate my migration journey (Kamon).*

However, Sion narrated how challenging and stressful it was to solicit financial support from his uncle to facilitate his migration journey and education in Canada because, culturally, he knew it was father's responsibility, not his uncle's.

*It really had a greater impact on my mental health because my family background makes me feel like, if your dad and mom can't afford to help you pay for your tuition, is that the end of my world, or is this how the world should be like, you'll be born, you are very passionate about something but your family background is pulling you down. That one was really stressing me, and going to my uncle because I knew it wasn't my uncle's responsibility to take care of me. This is a huge amount of money required to study abroad. It took me about a month or two before my dad and I actually went to see my uncle because we felt like if he turned us down, we would feel so bad. That time it was very stressful (Sion).*

Some participants' financial sponsors influenced their post-migration decisions, including expectations of compliance and a culture of reciprocity. Timon, who migrated to Canada as a student and now seeks asylum, shared how his sister in Canada, who financed his migration journey, continues to influence his decisions.

*My sister facilitated my journey. She sent me money, booked and paid for the flight for me. She did the whole thing basically. My parents were just encouraging me, that's all. My sister did everything. I try to, like, give back. I mean, she is someone who, if she says something, wants everything, whatever she says, has to happen. She doesn't like anybody else's opinion. So, when she says something, I give her the respect because she brought me here, and that's why I have to like, become, and just wait. So that's why I see sense of, you have to listen to her because she brought you here, you understand? (Timon).*

The decision to migrate was difficult for many participants because it involved numerous sacrifices, such as leaving behind spouses, parents, friends, loved ones, familiar languages, and places of worship. Participants' decision to migrate to Canada was either influenced by friends, family, or self-motivation. Financial support, particularly from their support networks, played a

significant role in facilitating their migration journeys. For example, some relied on their savings or income from selling property to fund their migration. Others received financial assistance from their wider support networks (e.g., parents, siblings, and friends), or a combination of these sources. However, financial challenges were not limited to the post-migration period and often emerged pre-migration or served as one of the motivations for migration. Some participants sought financial help from family members in their home countries, which adversely impacted their mental health and migration decisions. Some financial assistance was offered with the hope that the migrant would acquire additional resources and financial success in the host country and, in return, send remittances or help their families move to the new country. These expectations contribute to establishing and maintaining migration chains, while also fostering strong transnational family ties; however, they often contribute to a burden of responsibility and extra pressure on the migrant, who not only feels the need to achieve personal success but also support the success of those success further down the migration chain (Conrad Suso, 2019, 2020; Prothmann, 2018). Therefore, migration can be perceived as a form of investment by the migrant and their families in their home countries. Like any investment, the investment of migration comes with risks, as illustrated by the uncertainty surrounding participants' precarious migration status and their potential inability to meet family expectations, which often manifests as stress, frustration, anxiety, and depression in some participants.

### ***Culture of Migration***

This theme captured how migration has become part of the culture in many African countries. Participants from different African countries mentioned that migration to the West (e.g., Canada, the UK, and Australia), especially from sub-Saharan Africa, was a common phenomenon and a part of the culture in many African countries due to issues like

unemployment, economic instability, terrorism, and the search for better economic opportunities and greener pastures. According to some participants, this migration trend has increased over the last decade, with many young people relocating to countries like Canada and Australia.

Participants often referred to migration to developed countries as escaping, Jakpa (leaving your main domain), traveling outside, travelling, flying outside, or going to the diaspora.

*Migration to the West is very, very common. However, I was one of those last people who really thought about it. It's common, it's not alien at all. To be very frank with you, in the part of Nigeria where I'm from, I have lots of people all over the world, including Canada. You know, like I told you, how did I conclude that Canada was the most welcoming of all the countries? It is because I once had conversations with my friends who have been there for 10/15/20 years. So, I was able to, but I may be wrong, balance based on first-hand information I got from friends and former colleagues all over the world, yes (Samon).*

*Migration is common, and that's how the trend has been, especially in sub-Saharan Africa in the last half a decade, where there, um, it has a slogan which we used back home, which is called Jakpa, which means leaving your main domain, which is your home country, to another, to the Western world (Marcus).*

*Yeah, it's very common because nowadays they don't even call it migration, they call it escaping. It's like you're escaping from the suffering back home, and you're trying to make something better of your life. So, it's very common. Every person from different parts of Nigeria, citizens, migrates all over the world. They go to the UK, Australia, and Canada, just to find where they could settle down and work, and they make money, so it's very common (Timon).*

Kamon reported that although migration to developed countries was not common a few years ago in Kenya, it has now become very common. He stated that there are equal numbers of men and women involved in migration, especially among the youth, due to hopelessness, frustration, corruption, and the search for economic or financial success.

*At the moment, it's very common. A few years back it wasn't common, to be honest, but now almost, OK no not almost everyone, but a huge number of young people especially my age, the age between 18 to 20 (that's when you're done with High School) to mid-30s, yeah, people are really moving and not only to Canada but true countries like Australia, so Canada and Australia are the main countries where people are moving to from Kenya. I think they hold the most Kenyans abroad, yeah (Kamon).*

*I don't think it's about gender, really, because it's the same. There's the same number of, almost the same number of, men and women trying to move or moving. I would say, it's more of ah!! hopelessness in the country. That is what I will call it. Corruption as well. The country is too corrupt to a point where you get frustrated everywhere you go, everything you see every day on the news it's frustrating, and there are no jobs for young people, and yeah, people just want to move abroad and earn dollars, which is a lot of money when you convert it to Kenyan shillings (Kamon).*

Although participants reported that migration to developed countries is a common phenomenon in their countries of origin, some prospective immigrants may not be able to migrate due to the high costs involved in the process, such as visa application fees, tuition fees, and plane fares.

*“Honestly, yeah, it is common. But at the same time, it depends on resources, like it's not really an opportunity that everybody gets. So, it depends on your family. And yeah, all that stuff.” (Ceeja).*

*Many people want to travel outside, but then, the cost involved is too high for them to be able to afford it. They want to migrate not just to Canada, but any part of the world, but then they don't have the financial means to be able to travel (Sion).*

*Many people, like in my area, especially me in my area, a lot of people struggle a lot. So, there's no financial means, it's really hard for them. They really find it hard to meet the visa requirements or expectations for coming here. Yeah, but for me, I got lucky because my sister kind of sponsored me to come here (Darion).*

Many participants migrated in search of work and a better quality of life in host countries due to push factors such as corruption, lack of job opportunities, personal connections, and firsthand information from friends and colleagues who have settled abroad. However, as they sought to pursue their dreams of a better life, all participants had acquired precarious immigration status because of their temporary status as students, temporary workers, and asylum seekers.

Although migration is common in many African countries, not everyone who wants to migrate can do so. Several barriers, such as the high costs of migration (e.g., visa application fees, immigration medical examination costs, tuition fees, and plane fares), the inability to

provide supporting documents (e.g., financial statements), and difficulty in finding sponsors, all make the viability of migration questionable for many. According to Gaibazzi (2015), these obstacles may lead to "*nerve syndrome*," a condition that hinders a person's ability to function well and fosters feelings of hopelessness, or "*Babylon syndrome*," a phenomenon marked by daydreaming and wishful plans of travelling to Europe or North America (Conrad Suso, 2019). Contrary to the idealized dream, some participants felt like failures, hopeless, and wanted to return to their home countries due to the uncertainty about their migration status and their inability to achieve their migration goals. Therefore, some immigrants in host countries might also experience a similar "*nerve syndrome*" after migrating.

### ***Moral Reciprocity***

This theme captured participants' perceived moral obligation to financially support their families in their home countries. Many participants, who relied on their family's financial support to facilitate their migration journeys to Canada, saw it as a moral obligation to reciprocate that gesture by providing financial support for their non-migrant family members in their countries of origin. Despite their financial instability, some participants provided regular remittances to their families in their countries of origin to address their poor economic situation back home and their moral obligations as heads of the family or as providers to the family. Balancing their responsibilities with their precarious financial situation often led to feelings of depression, stress, and frustration.

*I had help from my family, my girlfriend, and my own savings. So, yeah, I would say people came together and helped me. But I think, you know, it's a normal thing when someone helps you feel the need to do something for them. Yeah, I send money home. I always send money home to my friends and my family, or help out with something, or maybe for their birthdays, for, oh yeah, pretty much anything, I do (Kamon).*

*I have my family back home. I'm a married man with two kids. Yeah, there's a lot of pressure because let me say from what we always see, know, and hear. When we come*

*here, we discover that it's not actually what we thought. We think when you just get to Canada, you get a job, you get a good job, you'll be paid well. Your family, your extended family, are expecting remittances from you. And when you get here, you discover that it's not what you were thinking. The pressure and the little money you are getting from here, and with the bills you have here, it's difficult to even satisfy them (Johannes).*

For instance, two asylum seeker participants (Miss Brown and Timon) and a temporary worker participant (Darion) indicated how they felt obliged to send money home due to their position in the family as the first child, to meet family expectations, and to help ease the poor economic conditions in their countries of origin, despite having unstable jobs.

*I do send money home because I'm the first child. I've been taking care of my parents and siblings even when I was back home. So, coming here, I do have to support them, and I've been doing my best in my own way. And it does put a financial burden and stress on me because I just started working, and I haven't really, because of bills, I don't really save much, and the little I have to save, I need to remit some to families, and that is also stressful, you know. Being in Canada is not that cheap, like you know, and I need money to do a lot of stuff like to go to school, to do one or two things, and so all these things are a burden on my head that makes me feel some way but I'm just praying that things go the way I want it (Miss Brown).*

*Like right now, I don't have work because my contract has already ended. But they just expect you to send something, just a little bit, though. Though they're kind of understandable. But you know, you can. You don't want to let them down, so you just push hard and do a little part-time job when you find some. So yeah, it's kind of stressful a lot, yeah (Darion).*

*I do send money home every month sometimes. Yeah, last week I still sent them money. Yeah, I do because they don't; they don't necessarily ask for it, but I know the situation of things back home. So, that's, I heard the news, this thing, fuel price is going up, everything is expensive, so you can't, although they won't complain to you know because you're hearing the news back home, so you have to like support and help them, yeah (Timon).*

Sometimes, participants had to make strategic decisions about their obligations to sponsoring family members because of their circumstances in Canada. For example, Miss Brown, a Ghanaian asylum seeker, did not feel obliged to financially support her uncle, who sponsored her, even though she admitted that her uncle experienced financial challenges and was unable to fulfill his promise to support her financially until she graduated. She no longer felt

obligated because she dropped out of school due to financial challenges and sought asylum.

However, she still felt obligated to financially support her nuclear family because she was the first child.

*Yeah, my uncle sponsored, yes. He paid most of the money, but after getting here, he was supposed to pay my fees, and then one or two things happened: my dad also fell sick. So, because of these things, I couldn't, like, start school. But then, my uncle sponsored, yeah. But if he had continued to help me like he promised, I would have been entitled to do all, like to say yes to everything he says, but unfortunately, as things happened, and he got angry and said he wasn't going to pay my fees again, so now that kind of you know entitlement is not there (Miss Brown).*

However, Sion, a Ghanaian student, viewed his obligations differently, even though Sion's uncle could not keep his promise of financially supporting his tuition fees until he graduated due to unforeseen circumstances and financial challenges.

*I feel like I'm indebted to the family. I have to pay back, not like paying whatever amount my uncle gave to sponsor me, no. But I have to make sure that, um, paying back in the sense of financially supporting the family back home (Sion).*

Many participants viewed providing financial support to non-immigrant family members and friends as a moral obligation, due to the assistance they received from family and friends to facilitate their migration journeys. Some expressed feelings of indebtedness and a desire to support their families back home through remittances. Despite facing challenges such as limited financial resources and coping with the financial stress and realities of life in Canada, this feeling of moral obligation persisted, even though some participants' health and well-being were often adversely impacted by the collective stress that they were navigating.

The International Monetary Fund [IMF] (2009) defines remittances as financial or in-kind transfers made by immigrants to family members or friends in their countries of origin. According to the World Bank Report (2022), remittances to developing countries have increased significantly in recent decades, from \$335.8 billion in 2008 to \$646 billion in 2020. Since

remittances constitute a major source of income for many non-migrant family households, the desire to send remittances was one of the main drivers of migration for some participants. For example, one participant stated, *“People just want to move abroad and earn dollars, which is a lot of money when you convert it to Kenyan shillings”* (Kamon). This was also evident in the quotes from some participants, where their desire to migrate increased when they realized that the perceived benefits of migration (e.g., economic success) outweighed the opportunity costs (e.g., unemployment) of staying in their home countries (Chezum et al., 2018). Similarly, some participants wanted to return to their home countries, as they perceived migration as not beneficial due to their precarious migration status.

Some student participants also received remittances from their parents to cover tuition fees and living expenses, indicating that remittance is a bi-directional process: from migrants to their families in their home countries and from their families in the home countries to migrants in Canada.

### ***Sentimental Giving Back to Society***

Interestingly, while some participants hoped to return after retirement or once their home countries' economies improved, others intended to return to support their growth. Some, however, intended to visit their home countries regularly while staying in Canada permanently to give back to Canadian society for the opportunities it had offered them. Because predicting the future was difficult due to uncertainty about their precarious migration status, some participants, like Marcus, remained undecided.

*I really want to also give back to the country, like for the opportunities it gave me, like for the education, and so on. So yeah, it's part of like me giving back and appreciating what I have, or, yeah, what's given to me? And also like enjoying the place itself, nature, and the people (Aaric).*

*I want my child to grow up in an environment where she will have better opportunities and however long it takes for us to achieve that, that's how long I have to stay here. Like for me right now, I'm content with just visiting back home, but not permanently staying there, and like in my foreseeable future (Sunshine).*

*I mean, we come from Africa, where our countries are still underdeveloped, and I think the best thing for us is to come to developed countries and see how they became developed, and go back to our country and try to improve our country. So, for me, that has always been my dream. That has always been what I've wanted. So, for me, when I finish school, I really plan to go back home and see how I can be of help to my country, yeah (Caesar).*

*Yeah, at retirement, it's still skeptical. But I think home is still the home goal at retirement. One thing I've learned from some of our leaders here they will tell you that old age in this land, you might not enjoy it properly, but you know it's you can go back home and actually enjoy your retirement plan and everything. Yeah, but we can't see what is going to happen in the near future; we can only plan for today. So presently, it's still an open check, which I don't know yet, depending on what the future holds (Marcus).*

Participants' return migration intentions were influenced by two sentimental attachments:

1) their ties to their countries of origin; and 2) their ties to Canada. Some participants demonstrated their ties to their countries of origin through engagement in transnational practices such as regular long-distance virtual communications via apps (e.g., WhatsApp and Telegram) for emotional support, visiting their home country periodically, establishing businesses in their country of origin, making plans to retire in their home country, and emphasizing their desire to give back and contribute to their home country's growth and the development.

However, some participants also demonstrated their ties to Canada by expressing their desire to stay in Canada permanently for better opportunities for themselves and their families, while visiting their countries of origin periodically. Indeed, some participants reported multiple attachments because they had integrated well into Canada and also maintained strong transnational ties to their countries of origin, highlighting the coexistence of these two attachments. However, it is worth noting that these multiple attachments and sense of belonging were fostered through meaningful relationship-building. According to Levitt and Schiller (2004),

migrants' multiple attachments and sense of belonging are dynamic and constantly changing or shifting based on their sociocultural, political, and economic relationships in both their countries of origin and their new countries. Levitt and Schiller (2004) have described this phenomenon as "the simultaneity" of ties. Additionally, because immigrants can live in multiple worlds simultaneously, especially in today's interconnected world, this can generate both simultaneous and conflicting feelings towards the home and host countries, as they can be virtually present in their home country and physically present in the host country (Boccagni & Baldassar, 2015; Baldassar et al., 2016).

Overall, safety concerns, economic stability in their countries of origin, migration goals, opportunities in Canada, and personal well-being influenced decisions about retirement locations. Some participants who had experienced employment in Canada and the inability to pay high international student fees often wanted to return to their countries of origin when they were experiencing feelings of failure due to their inability to achieve economic prosperity and meet non-migrant family expectations, which were two main drivers of their migration.

## **Chapter 6: The Evolving Experience of Health**

This sub-theme captured the overlapping and intersecting conditions that impacted the participants' sense of health, well-being, and success in both the pre- and post-migration periods. Pre- and post-migration determinants of health and well-being were not mutually exclusive and interacted across time and location to shape the participants' experience. These determinants were present during both geographic and time periods. They included evolving health status, evolving health knowledge, healthcare system challenges, participant-healthcare professional relationships, the intersection of religious/cultural beliefs and healthcare, environmental impact, migration uncertainty, semi-legality, age and agency, gendered health experiences, transnational experiences of discrimination, employment opportunities, money matters, life course backsliding, and it takes a village to survive. Ultimately, these determinants intersected in a variety of combinations to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta. This section begins with a discussion of participants' pre- and post-migration definitions of health and well-being and the role of mental health in these definitions.

### ***Mental Health is for the West***

During the pre-migration period, many participants defined health and well-being mainly in terms of physical and spiritual health, with little or no mention of mental health due to their cultural perceptions of what constituted mental health and the limited discussion of it in their countries of origin. Mental health was not considered an issue in their home countries but rather viewed as a Western concept. Stress and frustration were normalized as part of everyday life and were not viewed as mental health concerns. Many participants' definitions and perceptions of

health and well-being pointed to a lack of awareness and understanding of mental health within their respective cultures.

*My pre-migration definition of health and well-being was mostly medical. So, whether someone has any heart conditions or physical conditions or medically and physically, that's what I mostly consider as health, yeah, before coming here (Sunshine).*

*I used to define health and well-being as just how you're doing; are you feeling any pain, like are your legs OK, do you have a problem with your arms, yes, do you have headaches, nothing mental, just the physical body, and yeah, that's how I used to define it. Back then, I honestly didn't give it much thought, but I would say that's just how I used to define health. You know, the physical, everything was just, you know, physical (Kamon).*

*Health and well-being back home were more about physical and spiritual health. Ah, back home, we don't consider mental health. Let me be sincere, mental health is, mental health is for the West. Mental health at home, we don't even consider it because stress is like, is like part of life for us. Because the higher the population and the fewer facilities we have, we are bound to go through a level of stress on the road, getting to work, and everything. We've seen it as a normal life for us. We don't see it as mental health. But on the West side, we have seen that it's, there is more to mental health than that in sub-Saharan Africa (Marcus).*

Although a few participants perceived things like stress and frustration as mental health issues before migration to Canada, many participants did not perceive these states as mental health issues because they considered them normal occurrences of life that required natural coping mechanisms, unless they became chronic.

*Yes, in South Africa, I did consider stress and frustration as mental health issues (Abira).*

*Stress and frustration are not considered mental health issues back home. It's a normal thing that everyone goes through. You need to find a way to cope with it; everyone goes through it. So, you can survive, you know, even if you're stressed, you need to find coping ways. But to view it under the bracket of mental health, I don't remember it being viewed like that. Maybe like I said towards the end of high school, that's when it became more discussed, but till that time, there was that lack of knowledge on that (Sheba).*

*Honestly speaking, I did not consider stress and frustration as mental health issues. I think mostly because it's not something that is spoken about much. It's not something that has been normalized much. This is something that people back home pushed to the side. They don't take it seriously. So even if you think that's what you're going through, they will convince you back home that it's not that. It's not that (Talitha).*

*I'll say stress, for instance, is closely related to mental health, yeah. Yeah. I mean, for me, because stress is like a natural physical response to some demanding situations. And there are also like occasional stress, which is a normal part of life, and there's also, I think there's also like chronic stress, which is that is, when it becomes, when it persists, and also, I mean, we have occasional stress, you wouldn't really consider it as a mental health issue. If it is chronic stress, then I will say yeah, that's what I will consider as mental (Caesar).*

Participants discussed how their perceptions of health have evolved, especially regarding mental health, after moving to Canada. They highlighted the importance of mental health as part of overall well-being, modifying their previous beliefs influenced by cultural backgrounds and experiences. However, despite some participants including mental health in their definitions of health and well-being after migration, they still did not consider stress and frustration as important mental health issues because they were not culturally prioritized in their countries of origin, or because they felt it had not reached a level that required the services of healthcare professionals. Although some participants had not personally sought mental health support, the Canadian healthcare system's support for mental health services has significantly influenced their perspectives on health and well-being. The study revealed the importance of access to and utilization of healthcare as a fundamental necessity, contrasting the challenges experienced in their home countries, where healthcare was not as easily accessible.

*The only thing that changed, um, in my definition of health is how I perceive mental health. It's something that I never thought about back in the day when I was in Kenya. Um, I think it's from just seeing people with mental problems here because people sometimes, me as well, and yeah, I'd say that has changed a lot. I think there's that, and the fact that people also don't have the knowledge. People don't know that, I think they just don't understand it. People see people who are sick, mentally sick, and they don't know that that is a sickness. They say it's, you know, that, you know, they have crazy names back home. I'd say it's stereotypes, but I also say it's a lack of knowledge (Kamon).*

*My definition of health and well-being has completely changed. I was fortunate enough this summer to take a women's health course. So, that changed my perspective on health. Definitely. It's not just the absence of an ailment, right? It's more like your behavior, like how you live, your lifestyle, your eating, your coping mechanisms, your mental health. All*

*of these and other social determinants of health are incorporated. I would say that is important with regard to health. It's not just am I feeling sick, or am I coughing? It's like, am I mentally, ok? Emotionally, how am I coping? Physically, do I feel fit? Am I eating well? Am I doing the normal things that I typically do, you know, or am I going through a depressive episode? What must I do when those things rise up? They need to talk to someone, then you need to go to counseling or therapy or talk to a friend, you know? Yeah, it has changed (Sheba).*

*I personally don't think I have gotten to that level of seeking the help of mental health professionals. I wouldn't equate mental health with madness. But my feelings are like I'm not like depressed or having any strong mental issues right now, it's probably just like school stress, but that's like also really normal (Abira).*

Samon stated that his definition of health and well-being remains unchanged because he had adequate knowledge of mental health before arriving in Canada. The only thing that had changed was his perception of healthcare accessibility.

*My definition of health in Nigeria has really not changed. The definition has really not changed. It's only the accessibility that has changed. Health and well-being are a general state of Wellness. And I, as a person, strongly believe that access to healthcare is a basic necessity of life that should be readily available. Unfortunately, in the part of the world where we are coming from, those things are not readily available (Samon).*

Most participants' understanding of health and well-being was influenced by their cultural, religious, and spiritual beliefs before migration to Canada. Consequently, discussing study participants' mental health requires a clear conceptualization of how they understand this term within the context of how mental health and illness are discussed in Canada and beyond. The World Health Organization (WHO, 2014a) defines mental health as a state of well-being in which each person recognizes their potential, can manage the normal stresses of life, works productively and effectively, and contributes to their community. This definition recognizes that mental health is not merely the absence of mental illness, but fundamental to our collective and individual ability to feel, think, and act in ways that improve daily functioning, social relationships, and the ability to adapt to life changes (World Health Organization, 2014a). Conversely, a mental health disorder refers to conditions that influence an individual's thinking,

mood, or behaviour, which leads to distress and impaired functioning over an extended period (Health Canada, 2002). Although mental illness and mental disorder are often used interchangeably, the latter usually refers to clinical diagnoses that require medical and psychotherapeutic intervention, such as anxiety and depression. Accordingly, the definitions provided indicate that mental disorders and mental illnesses do not include temporary feelings of sadness, loneliness, or emotional distress. The causes of mental illness and mental disorders remain poorly understood, which further contributes to confusion, discomfort, and stigma associated with them (Phelan et al., 2000). Moreover, Galderisi et al. (2015) highlighted that this shift in terminology, from mental illness to mental health, has created confusion around the term mental health, as this preference is largely rooted in Eurocentric and North American values.

Some scholars argue that the WHO's definition of mental health does not align with the perceptions of many African immigrants because it dismisses the spiritual aspect of health, thereby acting as a barrier to accessing and using healthcare services among these groups (Shah et al., 2017; Yohani et al., 2020). This was evident in many participants' pre-migration definitions and views of health and well-being, which focused more on physical and spiritual health, and rarely mentioned mental health. Mental health was not typically a prominent area of focus, since stress and frustration were viewed as normal life experiences in their countries of origin, rather than mental health issues per se. For example, some participants described how the term mental health was often associated with "craziness" or "madness" in their countries due to a lack of awareness or understanding. Although many participants acknowledged the low level of mental health awareness in their countries, they also reported a growing awareness through increased mental health education.

Participants' post-migration definitions and perceptions of health and well-being varied; however, their perspectives on mental health evolved upon exposure to different experiences and education in Canada. Many participants recognized stress and frustration as relating to mental health and the overall importance of mental well-being, showing the cultural evolution of their understanding of mental well-being with their increased exposure to a Western perspective on mental health.

### **Evolving Health Status**

Many participants reported arriving in Canada in excellent or good health, as evidenced by the results of their pre-migration rigorous medical screening tests before being granted their visas, due to regular check-ups, or the easy access to private healthcare in their countries of origin. This is how some participants described their health status before migration.

*I would say that my health status was good because I remember during the um, you know, the medical checkups that you need to do as part of your migration application process, everything came back all right. All the X-ray scans, CT scans, and the full body examination done by the doctor were sent to them, and everything was good. My vitals were all good. I think even blood work was OK, yeah (Sheba).*

*I will say my health status back in Africa was excellent because I will say I was lucky; I come from a family where my father works in a multinational company where we have health insurance, which is covered 100%. So, I mean, before, in Africa, if I had any problem, I could go to one of the biggest hospitals in the country, and I would be treated for free (Caesar).*

*My health status back home was perfect. One of the things I've noticed may be because of where I worked. We are asked to do some level of, how do I up it, screening every year for your health, and once, once they see any flag, they call the staff, they have a few discussions with them, and they try as much as possible to also make sure such a thing is dealt with immediate effect. One of the principles of the organization is that they make sure we have the best health service. They make sure they are involved in our health status, and that the hospital has to send those reports to them. They make sure all their Staff are living healthily, and that's one of the things (Marcus).*

Although Aaric reported that his pre-migration physical health was below average according to his standards due to a lack of physical activity, it had improved since arriving in

Canada due to the many available spaces he utilized for physical activities such as walking. This, according to him, was not the case in Egypt due to overcrowding.

*My physical health. I'd say it was almost bad, maybe. Maybe below average, at least by my own standards, due to a lack of physical activity in Egypt. My health status has improved, I believe. Yes, it has improved, mainly because I'm just feeling better in general. Having access to myself, like doing activities outside, which was limited in Egypt, but here it's just like easier to do. So that's the main factor. So, like having spaces for walking in the city, or something, is, well, yeah, it is like a big factor for me doing activities outside walking. I just like walking a lot, so yeah. I'm just, like, feeling healthier because I'm doing some exercises outside (Aaric).*

Additionally, Timon reported a decline in his mental health while in Nigeria due to stress from unemployment, even though he lived with his parents before migration.

*My health status was excellent until I started growing up, and then I started thinking of leaving my father's house, and then, because I was staying in my parents' house for a long time while I was unemployed. So, it's just really recently, and I started like I started thinking about it, and then started playing a role in my mental health, but throughout my entire life, my mental health has been excellent (Timon).*

Many participants reported changes in their health since relocating to Canada. Some observed improvements in physical health due to greater opportunities for physical activity, while others experienced declines in mental health because of increased responsibilities, challenges in adapting to a new environment and unfamiliar environment, stress, loss, societal events, fear, and uncertainties, all of which intersected to influence their health and well-being. Importantly, participants mentioned seeking professional help and utilizing healthcare services as significant steps in maintaining their overall health and well-being.

*I would say that my health status has changed here. Like after like, taking the course, I was like, you know, I need to go and check on myself, you know, it's not just the absence of like physical ailment. I did some checkups, you know, doing some blood work here, oh, all my blood sugar level is high, so I need to reduce my carb intake, I need to exercise, you know, cause I'm my weight is not that good or like getting my eyes checked to say Oh, you have this and that you need to fix. So, it's like all of, like you're being hit with the wave and you're like, oh, wow, there are so many now, I'm exposed right to what health is. I'm now doing these things, so now I need to find a balance to everything with school*

*going on, the stress of midterms, assignments, and papers, but also eating right, living well, and making sure everything is fine. You know it's a lot, but yeah [laughing] (Sheba).*

*So, I would say for me, it has been on the positive side. I have not seen, based on the reports, that it has been OK. It has not been declining. The only pressure, like I have said already, is this high level of uncertainty that is right before us. Apart from that, apart from a high level of uncertainty in terms of the pathway, because it impacts your physical and mental health as well. Yes, you're thinking, you're thinking you're thinking; what's next, what if, what if there is, there are so many things that go around your brain that ordinarily shouldn't be (Samon).*

*I think my physical health in general is good, but there has been a decline in my mental health. I have only been to the hospital once, and that was because everyone was going through the flu and just passing it on to each other in the house, then. So, apart from that, I have not been to the hospital since then (Timon).*

Interestingly, Talitha reported that there had been changes in her mental health due to a lack of pre-migration family support, but it had also strengthened her spiritual health because she had to care for herself.

*My health status, I would say physically, no, not really. It's still the same. Mentally, it changes because I do have moments of depression where it's like now I have to actually get a proper job where I'm taking care of myself. Like full-time. There's no dad to run to when things are tough. There's no mom to run to because they are overseas. They are far away. It's you, so you have to get through the day. And spiritually, I would say, being far away from home, it has strengthened; I would say it has strengthened because now it's like I can't be dependent on them to spiritually get me through something, because now I'm grown, so I have to take care of myself as well. So, I would say yes, my health status has changed since migrating to Canada (Talitha).*

Kamon also reported that his mental health has declined, influenced by various factors such as the loss of two acquaintances and events in the U.S., including racism.

*I'd say my health status has diminished. Maybe it could be the same if I were still in Kenya. I don't know. But yeah, looking back at how I was back then, I'd say yeah, diminished for sure. I think maybe it's about me just growing up and thinking about things a lot, but I'd say mentally having to deal with everything, and you know, I've also experienced a few things like. I've seen people that I know pass away due to drugs, and that's, you know, mental health issues that lead them to do some, you know, crazy things, and they end up losing their lives. I've seen maybe 2 people that I knew since I came in, and yeah, that affected me. Also, the incident in 2020, during COVID-19, yeah, the George Floyd period, when yeah, all that was going on, and there was the other girl,*

*Breonna Taylor, killed a few months before George Floyd, and yeah, seeing that took a toll on me (Kamon).*

Although they had not visited the hospital since arriving in Canada because they did not have family doctors, some participants reported that their health status had not changed after migration, according to their standards.

*The thing is, since I have been in Canada, I haven't gone to the hospital. I haven't gotten sick. I go to the hospital when I fall sick. Generally, I haven't gotten sick. I haven't gone to the hospital. As I feel, I mean, I think. I'm OK, yeah. For me, yeah (Caesar).*

*I haven't really paid much attention to my health, not giving myself that much time to talk to professionals about what I feel is beginning to affect me. So, now I want to use the good health facilities here to really ensure that I'm in a good state. So, I want to, like I said, that I'll be visiting the hospital soon. I heard they have a family doctor, so I want to get one whom I can talk to about my health and then get the necessary care (Miss Brown).*

*Currently, I think I'm still good. I haven't yet had an opportunity to get a full medical check, so I cannot say that this is if I've developed anything since I've been here, because I don't have a family doctor, but I still feel healthy, like in my body, I still feel fine, yeah but mentally I feel more stressed out (Sunshine).*

Almost all participants described their pre-migration health as good or excellent, which they attributed to rigorous medical screening tests before admission to Canada. However, some participants experienced a decline in mental health after migration, mainly due to stress, frustration, hopelessness, uncertainty, loss of friends, and fear related to their precarious migration status. This presentation is consistent with the “healthy immigrant effect,” which suggests that many immigrants arrive in their host countries healthy; however, their health declines after migration and either *converges* with that of the native-born population or *overshoots* to become worse than the native-born population (Beiser, 2005; Vang et al., 2015). Interestingly, one participant's experience deviated from this reported pattern, and they reported that their physical health improved as a result of greater physical activity after relocating to Canada. Additionally, some participants reported growth in spiritual health due to fostering

qualities of self-reliance and overcoming the challenges that come with living away from home. Despite the uncertainty surrounding their precarious migration status and pressures of life in general, many participants expressed intentions to prioritize their health by seeking medical attention and making lifestyle adjustments.

### **Evolving Health Knowledge**

While some participants reported having adequate health knowledge before migration, others indicated that they had little to no health knowledge in their countries of origin due to a lack of exposure to health information, family influence, limited time for health research, and the unavailability, unaffordability, and inaccessibility of health and social services. Many participants expressed a need for increased education and awareness about mental health issues in their communities in Africa to prevent stigma and improve overall well-being. Some participants admitted that they had adequate health knowledge in their countries of origin, which influenced their access and utilization of healthcare.

*I think I knew a lot, and you know, like, with the Internet and having access to different informational sites, and I think maybe it also helped that my family is in the medical field. So, like having discussions around what kind of tests you need and what kind of care you need, I think that helped me personally if I needed advice. But generally, having knowledge and information about healthcare is very important because in communities, there are like health drives and they have a lot of the same things like men's health, women's health, like at schools, and just in general in communities, like people are usually aware and that they need to seek help when needed (Sunshine).*

*I would say that I gained more health knowledge towards the end of high school. That's when I was exposed to this whole idea of mental health, but till that time, there was a lack of knowledge on that. It wasn't quite prominent when I was in junior school. So, I was aware of mental health, but was I well, like, did I have a lot of knowledge on it? I would say no (Sheba).*

*I would say lack of exposure to quite a lot of things, really, for example, like, excuse me, the mental health thing. It was something that was not explored much. So, it doesn't mean that the people didn't experience mental health issues, but were there, and some of them went unnoticed and had unfortunate endings. But so like things that, like in lack of exposure to certain things, and um yeah, just being closed off and not being able to see*

*the world at large. Yeah, that's what, yeah. I would say I had limited health knowledge back then. Health knowledge, on a scale of 1 to 10, I would probably put it at a 5. It was a 50/50. No, I would put it on a 4 because now I know more than I did back then, so it'll probably be a 4 on a scale of 1 to 10 (Talitha).*

Interestingly, some participants admitted that although they had adequate health knowledge in their countries of origin, cultural and religious beliefs influenced their access to and utilization of healthcare.

*I would say that I had adequate health knowledge back home, but my religious and cultural beliefs definitely influenced my access and utilization of healthcare, either directly or indirectly, to this day. I am very religious. So, I would resort to prayers whenever I am not feeling well before going to see the doctor (Yanira).*

Some participants acknowledged that they lacked adequate health knowledge in their home countries and stated that they would have handled access and utilization of healthcare differently if they had a better understanding, especially regarding mental health care.

*But if, like, let's say I had received information about the importance of my mental health earlier, I feel like it would have impacted me differently in the times when I feel stressed, anxious, or depressed. You know, those services, those counseling services, utilizing them or therapy, right? Um but now it's like still so I'll say it's there's that awareness now and a lot of people are slowly accepting it, but I'll say that if people had more access to it when we were students, you know it wouldn't reach to this extent where lots of people are under severe depression or hearing about lots of people or colleagues, that might have committed suicide because you know they do not have, they do not know the importance of their mental health, right? So yeah (Sheba).*

*I didn't know about mental health when I was in Ghana. All I knew was my physical health: when I woke up, I was strong enough to do whatever I had to do. But I didn't even know about mental health. What I knew about mental health was if someone is mad. That's what I knew as mental health, but then I didn't have any idea about mental health. Although I was educated in Ghana, I knew nothing about mental health. I didn't know anything about it. When I was in Ghana, I thought mental illness was someone who was mad. I didn't even know how people who are actually trained as mental health workers deal with mental health issues and stuff. Even if someone told me that we have a mental health professional and that I could have actually contacted them for counseling, I wouldn't have done it because I couldn't have afforded it (Sion).*

*If I had the knowledge of, or if maybe I had major health issues back then, of course, I would have tried to find a solution, whether it was going to the hospital um or maybe*

*going to see maybe a traditional healer, which I also don't believe in. So, yeah, I'd say I would go to the hospital, but I never had a major issue (Kamon).*

Samon reported that the overall level of mental health awareness in his country of origin was nearly zero due to a lack of health education and men's denial related to adherence to traditional masculine norms.

*Ironically, I am the one who used to tell people in Nigeria that lots of people are sick without knowing. Maybe I took a lot of those shocks too, unknowingly. Because back in Africa, with mental health, until the person is mad, he is not mad [laughing]. So those stresses come, and just like you said, depending on your family setting, the way you set up your family, you know, the issue of the level of awareness of mental health here, we don't have it back in Africa. If you are not aware of something, you don't even know about it. So, it's not talked about, and it's not known. In Africa, you have to convince the man that he is sick. The man will tell you he's ok. Because the man doesn't know he's not ok. Lack of mental health awareness. The level of awareness of mental health in Africa is close to zero ooh!! Except for anybody who wants to deceive themselves, this is the Nigeria I came from. The level of awareness is very low (Samon).*

Some younger participants mentioned that they lacked adequate health knowledge in their home countries because they relied on their parents for everything, including access to and utilization of social and health services.

*I didn't have much health knowledge because my parents did mostly everything for me. But I wouldn't say that I had zero health knowledge. I will put it on a 20% knowledge (Ceeja).*

Many participants reported increased awareness and utilization of health resources in Canada due to easier accessibility of health information and resources. Participants recognized the importance of gaining new health knowledge, staying updated with changing health information, and knowing where to find available health resources.

*Yeah, I would, I'll grade myself on 80% because this is a developed country and it's in the Western world, there are a lot of new things, when I think I have known enough, I have not seen it all. So, tomorrow there's something new, every single day there is, um, there is a new program, there's a new update on the healthcare system because they improve it every single time. So, I will leave the rest of the percentage to new knowledge. And then, for now, I think I have an 80% rate (Ceeja).*

*Yes, I would like to put my health knowledge now at an 8. Because there is so much information at our disposal now, here in Canada. It's easily accessible. Yeah, I would say I know a lot more now, so if I need anything, I know what to do, I know where to go, and it's easy to, yeah, to get access to it (Talitha).*

*Yeah, from the little contribution we're getting from others, some ideas, I think I may not say I have full knowledge of everything, but I have some ideas concerning health resources that I can access. If I'm facing some challenges, I can run to and get the solution, yeah (Johannes).*

Timon mentioned that his perception of self-medication has changed due to his increased health awareness and challenges associated with obtaining some medications in Canada without a prescription.

*I have acquired a lot of health knowledge about health care and whatever. I mean, if I'm feeling something now, just, I don't have to like, self-medicate. There's not even any way of self-medicating because both of those drugs that we take in Nigeria, which you can easily buy, you can't get them here; you have to have a prescription from the doctor. So, it's really changed my, like, the way I think about mental, about healthcare, yeah (Timon).*

Since they relied on their parents for everything, including health information, healthcare access, and utilization in their home countries, some younger participants reported difficulty accessing and utilizing health resources in Canada due to unfamiliarity with the process, which sometimes led to poor choices. Nevertheless, Sheba asserted that she had learned a lot from her mistakes.

*I know that there are resources that are available to people with whatever they need, right? But there's that lack of being aware of these resources, if that makes sense, you know. So, it's like there's that, like you now have to try and figure everything out on your own. It's not like back home, where your parents have figured out, you know, they can give you their advice from their experiences. Like, it's like you are experiencing for yourself each day, you make a mistake, you're correcting it. You're learning from those mistakes, I would say. That is challenging, but in a positive manner, you know you're learning from your mistakes (Sheba).*

Additionally, Sheba mentioned the common Canadian belief that after a certain age, you should know when and how to access and utilize healthcare services; however, it was very new to her because of her prior lack of knowledge and experience.

*So, it's not like, oh, I need to go and get more information about that, right? And I guess sometimes like a lot of like the not the university, but let's say you're going to get a service like there's that assumption to say that you should know like how these things work, but really you're like I'm new, you know I'm quite, I'm still new, I'm really new, you know. If you don't have like access to learning about what health is or like access to this, like knowledge about these services, I'm talking, and also like a person's perspective who does not know how things work (Sheba).*

It is worth noting that some participants had difficulty understanding certain Canadian medical terms that differed from those used in their home countries. For example, some were not initially familiar with the term "family doctor" because, in their countries of origin, family doctors were referred to as general practitioners. This misunderstanding hindered their ability to access and utilize healthcare services. For instance, Sion initially thought that a family doctor was a family member who practiced medicine, which he believed came at a cost he could not afford. Additionally, some believed that a family doctor was part of a private medical practice that required private health insurance or out-of-pocket payments, which they could not afford.

*I haven't really researched well about family doctors. What does it mean? What do they do? What are the advantages and disadvantages of having one? Are there any charges to it? So, I haven't really researched it because I don't think I'm someone who gets sick regularly. So, I mean, since I've been in Canada for almost two years now, I haven't gotten sick of anything. You know this; these are some of the information you don't know. I mean. When you come to a country and you don't follow, maybe all the good people to advice, that's some of the information you don't get to know (Caesar).*

*Well, I had wanted to have a family doctor; but I don't know how to go about it because I'm not used to that. I didn't even know you had a family doctor in this world until I had a colleague at work, and I had wanted to upgrade my driver's license, so that's when I was informed to go and get some medical care. He told me I should go and see my family doctor and asked him who is a family doctor, but at first, I thought a family doctor was maybe in my family, a family member who is a doctor, exactly. I didn't know people have family doctors, so yeah, yeah, yeah. I've been well educated on the health side. For now, I know that oh family doctor is not about like you have your own for something, is something very important if you have it for yourself, it's gonna help you and yeah so that's something that I really appreciate about you educating me on that because I at first I had less knowledge about it but now I know more about it and I really appreciate that a lot (Sion).*

Some participants lacked adequate health knowledge, which impacted their health and well-being. According to the World Health Organization, health literacy involves social, cognitive, and personal skills that determine an individual's ability to obtain, understand, and use information to promote and maintain good health (Nutbeam, 2000). Previous studies have indicated a strong relationship between health education/literacy and overall health (Price et al., 2011). Participants' pre-migration level of health knowledge, especially regarding mental health, ranged from low to adequate, shaping their access to and utilization of health and social services. In the pre-migration phase, many perceived health mainly in terms of physical and spiritual, with little or no emphasis on mental health. While some participants admitted they had minimal health knowledge, particularly about mental health, others acknowledged that their lack of health knowledge was due to a lack of time, opportunities, or cultural beliefs. Many attributed the prevailing lack of mental health awareness in Africa, especially the misconceptions about mental illnesses, to different cultural perspectives and understandings of health. Some emphasized that their limited knowledge of mental health was mainly due to the stigma attached to mental in their countries of origin. A few expressed regrets about not learning more about mental health earlier in their home countries, highlighting the importance of early education and awareness in encouraging individuals to seek help and access mental health services. Family members employed in the medical field, social status, access to health information, social networks, and levels of privilege all influenced some participants' pre-migration health knowledge.

Participants demonstrated varying degrees of understanding and awareness of the healthcare system in Alberta. Many had gained health knowledge since arriving in Canada due to easy access to health information. Some participants lacked adequate health knowledge of the Alberta healthcare system and available health resources, including mental healthcare and

preventive treatments (e.g., screening), which hindered their access to and utilization of healthcare. Due to cultural differences in medical terminology, some participants initially did not know who a “family doctor” was because they were called “general practitioners” in their home countries. This confusion in terminology hindered their ability to access and utilize healthcare services in Southern Alberta and was further worsened by the shortage of family doctors. Such cultural differences in medical terminology likely increased communication challenges between some healthcare providers and participants, making it more time-consuming and difficult to explain medical conditions, healthcare concepts, and the health system. Since health services and resources are rarely publicized, some participants' awareness of the availability and accessibility of these resources depended on their existing networks in Canada (Goldring et al., 2009). Overall, participants acknowledged the importance of being informed and educated about healthcare practices and procedures in Canada, including the role of family doctors, accessing and utilizing healthcare services, the significance of prescriptions, and the need to continually expand their health knowledge to effectively navigate the Canadian healthcare system. Consequently, providing health education to precarious immigrants to increase their Canadian health system literacy may ultimately improve their overall health and well-being (Ahmed et al., 2016).

### **Healthcare System Challenges**

Participants expressed diverse perspectives on healthcare in their respective countries of origin, including challenges such as affordability, lack of equipment, long waiting times, neglect leading to medical mishaps, inadequate facilities in rural areas, and issues with accessing medical care. While there were dedicated healthcare professionals, issues, including insufficient health and social resources, poor infrastructure, and disparities between private and public

sectors, acted as barriers to access and utilization of healthcare. Some participants also stated that the exodus or migration of skilled healthcare workers due to low pay further impacted the healthcare system in their countries of origin.

*I don't think it's efficient. It's not efficient because it's not affordable. So yeah, given the crowdedness of the city, it's just like, yeah, it's just like cramping those people almost all the time. So yeah, most people like maybe up mid-class, yeah, and anyone above the middle class would not be using public health care. But yeah, the people who can't afford private healthcare are the ones who use public healthcare. So, yeah, it's just like the public, the public sector itself is bad because of the density of people. And also, a lot of doctors are just like, immigrating to other countries because of the bad pay they receive in the public health sector. So, that's the state of healthcare in Egypt (Aaric).*

*I wouldn't really describe it as good. Yeah, but I wouldn't describe it as bad either. It's just in between, but it could be better if things were taken more seriously, it could be better. It's not good, but it's not bad. Um, one of the things I've noticed the most is response time to emergencies. For example, let's take a car accident. The response time to that scene is too long. Like, people could be saved, or, for example, if someone is rushed to the hospital, um, the response time to helping that person before they pass away or something, or get the attention that they need, is quite slow. So, if that could be improved, I feel like that, um, the health part of the country would be, would be better. It would be good (Talitha).*

*The public healthcare system in Ghana is not impressive. It was bad the first time I visited the accident ward. I don't go to the hospital, but I visited a friend who had an accident in the accident ward. I cried because I saw people lying on the floor just because there were no beds to put them on, and they had like serious and terrible accidents. The public healthcare services in Ghana are very poor, so I don't even want to talk about it because this was in the city, and this was my experience in the city. I'm not even talking about the villages where people even find it difficult to get to the hospital because they have to cross another river to get to the hospital, and pregnant women are being carried by boats to cross the river. The public healthcare system in Ghana is too bad for me. If you do not have the money, you will die because sometimes they have to tell you they need to transport you somewhere, or sometimes they tell you they have to fly you to another country to do whatever they have to do for you, which is very bad (Miss Brown).*

Although all the participants lived in cities where major hospitals were located, some could not afford the high costs of private healthcare. As a result, they were forced to rely on low-quality public hospitals or alternative and traditional medicine, which often acted as barriers to access to and utilization of healthcare in their countries of origin.

*Even though you would have public health insurance, it covers the basic things. Most of the things you have to pay for yourself, and I couldn't afford them. So, I'll just consider local medications rather than going to the hospital, knowing that I can't actually afford it (Sion).*

Sheba observed that while some individuals with public health insurance might lack the funds to pay for medical services such as dental care out of pocket, those with private health insurance may also experience challenges in processing payments, understanding which services are covered by their insurance, and identifying which services require out-of-pocket payments. These issues all serve as obstacles to accessing and using healthcare.

*For those who can't afford private health insurance, I would say that they do have some barriers to it because, like I said, sometimes you need to pay out of pocket for some surgeries if you don't have private medical insurance. At the same time, even if you do have private health insurance, sometimes you could face some challenges in terms of your payments being processed after getting a service, if that makes sense. Also, maybe the lack of efficiency in the payment of your services under your private health insurance, and also for those that the public that can't afford the healthcare system, they'll have to now go to these big government hospitals, but sometimes, those hospitals, maybe they can't afford to treat so many patients at that point in time. So, there are downsides to it because they need money to pay for those services out of pocket, too (Sheba).*

Miss Brown voiced her dissatisfaction with Ghana's two-tier healthcare system because it created discrimination in access and utilization of healthcare. Those with private health insurance received better treatment in public hospitals because their insurance covered their costs, compared to those without it.

*I think the thing is, we have the government health card for public hospitals and private health insurance, which can be used in both public and private hospitals. And then we have people who come in without health insurance. The thing is, sometimes the nurses look down on people who use the government health card. Yeah, basically because they think you are here to get healthcare for free, you're not paying anything, so they really concentrate on whoever is paying before they take care of you with the health card. And even the health card doesn't cover everything. It only covers some parts of healthcare. Sometimes, the health card covers some medicines, but other medicines, expensive medicines, you have to buy them yourself. They treat people who pay without a health card differently from those with a health card, which shouldn't be so, but yeah (Miss Brown).*

Notably, some participants reported that although their home nations had excellent and skilled medical professionals, many institutions lacked the resources needed to treat certain conditions, such as experts and advanced medical equipment. Due to overwork and insufficient pay, many doctors experience burnout, which causes them to migrate from Africa to wealthier countries.

*Like, I think a lot, a lot of doctors are just like, immigrating to other countries. So, because of the bad pay they receive in both the public health sector and the private. The private health sector is profitable, but that's just like demanding. We do have some talented, very, very talented doctors; they are knowledgeable, like the universities that they teach, and are considered a hub in Africa. I do have confidence in them because they have a good reputation. And yeah, the doctors are just good (Aaric).*

*Africa and sub-Saharan Africa have some really great experts, if you can afford them, that Canada doesn't have, and that's why they are trying to bring in more doctors from sub-Saharan Africa into their country. I think Africa has the best when it comes to um doctors and nurses. Here, they have the experts, but also, we have good doctors who are mainly in the West now. We have good doctors who have migrated to the West, and you know, I still get in contact with them, like most of them that work back home, and some of my surgeon friends are in the United Kingdom presently (Marcus).*

*I would say, Zimbabwe also has that lack of medical facilities to facilitate a lot of patients, the lack of, like I would say, electricity, what do you call it? The electricals or the blackouts? But in terms of the physicians themselves, I would say that a lot of them are trying their best with the limited resources that they have. And as a result, because they're overworked, underpaid, they're not giving, sometimes they're not giving the best that they should, right? Or not attending to all patients' needs (Sheba).*

Interestingly, participants' opinions on the Canadian healthcare system varied, highlighting both positive and negative aspects of the system. Despite the free Canadian healthcare system, some participants pointed out drawbacks such as longer waiting times and a lack of family doctors, preferring quicker services and shorter waiting times in their home countries, while others appreciated the overall quality and coverage of the Canadian healthcare system.

*If I need help, I need to go to like those walking clinics, the pharmacy in like Canadian superstore, or I need to go they have like, I think it's called ambulatory in Coaldale,*

*where you can see a doctor, but you wait all night to see somebody. That's the only two places I've been able to access a doctor. And when I was at the college, they had a doctor at the college, but I'm not there anymore, so I don't have access to that (Sunshine).*

*To me, healthcare is good here. I haven't been to the hospital, not for once, but I'm thinking of visiting soon. But when I came here, where I used to live, there was a pregnant lady who also migrated from Ghana to Canada, and then when she was in labor, within a few minutes, we called the ambulance, and they were there, and you know everything was done fast. She was rushed to the hospital immediately and delivered. Everything was so fast and easy. It's not like Ghana, where it's not easy for you to call an ambulance and get them to you that quickly, you know. Sometimes they even demand money before they come, but I didn't see that here, so with that alone, I think healthcare here is on point (Miss Brown).*

*I'd say I prefer healthcare back home to Canada, if I need to be sincere with you. Um, you go to the emergency here, um, you stay, you stay hours, and you can never find a doctor. Back home, because we have private-sector health insurance, we have public health insurance; you can't wait that long back home. Once you call the doctor or you can probably get to the hospital. The maximum you can stay in a hospital is 30 to 1 hour. I think healthcare in Canada is pretty slow for me. For my state, it has good facilities when it comes to healthcare, and it's way better than what we've heard about the West. You get to the West, it's different. No, I think it's extremely different (Marcus).*

Many participants described past challenges accessing the two-tier healthcare system (private and public) in their respective African countries, including a lack of health resources, the high cost of care, limited access to services, inadequate infrastructure, and medical mishaps such as administering incorrect treatments, which led to fatalities (Azevedo, 2017). The World Health Organization [WHO] (2007) identified six core categories for evaluating the state of healthcare systems in different countries: (a) service delivery; (b) healthcare workforce; (c) healthcare information systems; (d) medicines and technologies; (e) financing; and (f) leadership/governance. Unfortunately, many African countries did not meet these criteria (Petersen et al., 2017). To address the high cost of healthcare, numerous African nations, including Ghana, Nigeria, Kenya, Rwanda, and Ethiopia, have implemented social health insurance schemes (Adua et al., 2017). However, some participants experienced barriers to accessing and utilizing healthcare, such as an inability to pay out-of-pocket for certain

procedures and emergency care in their countries of origin (Fenny et al., 2018), ineffective national health insurance systems (Adua et al., 2017), poor service integration (Petersen et al., 2017), shortages of human resources, and “brain drain” from Africa to Europe, the Middle East, and North America (Oleribe et al., 2018). As a result, some participants resorted to using alternative and traditional medicine. Despite these challenges, some expressed confidence in their home countries' healthcare systems, praised the expertise of doctors and nursing staff for doing their best with limited resources, and emphasized the need for improved resources and infrastructure to enhance healthcare delivery in sub-Saharan Africa.

Like other provinces, Alberta's healthcare system is publicly funded and managed by the provincial government. It offers universal access to essential medical services, such as doctor visits, medical procedures, and hospital stays, but does not include routine dental care, eye exams, or prescription medications for adults. Private insurance options through employers and post-secondary institutions also provide additional coverage. Alberta Health Services (AHS) is responsible for delivering healthcare in the province, including services at hospitals, clinics, community health programs, and primary care focused on prevention and non-emergency treatments.

Canadian universal healthcare, characterized by a decentralized federation of provincial and territorial health insurance plans, is often perceived as covering every person; however, this perception is misleading because some participants, particularly asylum seekers, experienced challenges accessing and utilizing Alberta healthcare services due to a lack of Alberta health insurance coverage and an inability to pay for out-of-pocket health costs (Odhiambo et al., 2022). Participants' healthcare access and utilization challenges varied. However, the common issues reported by participants in Lethbridge, Southern Alberta, included a shortage of family

doctors, poor proximity to clinics, limited or no access for some, and longer wait times for referrals and emergency care. All these challenges had the potential to adversely impact the health and well-being of some participants. Despite these access challenges, many expressed their preference for the Canadian healthcare system because it was free, while others preferred their home countries' systems due to their privileges in that context related to social and financial status before migration, and their perception that healthcare services were faster for them in their home country. Additionally, the free Alberta healthcare system encouraged some to seek medical help rather than self-medicating to avoid health risks.

### ***Participant-Healthcare Professional Relationship***

Participants had varying experiences with healthcare providers in their countries of origin. Some described respectful interactions where questions were welcomed, while others felt unable to question doctors about their health due to a lack of knowledge or fear of repercussions. In many cases, some participants mentioned that the patient-provider relationship is often shaped by patients' health literacy, social status, and financial situation.

*I mean, in Africa, we know what the doctor says is what you have. So, when I go to the doctor, he consults me, and he tells me this is what I have, he gives me the drugs, and that's it. I mean, I won't have to question him; this is what he saw. So, I mean, I'll just have to go with it (Caesar).*

*But if, let's say, I did have, like going to the doctors and the clinics, like I said earlier, or to a specialist, there was never that don't question mentality, there is like always, do you have any questions, and you know you raise your concerns. I remember taking my uncle once for his eye checkup, and of course, he's older than me, you know, he was concerned about what was being said, and I'll make sure to ask the questions and try and describe it to him. You know, there was never that like you have to do this, you have to get this prescription, you have to follow these rules, don't question. There was never that type of environment; you could always ask those questions. They even encouraged, sometimes (Sheba).*

*My relationship with my doctor was excellent. He was a great doctor. Yeah, he was a great doctor. He did give me the space to express myself, no matter how small the issue was, he was always, he was always great. He was um because he was in Botswana and I*

*went to school in Zimbabwe, and I'd if I had a problem, I would always leave the country to go back to Botswana to go and see him because he was just that good (Talitha).*

The inability to express themselves freely with some medical professionals due to fear of intimidation served as a barrier to healthcare access and utilization, which adversely impacted some participants' confidence level in the healthcare system of their countries of origin.

*Yes, I would have had more confidence. Yeah, if I can speak back and say what you are saying or, you feel afraid sometimes to ask further questions because you might sound like you're being antagonistic or something, or you're just being unnecessary. Um, I think if that barrier wasn't there, people would feel more free or I would feel more free to ask more information about the information that they are giving me, like if there's something wrong with me, and finding out more, like how can I find out more resources or things like that. Um, but usually you just listen and say yes, and they give you the medicine or whatever treatment you need, and then they go, and you go away (Sunshine).*

The study findings revealed that participants' age, health knowledge, social status, and financial resources all intersected to influence their relationships with healthcare professionals or providers, as well as their overall access to and utilization of healthcare in their countries of origin.

*Yeah, being young and also there are some big medical terms that you won't know at. I mean, being younger or being accompanied by your parents. So, I think if there's anything, it's always your parents who should ask the doctor, yeah. Because I know it's always my parents who will talk with the doctor and me, I won't really know anything much, yeah (Caesar).*

*You can't question doctors in Africa. The only thing is that when the doctor knows that you are knowledgeable. Because, for instance, I'll give you an example, because of my level of awareness, I have the boldness to go to the hospital and ask, "What injections are you giving me. A lot of people don't have that courage because they don't know what will happen next. But because of my level of awareness, I can remember very well the last one, my doctor; we had a very good relationship until recently, because he, too, has relocated to the UK. So, I could ask questions, we could sit down just the way we are talking, we discuss the issue, we rub minds, and he tries to explain to me, even with the limited resources that he had (Samon).*

*If you're knowledgeable and ready to take the "bullets." The passion that you get, you have the right to query. It is when you query them, when they know that you have the knowledge and have the resources, that is what puts them on that edge (Samon).*

Sunshine indicated that the existing power dynamics between patients and some medical professionals in South Africa are often rooted in a lack of interest in the medical profession. According to Sunshine, some individuals choose healthcare careers primarily for financial gain and, consequently, do not perform their duties effectively. During the interview, Sunshine recounted an experience regarding the power relationship between patients and medical staff in South Africa, which led her to write a letter to senior medical personnel to address issues related to the power imbalance between healthcare providers and their patients.

*Woah!! [laughing]. I think people who enter the health profession, like in recent times, I do think they do it more for money or for the fact that they have a stable income as opposed to actually having a passion for caring for community members, or worrying about things like confidentiality, or the way they need to treat the patients. And knowing that it doesn't matter what the background of that patient is, like confidentiality and not embarrassing people, or you know, like making certain remarks in front of them, I find that was amongst like older people that's been in the patient for longer, they kind of maintain that more as opposed to people who are more recently in the profession I don't know if that makes sense (Sunshine).*

*There was actually once when I wrote a letter to someone like a senior person. I was in the hospital, and it was about the care of the staff that was dealing with me. But other than that, you just sit and grind and bear because you dare not speak back because otherwise you don't know how they're gonna be treating you next, even though they're treating somebody else poorly (Sunshine).*

Some participants shared stories about medical negligence in their countries of origin. Samon and Kamon shared their knowledge about medical negligence in Nigeria and Kenya, respectively, and the inability to hold medical doctors accountable for malpractice.

*I'd say very bad [Laughing]. Yeah, I've seen people I know go through it, and you know, mistakes that should not happen in the hospital happened. You know, someone had a surgery, and something was left in their body. And yeah, I'd say you have to have a very low-class healthcare system for such mistakes to be happening every now and then. So, I'd say it doesn't work well (Kamon).*

*I would give the Nigerian healthcare system 40/100. Your limitation is your ability to query your doctor. I'll give you an example. I will have plenty of examples to give you. I lost a nephew due to a serious medical mishap. We couldn't, and we did not even attempt to file for damages. What happened? This child, a baby who was sick, went to a specialist*

*hospital, and the doctor evaluated his chart and prescribed a dose of an injection for the child. The mother was taking this child to the hospital, only for the nurse to give the child a different injection. This happened over six months. All the injections that the nurse had been giving to this child for the past six months were wrong. The child eventually died. How can we press a case? People don't press a case. Why even go to press a case? We didn't even report the case. So, that's why I said you can see that I say it is 40% (Samon).*

Some participants mentioned that they had not experienced challenging power dynamics with their healthcare professionals, such as family doctors, in Canada. However, they felt rushed and lacked enough time to discuss their health issues in detail during consultations due to limited appointment times. As a result, some participants expressed that they did not feel a strong connection with their healthcare providers. Interestingly, a few participants had no experiences to share because they had never visited the hospital or had no family doctor since arriving in Southern Alberta.

*So, yeah, like, he is listening, I'm saying almost all of what I want. But yeah, I'm just like, not feeling the actual like connection or care, maybe back and forth. Like, he is giving me the diagnosis or the prescription, the referral even, but yeah, I'm just not feeling that they have enough time with them (Aaric).*

*And it's like, um, everything now seems quite rushed. But as a person, you also understand that they also have other patients that they're taking care of. And there is still that patient-physician care, but it seems as if it's like getting less and less because of the number of people that need assistance, and the timing, too, is just short, if that makes sense (Sheba).*

*The Canadian doctor will Google whatever he may be showing you, your intestines, how they look, your eyes, how they look on the computer. He doesn't have this facility to show you. He will only be explaining to you, maybe drawing something on the paper, and so that relationship does exist. The cordial relationship between my doctor and me does exist. Just like here, the official is official. He will not attend to you if it's not official; you have to book an appointment to see him, and that is just the way it is. I don't have, unlike Nigeria, where I can call my doctor off record and say I will come and see you. We don't book appointments in Nigeria. I just asked if you are available, and he said yes, OK, I'll come and see you (Samon).*

The study revealed that participants' age and health knowledge also intersected to influence their relationship with healthcare professionals in Canada.

*I was still young, you know. It's like, oh, go and get this medication, you know? And if I did have questions, I'll ask, and you know, they would take care of me even though they have a lot of patients that they need to take care of, right? But now, as I'm older, I need to know what's going on because my body, right? But I would say that I'll say both of them are good in terms of patient-physician care. But like the time I would say for me, like now, because I have more questions, I'm more inquisitive, it's like less for me here, where I have more questions because I'm currently in Canada (Sheba).*

*When I was registering for school and stuff, that was my first time hearing that at my age, I can have a family doctor. So that's the first day I got exposed to family doctor stuff and everything, so I didn't really want to rush into it. When they asked me Oh, do you have a family doctor? I told them Oh, no, I don't have a family doctor. And then they said if you want to get one, they told me a few information about it, and then I was like, OK, I'll look into it. But I didn't think about it (Ceeja).*

The study findings identified the geographical location of family doctors as a barrier to accessing and utilizing healthcare in Southern Alberta. Many participants did not have family doctors because of a shortage. The available doctors were often far from their homes, and some participants lacked transportation to reach them. As a result, both the shortage of family doctors and transportation issues impacted some participants' ability to access and utilize healthcare in Southern Alberta.

*I don't have a family doctor. Yeah, so I've checked the doctor's acceptance list, I don't know what they call it, waiting list. Um, and the closest doctor that's taking new people that I know of, and since our last check, which was like 3 weeks ago, is further South, it's called Milk River or something. Anyway, it's like almost like an hour almost an hour away from here. That is the only person who's accepting new people. Everywhere else, like every clinic I've searched here, it shows on the network that they're not taking any new people (Sunshine).*

*I don't have a family doctor. Yeah, I think it's going to be a challenge for me, even if I get a car and I get a doctor right in Coaldale, there is going to be a challenge for me to be driving right now from here to Coaldale. Yeah, it's going to be a challenge, yeah (Johannes).*

Interestingly, some participants indicated they have never sought assistance from health professionals, such as counsellors or therapists, because of financial constraints and a lack of courage.

*No, I didn't seek any professional help when needed. Sometimes, if you want to get one, it will be like you have to pay some money to get one. All those kinds of stuff, those procedures and stuff like that, and to get the money to pay is difficult. You can't afford it. So, it's some sort of discouragement (Johannes).*

*I don't have enough courage to seek help, maybe that's me, that's everything, well, I didn't do well. So, I didn't have enough courage to tell anyone, to seek help, yeah, that's just it. It was difficult, I wouldn't lie to you, as most of the time I was sad, I was sad I was at home, I couldn't do anything, I was sleeping on my bed (Timon).*

Despite all the challenges associated with the shortage of family doctors in Alberta, only Sion was in contact with a medical doctor, who happened to be his nephew, in his home country, for medical advice.

*My nephew is a doctor, so I actually talk to him sometimes when I find I feel some body pains or something, then I'll explain the situation to him and he will be like, OK, this is the result. But even if he tells me this is what actually happened, I still go to the hospital. I don't really take medication the way I used to in Ghana. For him, because he knows, because he's in the health sector, he knows the implications of that kind of thing. So, he usually tells me, Uncle, go to the hospital. I know this is the situation, but it might be something different. So, I will still go to the hospital. He only gives me advice (Sion).*

Some participants experienced a power imbalance between themselves and their healthcare professionals, particularly physicians in their countries of origin, often preventing them from expressing themselves freely due to cultural norms or fear of being perceived as antagonistic. However, other participants described their relationships with healthcare providers as cordial and felt comfortable asking doctors questions about their health, especially when they had adequate health knowledge, privilege, social status, and confidence. Interestingly, some participants believed that some recent young healthcare professionals in their countries of origin lacked the passion for patient care compared with older, more experienced professionals, which hindered their ability to perform their duties satisfactorily. Some participants also voiced concerns about confidentiality, treatment, and negligence in their countries of origin. For instance, Samon (from Nigeria) and Kamon (from Kenya) discussed medical negligence in their

respective countries. Samon recounted a tragic incident involving a medical mishap that resulted in the death of his nephew, and the difficulty in holding medical practitioners accountable due to their influence in Nigerian society. Indeed, a 2020 study in Nigeria indicated that medical negligence is a significant factor contributing to maternal mortality (Adejumo & Adejumo, 2020). Similarly, a 2021 study in Kenya revealed that medical negligence led to numerous health issues, including misdiagnoses, surgical errors, and medication errors (Kyalo-Ikol, 2021).

Many participants described their relationships with healthcare providers in Alberta as generally cordial compared to those in their countries of origin. They highlighted differences in patient-physician relationships, access to doctors and medical care, and the ability to discuss health concerns freely without fear of intimidation. However, some found it difficult to form personal connections with physicians in Canada due to limited consultation times and a more formal approach to making appointments compared to their home countries. Additionally, some did not have a family doctor because of a shortage of family doctors in southern Alberta and long waiting lists to access one. As a result, they relied on walk-in clinics or school health centers for immediate care. This led one participant to continue consulting his nephew, a doctor in his home country, for medical advice. This is consistent with previous findings that some precarious status migrants treat health issues through unconventional methods such as self-medication and consulting with physicians in their home countries (Bendixsen, 2017, 2018). Some immigrants also maintain contact with their home country doctors due to additional barriers to healthcare access in Canada, including language barriers, longer wait times, lack of family doctors, a preference for culturally competent providers, religious or cultural beliefs about diagnoses and treatments, and high costs of uninsured private services like dental and eye care (Calvasina et al., 2015; Villa-Torres et al., 2017). Overall, participants valued open communication, empathy, and

accessible healthcare services. Consequently, many maintained good relationships with their healthcare providers, including family doctors in southern Alberta.

### **The Intersection of Religious/Cultural Beliefs and Healthcare**

This theme captured how religious and cultural beliefs influenced the participants' perception, access, and utilization of healthcare services. It highlights the complex relationships between faith, culture, and health, and how these factors influenced participants' healthcare choices, treatment adherence, and health outcomes. Many participants from diverse cultural backgrounds shared their views on the relationship between prayer, traditional medicine, and modern healthcare, and how they influenced their attitudes and behaviours towards access and utilization of healthcare. Some depended on prayer before seeking medical help, while others prioritized visiting medical doctors. The study revealed that cultural influences, family traditions, and financial constraints shaped participants' approaches to managing illness. While some trusted traditional medicine for its effectiveness and affordability, others stressed the importance of modern healthcare. Additionally, some reported that the use of herbs and home remedies was common in various African regions, especially during the COVID-19 pandemic.

*I just pray and I pray to God if I'm sick, God helps me to feel better. And uh, just like that, for my family's sake, I pray for them. God help them to feel better. Yeah, I believe in God. I believe that God is the one who does everything. Even if I go to the hospital. If it wasn't meant for me to stay, even though the doctor could try, and if it was my time to pass, I would still pass, but if it was not time for me and God didn't want me to pass, I'd still live a life. So, actually, for me, before I go to the hospital or if I'm sick and need to go to the hospital, I always pray first before I go. Yeah, I believe in God (Raisa).*

*Prayer and going to see the doctor coexist. But it doesn't mean, it doesn't mean I'm praying and I will not visit the doctor. No, like visiting a doctor and at the same time praying and hoping for recovery (Aaric).*

*I come from a very Christian background, not like, yes, we are religious, but we also like believe in God, like the whole relationship thing. So, yes, if you're feeling sick, there's the whole like prayer to say, like Lord help me to be well, you know all of these, all of this and that, right? But then maybe there's a level whereby I would use the natural products*

*like using like lemon tea or ginger or whatever; home remedies are not working, and not to say that the prayer is not working, but you can say that yeah, I need to go and see the physician. So, I'll say that to an extent did influence me, but still, like if my siblings were feeling sick, I would still take them to the hospital and still pray at the same time, so yeah (Sheba).*

Additionally, although the use of traditional/alternative medicine was popular in participants' countries of origin, it intersected with financial status, level of employment, health knowledge, and level of education to influence attitudes and behaviours toward access and utilization of healthcare

*I never used traditional medicine. But it is popular in Egypt. Like, my parents are just like they have finished higher education. They're working like a well-respected job, and so on. So, they are knowledgeable. So, yeah, this is their influence on me. Probably less fortunate people who are not probably educated properly or are easily influenced, like with like, natural healing, and something like that. These work, but I don't use them if I may say, yeah (Aaric).*

Some participants also used alternative or traditional medicine because they believed it cured illnesses like malaria and typhoid more quickly than Western medicine.

*I used traditional medicine to treat typhoid illness back home. It cures faster than the orthodox drugs. So sometimes, we feel like the orthodox drugs don't work as fast or quicker for us than the herbal, because the herbal is liquid, and anyhow you take it, you just use the washroom or you urinate, and then you feel better after. I think it's because of the culture, you know. So, where I grew up like we are used to that, and sometimes our parents even growing up my mom, for instance, she will add a mixture of ginger cloves, um, and you know, some mixture of things with some leaves grind it and even use it on you, sorry to say your anal or like using enamel syringe, yeah. I think is the culture, like when you grew up, it's not about age, and even till now, I still feel like getting herbal medicine to take one whenever I feel weak or feel sick, you see (Miss Brown).*

*Yeah, I have one woman. Let me say she's a specialist when it comes to those kinds of stuff. She prepares some leaves and cooks them like a liquid for you to drink when you have some, maybe stress, or malaria, typhoid, and all the likes. So, she's very good at that. So sometimes when you go through that stress or those symptoms, you try to get to her. Yeah. Give her a little money, and she would give you some herbs (Johannes).*

Additionally, because it was widely believed that any feverish symptom was related to malaria, some participants self-medicated or utilized traditional and alternative medicine.

*Because usually when we fall sick, we know it's malaria, so we won't. So, we just go to the chemist and get some malaria drugs and just drink them, and in two days you are OK. And nobody knows (laughing) you continue your life, yeah (Caesar).*

*I'm from the Yoruba tribe; we don't joke with our health. We don't usually go to the hospital for a checkup. Once someone is feeling feverish or whatever, everybody just assumes it's probably malaria or something; it's just something everybody does. So, I think it might be cultural because people just don't like going to the hospital. We have this native medication that is called Agbo, which, whenever you are sick, you can just take it. But as we grew older, we found out that we had to go to the hospital for a check-up because what is actually wrong with you might not be malaria. So, it's not good to self-medicate, and we have to learn that as we get older. But when I was young, my parents just self-medicated us. We just go to the pharmacy and get some drugs, and take them. So, age has a part to play because as we grow older, we start to learn that you can't self-medicate whenever something's wrong with you, you have to go to the hospital for a checkup (Timon).*

Although some participants expressed their belief in prayer and accessed and utilized healthcare, they never used alternative or traditional medicine or self-medication in their countries of origin due to limited exposure to these modalities or a preference for prescription drugs. However, all participants acknowledged that the use of traditional or alternative medicine was common in their home countries.

*I always had medicines like penicillin. So, I was never really exposed to herbal medications. I've always been like if I'm ever sick, it's mostly like a cold or the flu. I guess I do pray. But like the doctor is always there. I do better with medicine [Laughing] (Abira).*

*I've not used traditional medicine before, but I have met people who believed in those traditional medicines. I normally took the prescribed ones, yeah, we normally went to the hospital, yeah (Darion).*

*The use of traditional medicines is very common in my country. I react to a lot of drugs, so I don't try traditional/alternative medicine or self-medication. It's a no, no because of the way it happened. There were certain foods that I have been eating since I was born, there are certain tablets that were taken at a time in my life, I started reacting to them for that reason, except that the medicines were prescribed. Even paracetamol, I don't take it. That's me (Samon).*

Caesar believed in going to the doctor when sick for proper diagnosis and treatment, but not in prayer, even though he occasionally self-medicated or used traditional or alternative medicine.

*I don't believe that if you fall sick and you pray, you will get well, even though I've seen pastors healing people, but yeah, they still became ill. For me, if I'm sick, I do the necessary by visiting the doctor or going to the chemist to get some medications (Caesar).*

Some participants' attitudes and behaviours towards accessing and utilizing healthcare were influenced by cultural beliefs about mental health. Since they never felt comfortable talking to strangers (such as counsellors and therapists) and believed their problems were too minor to seek professional help, many preferred discussing their health issues with friends, family, pastors, and community leaders rather than formal support services like counsellors.

*It doesn't feel right to talk to strangers or something like that. Oh yeah, [Laughing], oh yeah, [Laughing]. That idea feels weird to me (Kamon).*

*My parents happen to be leaders in our church. So, that narrative of mental health, they tell you it's all in your head, just pray. It's all in your head, just pray. If you claim you're depressed, they tell you it's all in your head, just pray about it. There's no need to seek therapy, there's no need to go and see a psychologist. There's no need to seek people who are in that industry. All you have to do is pray, so that narrative was also pushed quite a lot, religiously (Talitha).*

Although some participants had good health insurance benefits, they used traditional/alternative medicine, self-medication, and Western medicine because of cultural beliefs.

*We use herbs; we use our natural resources to heal ourselves. Yes, no, there is no doubt about that back home. Sometimes when you're sick, um, your parents tend to, despite the fact that they will take you to the hospital, you know? Like my own family, my own siblings, first thing my dad would do, once you're sick, you go to the hospital and you know you get some treatment. And once you get back home, probably your grandma knows that you are sick, she comes from the village, and she brings a lot of herbs that you have to cook. They will tell you it keeps you stronger and everything, and we believe in those things because we see our grandmas, as you know. Because in the African society, we have this communal life and we believe in what our elders tell us, and so most times,*

*when we do that, it solidifies or probably gives us more strength, you know, using herbs. Also, growing up, after a while, you know, because of the level of my activities or probably the job, I don't have time to do all that. Mine is just to call my doctor immediately, OK, I have this, I have this, OK, can you do this and do that, and that's what I follow thereafter. And it literally works for me, but also I won't push off that because Agbo really works. Yeah, it really works (Marcus).*

Additionally, even though they had comprehensive private health insurance coverage, some participants still used traditional medicine influenced by age, proximity to healthcare facilities, and family beliefs. For example, some participants said they only used traditional medicine when they travelled to the village or when they were with their grandparents.

*I will say that when I was little, I used to go to the village for vacation to meet my grandparents (my grandfather and grandmother). I know when we used to fall sick in the village, you know, our grandparents always had these additional drugs, when you just have a stomach-ache or something, you just tell your grandma. She always has this medicine in the house, which he gives you, and the next one or two hours, you're good. So, I would say I used traditional medicine when I visited the village, but not when I was in town or city, and with health insurance. I had 100% health insurance. So, when I am with my mother, it is different because immediately I fall sick, she will just take me to the hospital, and I will have some drugs there (Caesar).*

*Yeah, that's why I said if the health facility is far like that, your mother, your grandmother, do traditional medicine for you and they give you something to help, to hold you for like some hours or a day until you go to the hospital (Raisa).*

Furthermore, some participants accessed and utilized healthcare in their home countries; however, their use of traditional or alternative medicine increased during the COVID-19 pandemic because there were no vaccines or other medical options.

*I used traditional medication too. So, usually when you catch a cold or you have the flu or any of those things, especially during COVID-19, because we didn't really have enough resources back home in Africa, like to take care of those diseases and all those pandemics. So, usually, my mother would make a concoction where they would put mint, lemon, and ginger, sometimes with garlic, sometimes without garlic; it would work either way, and we would try that. So that one is a concoction. Then we call when we'd put, um, water, boiling water, into a pot and would put lemon and maybe this other medication called a tsunami. It's sort of like a liquid, and it's very strong. It has a mint smell and it's very strong. And they'll put a Vicks rub and they'll put it in that pot that has boiling water and cover you up with a blanket. We call it Kunatira. And it's something that helps clear your throat, and clear your nose, and everything (Ceeja).*

*We have, like, I don't even know how to call it in English. Um, we have people who grow different herbs in their gardens in their backyard. Yes and then you don't even know what outcome these things are so you say I need something because I have a cold or my stomach or and you like me like me personally I don't like taking medication for anything but because I know those things work I will ask someone like always like some old lady in the neighborhood who cures everything and you would go there and ask can you please give me something for my cold or my stomach or something and I think especially during COVID people were just looking for alternative, alternative things cause it's something new and you don't know and then they will tell you take Vitamin D but you don't know if it actually works (Sunshine).*

*I used traditional medicine, especially during the time of COVID-19. Um, if someone got sick, going to the hospital was not an option; they would make you take, I know, for example, there was boiling water, boiled onions in water, or warm milk with turmeric, and all types of concoctions that were made during that COVID time. But going to the hospital was definitely not an option (Talitha).*

Although Sion acknowledged the importance of Western medicine, he explained that poverty and cultural beliefs influenced his use of traditional and alternative medicine and self-medication in Ghana.

*When I was in Ghana, sometimes, when you are sick or something, even though some people value Western medicine as it stands now, where I was living, we are still used to traditional medicine because that's what we are used to, and that's what we believe in, that it works better than Western medicine. Even though you would have public health insurance, it covers the basic things, most of the things you have to pay for yourself, and I can't afford it. So, I'll just consider local medications rather than going to the hospital, knowing that I can't actually afford the hospital (Sion).*

Importantly, Sunshine highlighted that it is wrong to generalize the African culture because Africans are diverse groups with various tribes, religious beliefs, and cultural practices.

*And yeah, you know, like this thing with Africa is there are so many different tribes and you can't just say Africa because we are all so different and all have different experiences, all have different faiths and beliefs and things and stuff, so even when you might just get a whole big diverse, what is it? Diverse? (Sunshine).*

Participants shared their views on health and wellness practices, including the use of traditional medicine, prayer, seeking medical care, and the stigma around professional help like therapy, reflecting a mix of cultural traditions and modern healthcare approaches. Many

participants mentioned that their pre-migration cultural and religious beliefs still influenced how they accessed and utilized healthcare services in Southern Alberta. For example, many continued to rely on traditional or alternative medicine and prayers for treatment and healing, including those who migrated to Canada at a young age because they believed these methods worked effectively. Additionally, many continued to seek help from informal support services such as friends, family members, pastors, and community leaders to discuss social and mental health issues because they felt comfortable with them. Many participants refused to seek help from formal support services such as counsellors because they viewed them as strangers, or their problems were not at the level that required counselling services, or due to a lack of exposure to formal support services. Cultural shock and differences in communication norms also influenced some participants' social interactions and their adaptation to the new and unfamiliar environment.

*Yeah, to this day, I still prefer to pray over something instead of just jumping straight to go to the clinic or a doctor. But if I know that this is too much or I've been seeing it for a consecutive number of days, I will still like, seek medical attention, like going to the health center at this university to get some assistance, or if it's like emergency, going to triage, but it's rare. I've really gone to triage and try to avoid that place as much as possible. Yes, I do use traditional/alternative medicine. [Laughing] I'll always do a lemon tea if I feel a cold coming, with honey (Sheba).*

*I just never grew up in an environment where I would go to a therapist, and it just gave me the mentality that I don't think I will need a therapist anytime soon, because I went through all those problems in Africa. But I'm still OK. So, yeah (Ceeja).*

*Yeah, I'd say culture for sure because of how I was raised. We are how we end up being like the people who, you know, brought us up. I'd say my environment and I never saw people from my family talk about a therapist or going to see someone, you know, and maybe that played a huge part in who I am today. Although I've had conversations about it with my friends, and sometimes they make sense, I'm still not convinced. And yeah, I'd say, um, maybe the culture, because I'd assume someone who was born and raised here wouldn't have the same opinion as me (Kamon).*

*My religious beliefs still influence me. Yes, it does. Um, if I do feel a little down, a little depressed, I do pray. I do pray and read my Bible a little. Just get some time with God before I even consider other options that are there (Talitha).*

Additionally, the continued use of alternative or traditional medicine, as well as self-medication, was driven by the belief that visiting the hospital was a waste of time since doctors rarely prescribed medication after the long wait in the emergency room, and due to the lack of culturally appropriate care.

*Yeah, I still use traditional medicine. Sometimes, I just feel, uh, I think I need to boost my immune system. I think I have um lemon, lemon juice, and lime juice in the fridge. I just boil hot water and I put them in it, you know? And just take it and you're fine, like you're just fine. Like, because the hospital you want to go to will still tell you to go chill or probably wait for some days for you to, but you know, because it's something we know. Even though we don't have access to some of those herbs, there are other alternatives like ginger, lemon, and you can put them together, boil them, or probably put them in hot water and just take it up, you know? So, I do that once in a while when I, yeah (Marcus).*

Some participants indicated that they would stop using traditional medicine once they get a family doctor, or that they had reduced their dependence on traditional medicine because of free healthcare in Canada.

*Yeah, when I first came here, I bought some from an African shop to treat my symptoms, and I felt relieved. Yeah, I feel it's urgent for me to get a family doctor. I recently applied for a health card, and I'm sure you should be in between today and tomorrow. So, as soon as possible, I'll just get a family doctor because I think I should put a stop to this self-medication thing, thinking that when I take those herbs, I will be fine, and you know. You know I've had that thing (using local herbs) since childhood, so that's what is really working on me still, but I think getting my family doctor will help me (Miss Brown).*

Interestingly, although Sunshine came from a family of healthcare professionals and acknowledged that they could give her better health advice than those of her informal social support networks, she never sought help from them due to personal choice, a lack of private health insurance, the lack of a family doctor, and the inability to pay out of pocket. She added that compared to others who need medical assistance, her challenges were minor. She also patronized the naturopathic shop in Lethbridge.

*I like going to the naturopathic. What is this shop called? Naturopathic shop. Yes. I like going there. Yes, I go there. [laughing and laughing. I don't think my issues need professional help. Because I don't think that a professional can help me with my issues [Laughing]. I feel like, yeah, it feels different to speak to a stranger when you think that. Like, I feel like my problems cannot be solved by a professional person, and I just need someone to talk to. I don't even want to speak to a stranger, let me just say that. I know, like a counselor; that's their profession, and they will probably give me better advice than the people around me. But I feel like I prefer [laughing] people I know over someone I don't know (Sunshine).*

*I think I will pray first before seeking medical help [laughing]. I'm not really desperate now, like I can't do anything else. I don't think it's a cultural thing because my family members see psychologists and stuff like that regularly. Yeah, so I think it's just personal preference. I think other people have bigger issues than me [laughing]. I feel like my problems aren't that huge that I need to seek out a counselor and especially if I need to pay someone. I don't have medical insurance, and I can't just pay out of pocket to go speak to someone, listen to me, when somebody else can, just sit still and listen to what I have to say. Maybe it is because I don't have a family doctor (Sunshine).*

The study revealed that cultural differences also influenced some participants' communication and social interactions with Canadians. For example, some participants mentioned that the cultural norms of maintaining eye contact during conversations and calling the elderly by their first names influenced their interactions with Canadians because these behaviours were considered rude in their cultures of origin.

*The culture shock was also quite different cause to communication with adults. Back home, you know that you don't call an adult by their first name if they're not your parents or if they're not your grandparents. You call them auntie and your uncle. But now, having to call the professor by their first name was kind of a culture shock for me. To this day, I still can't do it. So yeah, those are just, yeah, a few of the challenges that I faced. Where I work, they always have a problem with me not being able to maintain eye contact. So, they consider it rude that I don't maintain eye contact, but back home, maintaining eye contact with an adult is a sign of challenging them. So, it's something that I'm still trying to get used to as well (Talitha).*

The terms "religion" and "spirituality" are often used interchangeably; however, they are related yet distinct concepts. Religion refers to an organized activity based on traditions, scriptures, rituals, and sacred spaces, including churches, mosques, synagogues, or temples (Musgrave et al., 2002). Spirituality, on the other hand, is difficult to define but generally refers

to “a basic or inherent quality in all humans that involves a belief in something greater than the self and a faith that positively affirms life” (Pederson & Pederson, 2023). Based on these definitions, one can be spiritual without having any religious affiliation or connection to an established organization. Although the participants held diverse religious views and beliefs, they all shared a belief in a higher power or a supreme being. One participant stated, *“You know, like this thing with Africa is, there are so many different tribes, and you can't just say Africa because we are all so different, and all have different experiences, all have different faiths and beliefs.”* Some of the major religious groups in Africa include Christianity (such as Pentecostalism, Evangelicalism, and Catholicism), Islam, and African traditional religions, which are practiced by tribes, such as the Asante of Ghana, the Dinka of Sudan, and the Orisha of Nigeria. Many studies support the restorative effects of religion and spirituality on mental, emotional, physical, and spiritual health (Koenig, 2012; Park et al., 2012). Therefore, many participants migrated to Canada with their pre-migration worldviews and cultural identities, which informed their beliefs, worldview, approach to health, and their coping strategies.

According to sociologists, culture involves the values, beliefs, language systems, communication methods, and practices shared by a group of people. However, culture is not static; it constantly changes, is often challenged, and is redefined as individuals interact with their environment (Kasturirangan et al., 2004). While some participants adhered to their home cultural identities and worldviews, including longstanding religious beliefs rooted in their strong faith and spirituality, others adapted to Canadian culture and incorporated aspects of it into their beliefs, lives, and practices. Notably, the social and religious lives of many participants were closely interconnected, resulting in the establishment of immigrant cultural and religious communities in Canada. These communities and religious institutions, such as churches and

mosques, help preserve immigrants' cultural and religious identities, which can promote positive health outcomes for those participating in religious activities (Biney, 2011).

Many participants acknowledged that one source of cultural continuity was the use of traditional or herbal remedies to address health issues, as was a common practice in their respective countries of origin. Engagement with these traditional or herbal remedies was influenced by multiple factors, including limited income and financial resources, and cultural and religious beliefs. Although the term complementary and alternative medicine (CAM) is often used interchangeably with “alternative medicine” and/ or “complementary medicine,” the WHO (2013) defines CAM as medical procedures that are not a part of or fully incorporated into a state's or nation's conventional medicine and dominant health care system. Johns Hopkins University defines Traditional Medicine (TM) or CAM to include acupuncture, ayurveda, homoeopathy, naturopathy, and Chinese or Oriental medicine as a distinct category under the definition of CAM, body touch (osteopathic and chiropractic medicine, massage, body movement therapies, Tai chi, yoga), diet and herbs (dietary supplements, herbal medicine, nutrition diet), external energy (electromagnetic therapy, Reiki, and Qigong), mind (meditation, biofeedback, and hypnosis), and senses (art, dance, music, visualisation, and guided imagery). Despite the World Trade Organization’s (2022) emphasis on the significant contribution of traditional medicine, including the prevention and management of chronic diseases in many communities, it has received less recognition in many developed countries, including Canada, which has emphasized Western allopathic medicine as the scientifically backed gold standard of care. It is worth noting that the Indigenous peoples around the world have used traditional medicine since time immemorial for the prevention, diagnosis, and treatment of mental or physical illness, and the maintenance of overall health and well-being (WHO, 2019). African

traditional and complementary medicine practices have their roots in local belief systems and religious and spiritual contexts (Pederson & Pederson, 2023). Participants who used natural or herbal remedies in their respective countries acknowledged their effectiveness and the ingrained cultural and religious beliefs that accompanied this approach to supporting health. Some participants acknowledged the coexistence of traditional supplementary medicine with Eurocentric medical concepts in many African countries. For instance, there has been mounting pressure on policymakers to develop policies that incorporate traditional or herbal medicine education into medical school curricula in some African countries, including South Africa, due to the extensive use of herbal medicines (Chitindingu et al., 2014).

However, some participants never used natural or herbal remedies due to limited exposure, family values, and their beliefs. Many participants' pre-migration attitudes and behaviours towards access and utilization of healthcare were influenced by their home countries' approaches to health and wellness, which were rooted in their religious, cultural, and spiritual beliefs and practices related to prayer, traditional medicine, modern healthcare, and interconnectedness. While some participants prioritized prayer alongside medical treatment for healing, others relied more on CAM because of cultural, religious, spiritual influences, or financial constraints in their home countries.

Recently, there has been an increasing awareness of CAM, as it has become an important part of some patients' healthcare in Canada (Canizares et al., 2017). Although conventional medicine remains the primary source of healthcare in Canada because the biomedically-focused Canadian healthcare system does not fully recognize CAM for healing and treatment, some people prefer CAM, such as massage therapy, homeopathy/naturopathy, or acupuncture, for wellness and treatment (Bishop & Lewith, 2010; Canizares et al., 2017). Influenced by their

cultural background, personal experiences, and religious beliefs, some participants continued to use traditional remedies, such as lemon tea, hot water with Vicks for steam, and self-medication with homemade mixtures to manage certain ailments. These participants preferred CAM over Western medicine and immediate medical intervention. These findings consistent with previous research suggesting that that CAM use is influenced by multiple factors, including individuals' social networks (friends, teachers, neighbours, and parents), geographic location, culture and media, online health information, and personal traits (e.g., age, gender, holistic outlook, open-mindedness, health status, and openness to new approaches) (Millar, 2001; Patterson et al., 2008).

Although not covered by provincial health plans in many provinces, holistically inclined adults are more willing to choose CAM despite its cost, underscoring the importance of the mind in the healing process (Neiberg et al., 2011; Patterson et al., 2008). Additionally, individuals living in Western Canadian provinces are more likely to use CAM than those in Eastern provinces (Millar, 2001; Patterson et al., 2008). Furthermore, some studies suggest that CAM use is influenced by an individual's desire for increased life expectancy and the high costs of conventional medicine, treatments, and medical care (Rojas et al., 2022). For example, many countries approve acupuncture as a form of pain management for cancer patients (Deng et al., 2018), yet it remains uncommon within the Canadian healthcare system. Moreover, several studies show the safe use and effectiveness of Chinese herbal therapy in managing cardiovascular disease (Luo et al., 2013).

Despite pre-migration beliefs and practices supporting CAM and traditional medicine, some participants changed their pre-migration attitudes and behaviours and accessed or utilized Western health and social services when needed, or worked to improve their access to and

utilization of healthcare professionals, including family doctors. Overall, participants discussed different approaches to managing health and wellness in Canada. While some combined traditional practices with modern healthcare options based on personal beliefs and experiences, others temporarily relied on herbal remedies or over-the-counter medications due to limited healthcare access and financial constraints. Interestingly, cultural shock and adjustment challenges related to healthcare delivery were also discussed, such as addressing adults by first name and differing norms around eye contact, which influenced their social interactions.

### **Environmental Impact**

Many participants shared various pre-migration environmental challenges that influenced their health and well-being. These included overcrowding, extreme heat, traffic, pollution, high living costs, a lack of basic social and health infrastructure, the high expense of transportation to access healthcare, preventable diseases like malaria, limited space for physical activity, terrorism, unequal opportunities, the effects of COVID-19, and adverse economic conditions.

*It's, it gets kind of hot. Very, very hot, like in the summer. That would be considered a challenge to many. Also, priority is the density, population density. Opportunities are not well distributed across the states. Cairo and Giza, obviously, the greater Cairo, like the Metro City, Cairo. The opportunities, yeah, mainly opportunities are there, so people just move their lives from the smaller cities into Cairo, so Cairo is very, very, very crowded and busy. The density is unbearable. So yeah, Crowdedness would probably be a big thing, a big challenge (Aaric).*

*Mental health may be a little bit. And I think a lot like COVID had something to do with it. Um, because everything was fine, and then COVID came, and we had like job cuts at work. So, there was a lot more pressure at work, but we had to adjust to our organization, and eventually, you kind of deal with it. You get home like tired, so you just feel more tired than before COVID, and I came here like just as COVID was ending (Sunshine).*

*The traffic was a problem. The basic infrastructure. I had my car, and I drove to and from work. So, just imagine so many hours were wasted. I had to leave the house by 5 am for work, I was supposed to resume at 8:00, so that I would not go and stay endlessly in traffic. So, it is the general, I think I'd better put it that way, the general infrastructure and way of life that gives you the comfort you desire, are not there. Yes, that's just the truth (Samon).*

Some participants stated that one of the major pre-migration challenges was the unsanitary environment that contributed to the spread of preventable diseases like malaria and typhoid.

*I think one of the things I also give to them is that there are no mosquitoes. There are no mosquitoes here, but in Africa, mosquitoes, ah! ah! mosquitoes will bite you, right? Like, seriously, mosquitoes will bite everything about you, [laughing] like you can just imagine. Like every day, the level of insecticide you have to buy, like, you know, keep the house clean, make sure everything is tidy, you know, and you're still getting mosquitoes from your surroundings, maybe because your neighbor is not clean or something, you know, that impacts our health (Marcus).*

*Yeah, when I was back home, I remember I used to be sick sometimes due to my environment, especially with little infections like malaria and other stuff. I think when I changed the environment and came here, there was a little bit of change. I'm not that sick, yeah (Johannes).*

Additionally, Samon reported that his main environmental challenge was the terrorist activities in Nigeria, which influenced his decision to migrate to Canada.

*So, I was in the office by 6 am, listening to the radio, and the news came that the militants of Boko Haram had entered the Defence Academy in Kaduna. This thing I am telling you is not a secret, as the day that thing happened. If you Google it, you will know the day. So, that was the day I said, Wow, it's no longer safe for us to remain here for too long. So, what had happened then struck me that I needed to move. The first thing that came to mind was to let me move my family to safety, even if I was going to remain in Nigeria. So, you see, for those who know me before that time, the issue of traveling was never in my equation. So, at that time when I listened to that news that morning, I didn't know where I was going, how I was to go about it, I didn't know. What did I do? I picked up my phone, called my former colleagues, called my friends, those that, um, I had at that time, and some of my colleagues had their roots in Canada. Earlier, a lot of them moved their families, even when they were remaining in Nigeria, to Canada (Samon).*

Nevertheless, some participants mentioned that despite the environmental challenges they experienced in Africa, the quality of organic food there contributed to their overall improved health and well-being.

*I would say just, um, the food quality. I'll say that that was a very good thing that made me remain healthy, you know, the fact that fruits and vegetables were in abundance, and whatever season you're in, you get very good quality fruits. Even though I was not exercising as much because I was not inclined to do any physical activity at that point;*

*just doing home workouts, um taking my siblings to school, or just running errands that were sent by my parents, in the sense of just going out here and there, not like going out and partying, but just taking a drive here and there that that was very good for my I would say my health and well-being before I migrated (Sheba).*

*Africa has the best food. Africa or sub-Saharan Africa has the best food because they are, they are not, they don't have some level of chemicals added in them, you know? So, they have good, healthy foods. So, most times we tend to eat good, healthy food at home. So, and then also you must be able to have some level of comfort within your house, those are things I call health for me (Marcus).*

Some post-migration environmental challenges included transportation challenges, concerns about food quality, housing, high cost of living, adapting to cold weather, and the challenges of learning to navigate a new country.

*And yes, I think we just always have changes. I think that is worse than you like initially, just the fact that you are coming here and starting in a new environment. New everything and then now you still need to keep up to date with all that, and it's not like they say stuff and it's only going to be effective in a year or two years' time, it's like tomorrow it's going to change, that's stressful, yeah (Sunshine).*

*The first one is the weather, for sure. That's a very big blow for me when I got here because I remember I used to walk, and I used to take the bus to walk around, it took me like an hour, and so it was really hard. Looking back, I don't know how I used to do that (Kamon).*

*And one of the things I'm also worried about is that there is organic food, and you have non-organic food. Those non-organic foods are just my few concerns because there are a lot of chemicals in them, you know, in the germination of all those fruits. I couldn't understand that in the first place, when I came in, because I just saw that there were some foods that were more expensive than others. And I'm trying to look at what the reason is, what is the reason, you know? But it's not like that back home, we have majorly organic foods back home because we have good farmlands and, um, the like (Marcus).*

Although the idea of environmental determinants of health is relatively easy for most people to understand, accessing information about environmental health and how to reduce potential exposures and risks is often difficult (Jagals et al., 2022). Large-scale environmental issues, such as natural disasters and climate change, are known to have significant observable impacts on health (Jagals et al., 2022). These environmental factors are usually better known and

understood because they have garnered broader advocacy and more public attention (Jagals et al., 2022). However, infectious and non-communicable diseases are often influenced by more subtle and local environmental conditions, circumstances, and agents. As a result, these factors are frequently overlooked, underestimated, or misinterpreted, leading to societal decisions that may worsen rather than help decrease these harmful environmental effects (Jagals et al., 2022).

Participants experienced various pre-migration environmental conditions that adversely impacted their health and well-being, including overcrowding, heavy traffic, transportation shortages, poor sanitation, exposure to preventable vector-borne infections like malaria, air pollution, and the high cost of living and healthcare. Additionally, some experienced safety issues, including exposure to terrorism, which motivated their migration to Canada to ensure safety and well-being for their families. Despite these challenges, some participants believed that their health and well-being were positively impacted by access to quality food and a healthier environment in their country of origin.

In Canada, participants experienced numerous environmental challenges, impacting their health and well-being, such as adapting to harsh winter weather, overcoming communication barriers due to accents, dealing with transportation issues, managing the high cost of living, addressing discrepancies in advertised accommodations, understanding unfamiliar job market realities, navigating differences in food quality and prices, and adjusting to different societal norms, including communication styles. Despite these obstacles, participants adopted various coping strategies to manage these challenges, highlighting the resilience and flexibility required to settle successfully in Canada.

## **Chapter 7: Persisting Precarity**

This chapter discusses the transition of some participants from one precarious situation to another by drawing on the words and experiences of precarious African migrants to Southern Alberta. This pattern of experience was particularly evident among international student participants and was influenced by the likelihood that more participants will fall out of legal status due to the constantly changing immigration policies. This chapter explores participants' pervasive and enduring transnational experience of precarity, highlighted through themes such as migration uncertainty, semi-legality, age and agency, gendered health experiences, transnational experiences of discrimination, employment opportunities, money matters, life course backsliding, and it takes a village to survive. Although the study sought to capture the breadth of experience within the diverse group of African immigrants with precarious status in southern Alberta, there was greater representation of international students and temporary foreign workers in my sample. Therefore, these findings are particularly relevant for these populations, which is a valuable contribution given the number of international students in Canada, and the shifting government policies that will likely contribute to more of these students falling into precarious status. The study revealed that precarious migration status significantly influenced the health and well-being of international student and temporary foreign worker participants because it intersected with other social determinants of health, including age, gender, racism and discrimination, employment, income, religious and cultural beliefs, health knowledge, and social support networks.

### **Recent Immigration Policy Shifts**

Notably, recent reforms introduced by Immigration, Refugees and Citizenship Canada (IRCC) have altered the framework regulating international students in Canada. These changes

reflect broader government objectives related to sustainable population growth, housing and infrastructure pressures, labour-market demands, and protecting the integrity of the international student program (Immigration, Refugees and Citizenship Canada (IRCC), 2024). One of the most significant reforms is the establishment of a national intake cap on new study permits. Starting in 2024, the federal government implemented a cap on most new international student permit applications, leading to fewer permits approved compared to previous years. By 2025, the annual cap was set at 437,000 permits, approximately a 10% decrease from the previous target (CIC News, 2025; IRCC, 2025). To enforce this cap, IRCC now requires most international students applying for a study permit to submit a Provincial/Territorial Attestation Letter (PAL/TAL), confirming they are included in the provincial allocation. This requirement was gradually introduced beginning January 22, 2024 (CIC News, 2024; IRCC, 2024). The PAL system effectively decentralizes admission quotas, granting provinces and territories significant control over the number of international students they accept (CIC News, 2024; IRCC, 2024). Along with permit caps and attestation letters, IRCC has increased the financial capacity requirements for study permit applicants. As of January 1, 2024, applicants must demonstrate sufficient funds to cover living expenses in Canada (IRCC, 2025). Work permit regulations for students have also been revised. As part of the regulatory changes effective November 2024, eligible international students are now permitted to work up to 24 hours per week off-campus during academic terms, up from the previous limit (CIC News; IRCC, 2024). Perhaps most critically, the rules governing the Post-Graduation Work Permit Program (PGWP) have been tightened to better meet Canada's labour-market needs. Under changes effective September 1, 2024, students enrolled in programs delivered through certain "curriculum-licensing" (public-private-partnership) arrangements are no longer eligible for a PGWP upon graduation (IRCC,

2024). Moreover, the PGWP eligibility criteria now emphasize “field of study,” aligning with labour shortages, which limits access for graduates of many diploma and certificate programs (CIC News, 2024; IRCC, 2024). IRCC has also set language proficiency thresholds for PGWP applicants, such as requiring a baseline Canadian Language Benchmark (CLB) level for some graduates (CIC News, 2024; IRCC, 2024). Similarly, eligibility for open work permits for spouses or common-law partners of international students has been restricted. Starting with the 2024 reforms, only spouses or partners of students enrolled in master’s, doctoral, or designated professional degree programs remain eligible; those of undergraduate or diploma students are no longer qualified (IRCC, 2024). These changes mark a shift in Canada’s immigration and education policy: moving away from broad enrolment growth towards more selective admissions, labour-market needs, and managing temporary resident flows. The reforms also reflect growing concern over socioeconomic pressures, such as housing, infrastructure, and services, associated with the rapid expansion of the international student population (CIC News, 2024; IRCC, 2024).

### **Migration Uncertainty**

Some participants reported facing challenges during their migration processes, such as visa application denials, difficulty securing financial sponsors, longer processing times, missing documents, high costs of immigration consultants' services, trouble contacting IRCC, and limited knowledge about visa procedures. Conversely, other participants stated they did not encounter any issues throughout their migration process. Even though these stressful pre-migration challenges adversely impacted their health, the affected participants remained resilient and stayed committed to their migration goals.

*I haven't been refused before and the process was actually easy since I am myself, um, like I'm an academic myself, so I'd like to I just like to research stuff. It's kind of a hobby*

*to like reading and stuff. So, like immigration websites, the IRCC website is actually very well documented, with those articles following frequently asked questions. Each process and each requirement are detailed in there. Um, um, so yeah, applying for the visa was not like an issue for me or a huge problem. And I think I got the decision for my application relatively fast. So yeah, it was just like a positive experience overall (Aaric).*

*I was denied because of a lack of supporting documents that I had, but because I did not know that those were required, it made my application look inadequate; hence, I was denied. However, I was still able to reapply because, in the letter of denial, they said that I could still reapply. So, since I was given that opportunity, I went to get more research from other institutions back home in Zimbabwe that do the application process for students. So, when I was able to get all of the information, I was able to then reapply, and hence it was accepted (Sheba).*

*We were refused the visa the first time we applied. Then we were granted the visa when we reapplied. We all did the medicals together, you know, IRCC, you're talking to somebody you cannot see, the hospital in Nigeria, too, was not friendly, was not forthcoming to say whether they submitted the forms, the only thing they say, we have submitted, we have submitted. Meanwhile, the IRCC is saying that they can't see it. So, we have to, I have to do another medical before they issue my visa. So, I think, all this visa application process got completed sometime around late October or early November. So, we had November and December to prepare for our coming, to resume in January (Samon).*

According to some participants, the supporting documentation for Canadian international student visa applications, which requires applicants to demonstrate enough funds to pay for a year's tuition, is misleading because it does not reflect the actual financial challenges many students experience in Canada, resulting in school dropouts, stress, frustration, and depression.

*With IRCC, once they give you your estimated tuition fee for one year, you need, let's say \$1,000, \$10,000, they expect you to come in with that money. The impression it creates is that for the student coming in, by the time you come in for the first year, you will be able to get something to sort yourself out for the second year. To the best of my knowledge, in their requirement, you are not expected to show that you have money for years one to five when you are coming. But based on what is obtainable now, no student can work for money to pay for their house rent with a 24-hour-a-week job. So, they're saying that they should drop out of school. That's what they are just saying, and that's what it means. I think there should be a better way to attend to those things. I know what they said is that students are abandoning their courses (Samon).*

After migration to Canada, the constantly changing immigration regulations and landscape caused stress, anxiety, feelings of failure, frustration, and fear related to uncertainty,

which adversely impacted the health and well-being of many participants. Although some participants initially chose the “study” migration pathway because it was perceived as the easiest and fastest route to regularize their stay, some expressed regrets about their decision due to recent changes in immigration policies for students in certain fields of study, which limited their path to Permanent Residence (PR). Moreover, these ongoing changes in immigration policies impacted participants differently depending on their unique combination of migration history, age, income, gender (including personal goals such as childbearing), field of study, employment type, awareness of new immigration policies, and intentions to return to their home country. Importantly, these policy changes created barriers for participants pursuing permanent residency in Canada, impacting their health and well-being due to uncertainty about their future in the country.

*The new immigration policy change impacts me. I don't think it's guaranteed in any way. I think it's a big gamble, especially now that they've changed the policies. Eei!!!, yeah, I'd say it's, aah!! Tricky. Yeah, I'm also trying to get my permanent residence, and yeah, sort of feel stranded, so yeah, I'd say there's no sure bet to getting it. I don't know, but my plan is not to stay here for the rest of my life, but if I'm going back home, I also [laughing] want to go back home on my own terms, for sure. Um, I'm trying to get a PR right now. I finished school. And um, yes, I haven't found a clear opening for me to do that, and yeah, with time you start thinking about it and you start thinking about what if you don't get it, and yeah, I'd say [laughing] it's not much, but it's something. Gaining permanent residence is not easy, yeah. It's not straightforward (Kamon).*

*Well, some of the challenges are sometimes the immigration policy changes that they make. Yes, it really affects my mental health specifically. Yeah, some decisions, like student restrictions and those kinds of things, are really very challenging. It's stressful sometimes, and you hear some of the decisions you start to think about, oh, so how am I going to go about this, and it makes life really tough for me personally. Yes, to be honest, because right now when I'm there I think a lot because I feel like, OK, now students are being restricted for this number of hours and we know all that if you go beyond working those hours, it will affect your future in the sense that when you're applying for PR they can use that against you, for you to be denied. So, I'm confused, I'm thinking, I don't know what to do, should I work and later when I'm applying for the PR and they refuse me then I know OK I've worked, or should I follow the exact hours that I'm supposed to work and maybe I wouldn't be able to pay my bills and whatever that happens, should*

*happen, or what should I do? So, it's kind of a confusing thing; it's really draining me a lot because whenever I wake up, that's what I think about (Sion).*

Additionally, some participants' health and well-being were impacted by their family members' visa application denial. For example, Marcus shared how his family's visa rejection impacted his health and well-being due to a lack of social support in Canada.

*Like I said earlier, they rejected the visa for my family. It's mentally draining, it's emotionally draining. To be sincere, these things are not what we expected. And those things have caused a lot of mental health challenges. To myself, because there are some of these policies that are literally affecting me. Because when you are separated from your family for many years, and the country in which you stay is giving you stricter policies day by day, year by year, not even considering those who had their genuine reasons for things, you know. It's really impacted me a lot. Yeah, I'm African and I'm built into family, we are family-oriented, we are communally oriented, but here they're not communally oriented. So, sometimes you just want your circle, you want the free flow of communications you have, you know, those are the things. However, we are trying as much as possible to also look at various associations that will not make you feel bad, you know, and also try to extend the love to other African brothers and see how things could literally go. But to be sincere, it has some mental issues; it has taken a serious toll on me, particularly my mental and emotional health, yeah (Marcus).*

Many participants reported that the pathway to permanent residence was not straightforward due to constantly changing immigration laws, which adversely impacted their health and overall well-being because of fear and uncertainty.

*[Laughing loud] Uh-huh. It's not. In fact, I'm trying to fill out an application now for this, uh, AAIP Express, whatever. This pathway to PR is zigzag. At this moment, it is not straightforward at all. These new immigration policies impact my health. Sure! Sure! [loudly]. If you understand the gravity of this pathway, I think it's heavier than we see. Like we tend to play it down. I came here for the safety of my children and myself. So, with all the current immigration policy changes and pathways, what is my guarantee that I'm safe? So, whether it is impacting my health, not only myself, it's impacting the health of every person in a similar situation. The greatest enemy of man is fear. OK, there's nothing that creates fear like uncertainty, yes. The greatest enemy of man is fear. When you don't know what's next, it is killing (Samon).*

*I think mentally it's affecting me because I felt ahh!! Um, let me say I feel like I failed in some way. Although I know it's not my fault, I still feel like a failure. Also, because I didn't actually want to do it, I went to the refugee pathway, but there was nothing I could do. So, because of that, I feel bad, and I usually feel like, um, I don't know, it's just that it's been difficult for me, yeah, but there is nothing I could do. It was a time when I even*

*thought I would be going back to Nigeria, because I was devastated throughout the summer, because my study permit had expired, and I couldn't get a job. I needed the money from summer work to pay for my tuition fee. So, if the work is not coming even if my study permit is eventually approved, how am I gonna receive funds to pay for my tuition fee? So, all these thoughts were going on in my mind. I was frustrated. I was just hanging in there. It was a difficult summer for me, and my employer was also disturbing me about my status because I told them I applied for the extension of my study permit, and I gave them the confirmation letter from IRCC, and they were expecting me to give them feedback. So, I didn't for a long time, so that was playing on my mind, and also I couldn't get another job because I was just working like two days a week. I needed more hours so that I would get more money to pay for my tuition fee. All those things were playing on my mind, and it really affected my mental health (Timon).*

Some refugee participants also reported that they lacked an Alberta health card due to lengthy bureaucratic migration processes, including extended application times, which influenced their access to and utilization of healthcare.

*I came here as an asylum seeker. It took me a while and a lot of processes to go through. I was almost like, Oh, is it how it's going to be? But I thought about it and said to myself, it is a system we need to follow. So, I think I finally got that. Now, though I'm still waiting for my hearing, I keep talking to my lawyer, and every time he tells me that immigration has not said anything yet. So, it's also a challenge for me. I'm also worried about it. My only challenge for now is just this issue of documents that I'm waiting for my hearing, the length of it is too much. I know it's the Canadian rules and part of the rules and regulations, I see it as necessary, but to me, it's too much. I've been waiting for it to come so I can get my health card as well, yeah. And also, if my hearing comes, I can apply for my health card, and I can see if I can apply for my family to come. So, I can see them as well (Johannes).*

Because family members offer support, some participants viewed the new immigration policy as discriminatory because it permitted graduate students to sponsor their families into Canada but denied undergraduate students the same privilege.

*To me, it doesn't make sense. Someone who's taking a master's can bring their partner, but someone who is doing their undergrad cannot. It doesn't make sense, and there's no logic behind it. Yeah, people bring their sponsors for support, you know, this makes it easier for you when you have someone, someone supporting you. I think it's really inconsiderate to do that, and I honestly think if they can't just treat immigrants well, they shouldn't even give them their visas to come here (Kamon).*

Additionally, partly due to restrictions on student labour hours and income, some participants indicated that the recent immigration policy changes and increasing tuition costs had disrupted their financial situation and goals. Many believed that the new immigration policy should have targeted new immigrants rather than those already in Canada.

*Also, financially, in terms of tuition, tuition fees, we see, I think, the university also increases its fees each year or so. For me, if that will increase fees, it shouldn't affect everyone. It should affect those who are going to start at that time they're increasing the fees. Because why will I leave my country knowing I'm supposed to pay \$21,000 per year, and because I'm doing maybe a four-year course in my third year, I see myself paying 25,000 or so, like it's not normal, yeah (Caesar).*

While some participants' temporary migration status remained the unchanged, others experienced a change from one temporary status to another: from student permit holders to post-graduate permit holders, refugees, or asylum seekers. Due to evolving financial challenges, Miss Brown and Timon, who arrived in Canada as students, were now requesting asylum, which illustrates how evolving circumstances can easily disrupt initial plans. The effects of migration status changes were experienced differently by those affected. For example, while Timon quietly cried in his room to cope with his migration challenges to protect his masculinity and avoid ridicule from peers, Miss Brown accepted her new vulnerable migration status and its challenges and hoped for a better future.

*I didn't actually discuss any of this with anybody. My status recently changed from a study permit holder to a refugee. When I was at my climax and everything was not going well, I would just go inside my room and cry because, um, it was difficult and I couldn't tell anybody. Who do I want to tell that my study permit was denied? Before you know it, everyone will start saying it. So, I just came to myself, I didn't seek any help from anyone because I didn't know. Um, I was going through a lot then. It was just the support I got from my mom and my dad, who were just calling me every day asking: How are you? Is everything going well? You don't have to think about it. So, it was the same social support I have back home that really helped me. There is no professional help anyway. I don't have enough courage to seek help, maybe that's me, that's everything, well, I didn't do well. So, I didn't have enough courage to tell anyone, to seek help, yeah, that's just it. It was difficult, I wouldn't lie to you, as most of the time I was sad at home, I couldn't do anything, I was sleeping on my bed. There was no job, only days of work in a week, and I*

*was looking for other jobs. I knew that if I applied for other jobs, they gonna ask me for my study permit, so I couldn't apply, so I would just hang in there (Timon). I've changed from student to being a refugee claimant. However, approval depends on what your asylum claim is. So, you have your facts, and you think your facts are on point. Yeah, I think Canadians are people who really think about humans. Um, they really think about humans and their freedom. So, if you have your facts, I think, yes, your way to getting PR is, it's 90%. My status now impacts me in a way, yeah. I was thinking about it before then, you know. I've been thinking about it. But after I think about it, I'm OK. I think it's not even something to be really scared about, like I was, and I feel that I'm now being protected more, like I'm OK, I'm in safe hands than before, yeah (Miss Brown).*

The new immigration policy changes impacted participants differently depending on their intentions to return home, financial support, or fields of study. For example, some student participants who planned to go back home after their studies experienced the impact differently from those who intended to stay in Canada but enrolled in programs that do not qualify for a PGWP and a pathway to PR. Additionally, some participants said that the new policy changes did not affect them as much because they were either financially supported by their social networks, were in STEM programs, or had no plans to settle permanently in Canada.

*Honestly, the new immigration policy changes do put a little pressure on me. But not that much because you know my sister financially supports me here. So, I'm not really struggling that much, yeah, because she supports me a lot. Yeah, yeah, so yeah (Darion).*

*Although the new immigration policies don't impact me because I'm in the STEM program, like I said earlier, for me, when I finish school, I really plan to go back home and see how I can be of help to my country, yeah (Caesar).*

*I'm in the STEM program, so I'm not affected much by the immigration policy changes. But I feel like it's actually overwhelming in a way because of this situation, because many students are hoping for a better future, and everyone is hoping to maybe, some are hoping to stay here, some are hoping to move to a different country, some are hoping to go back home. (Ceeja).*

Some participants believed that the new immigration regulations would cause many students who had planned to stay permanently in Canada but are now ineligible for the PGWP to have their plans disrupted. They argued it could lead to an increase in immigrants with precarious migration status in Canada if returning to their home countries is not a viable option.

Additionally, some participants mentioned that the new policies might force some students to enroll in programs they never initially desired to meet the PGWP requirements.

*I feel like it's a very hard thing to take in because for the students who want to stay here so badly, but they're studying something that's not in the healthcare system or anything that has been put up by IRCC, it's going to be so hard for them. They're going to start wanting to get into degree programs they did not want to do in the first place. Some are going to force themselves to try new things that they never dreamed of. So that's going to divert them from their dreams and want to improve themselves in whatever way they choose (Ceeja).*

*Um, I feel like that takes for some people who had the intention of going through that route when they first came to Canada, I feel like that would be stressful for them. Because people would have come here with plans and intentions and goals, and then for it to change, while they're halfway through, or maybe someone is just about to graduate, and then the rules change like that. I feel like that would be, that would be a lot to take in (Talitha).*

Some participants indicated that the changes to immigration policies, which reduced the maximum number of work hours to 24 hours per week when school is in session, affected their finances and health because many students also came to Canada for work to financially support their education.

*Let me just say that 60% of those who like coming to Canada to study are not just coming to study, they're just, they're coming because they need PR, and studying is the best path to get it, you understand. So, why change the rules, and maybe like when they said we should start working more than 40 hours, 40 hours or more, I mean, like 100% of the students here were very happy because most of us are going through financial issues. So, by working more hours, we get more money, you understand. Everyone was, everyone was OK and good. With the recent changes in the employment hours, it is very tough for students because some have already planned how much they will be earning and how they gonna be paying for their fees, their house rent, their mortgage, and whatever. So, by just coming up and just changing the rule to like 24 hours, it's going to affect them not only financially, but mentally, that's all (Timon).*

*As it stands now, I don't know the number of people who have been affected by this 20-hour or 24-hour decision. I know some people are out there crying within them. Sometimes they go to lecture halls unhappy because they feel like, oh, I have bills to pay, how am I going to pay my bills? So, while at the lecture hall, he or she will be thinking about his bills, so, at the end of the day, is she focusing on his studies or not? He's not focusing, He's thinking about his bills (Sion).*

Notably, some participants indicated that the new immigration policy that required graduates eligible for PGWP to pass the English Language Proficiency test before they could apply was stressful, robbery, unfair, discriminatory, frustrating, and financially and mentally draining, considering the high international tuition fees they had paid for years.

*I recently heard that if you want to apply for PGWP, you need to do an English Language Proficiency Test (IELTS or CELPEP), or something now. So, after you finish school in Canada, studying in English, you need to do an English test to prove that you can work in Canada. So, you know, things like that, or when for certain courses that you apply for at the colleges, you need to do an entry test as well, that's testing your English or your math skills, or whatever you are doing. Funny enough, the language proficiency test score expires every 2 years. It's like, hey, you forgot to speak English after two years, after being in an English-speaking country for two years (Sunshine).*

*I'm so sorry. That, to me, not to be rude, sounds like a lot of nonsense. Because for me to be able to do the bachelor's degree, right? We needed to speak in English. I qualified for the degree program, and I even graduated, which means that I'm fluent and proficient in English, even though it's not my first language, it's not my native tongue, right? To demand that students do that, to me, seems like a form of discrimination, because you're clearly saying that students do not know English when we clearly do. I'm sorry [sighs high] that I'm infuriated after hearing that. That is very frustrating for them to be able to do their studies and to be at those specific levels. Of course, I'll say that maybe they learned, even if they learned in their native tongue, for them to come and do their degree, it means that they know English. I don't want to assume that they don't. To write an English Language proficiency test after graduation in Canada is unfair and discriminatory. For me, it's a form of robbery of money. To write papers, especially academic papers, that require a very good level of English, you need to be very fluent. So, that to me is a form of racial discrimination, and I won't stand for it at all (Sheba).*

*I read somewhere that IRCC says that a man who has come to Canada to study for a master's degree program or a BSc program, graduated, and finished his courses, now has to go and take an English proficiency test to apply for PGWP. It doesn't make sense, and I don't know for whatever reason, but for the man to have been able to go through the school to pass his courses, it means he is able to, because the essence of English is to communicate, and the person has been able to communicate to pass all his courses. I will be quite surprised if the man cannot communicate in English after doing 20-30 courses, and he is passing them (Samon).*

Interestingly, some participants were unaware of the new immigration policy changes because they had not been following the news.

*OK, honestly, for me, I haven't been following that much news about that. Honestly. Yeah. For me, I've not been following that news that much, but I have heard of those kinds of things. Most things that I've heard are about the student permit, those student permit holders. Their working time has been reduced. Yeah, so honestly, um, I really don't know how to partake in that. Yeah, because I haven't been paying much attention to it (Darion).*

*With the rule changes that are happening right now, I would say that the pathway to PR is not a straightforward one. I don't really have much information on that part of it, but with what has been circulating on the Internet lately, I wouldn't think it's a straight pathway. (Talitha).*

### ***Semi-Legality***

This theme captured some participants' attitudes and behaviours toward immigration policies that were not entirely compliant with the law. Kubal (2013) highlights that semi-legality offers an alternative to the binary divide of legality and illegality, suggesting that the issue is never simply black or white. The study revealed that some participants did not adhere to the conditions of their precarious migration status. For example, some students admitted to working more than 24 hours a week due to financial challenges, which they feared could have serious consequences for their PGWP application after graduation.

*To be honest, I would say that at some point in time, my migration status changed because I was not following the conditions of my status. But I actually fell back on track because my reason for coming here was to study. So, after deferring the course, I was in the country for five months without a job. So, life was tough. I gave up. I had wanted to go back to Ghana because I felt like, NO, right now I came here for school, I'm not going to school, and I'm not getting a job, so why am I here? The purpose, the reason behind my being here, hasn't been accomplished. So, going back is not the best decision for me. So, I thought about it because if I went back, that meant I was a failure. So, I decided that, OK, I will face the battle (Sion).*

*I had some financial issues while I was back in 2022. That I didn't get a job in the summer, so I had to miss um I had to miss the fall term of 2022. And because of that, I was working, and I missed a semester in school. It's against the law for me to work during that time. So, I mean, because I missed school because of financial issues. There was nothing I could do more than to like work. So, at that time I was breaking the rule, and also when it got to um the next term, which is the spring of 2023, I didn't have enough money. So, I only registered for two courses, which means I was a part-time student, and also as a part-time student, you don't have to work; I was still working. So, financially, it's affected me, and then that's what made my study permit extension be*

*denied, and I went through a lot then. So, right now I'm not on a study permit anymore (Timon).*

The tightening of physical and digital borders, including shifting visa restrictions and migration categories, poses a challenge in contemporary Canadian immigration policy. These changes have been implemented in Canada and other countries to exercise regulatory authority, assert sovereignty over territory, and maintain internal security (Schneider, 2012). There is no inherent right to immigration; therefore, immigrants subject to Canadian immigration laws must obtain a visa from the Canadian embassy for their specific migration category (Gill et al., 2014). Despite these strict migration policies, there has been a significant increase in precarious status immigrants, including Africans, due to the inadequate and constantly changing process for obtaining citizenship or permanent residency (Gagnon et al., 2021).

Participants' experiences with the visa application process ranged from smooth and uneventful to profound difficulties. For instance, some experienced visa rejections for themselves and their families, often due to missing supporting documents such as financial statements, missing medical exam reports, challenges in meeting all application requirements, and challenges in contacting IRCC. The visa application processing timeline varied from three months to over six months. Some participants highlighted that proving that they had sufficient financial resources was a major challenge in their visa applications. All participants held temporary migration status or were non-status individuals, such as asylum seekers, who were awaiting a hearing or the approval of their migration status.

Many participants experienced challenges navigating Canada's complex immigration system, which caused anxiety about their future in the country. As a result, the ever-changing Canadian immigration policies increased financial stress, anxiety, depression, and uncertainty among many participants, who also dealt with additional migration-related challenges such as

precarious employment and financial challenges. For example, recent immigration policy changes, like restrictions on work hours and new requirements such as English language proficiency tests for Post-Graduate Work Permits (PGWP), impacted students' mental health and raised questions about fairness and discrimination. Notably, some participants possessed detailed knowledge about Canada's new immigration policies and those of other developed countries, such as the UK and Australia. As one participant stated, *“Just because the UK has done something of such or probably Australia has done something of such does not mean you have to copy them.”* Other participants had limited or no knowledge of the current policies, either because they were unable to follow the news or because their social support networks lacked information about migration policies. The level of knowledge about immigration policies within a migrant’s social network is important, as access to well-informed individuals can provide valuable advice and information that support successful integration into Canadian society (Creese & Wiebe, 2012), which in turn positively influences their health and well-being.

When applying for a Canadian international student visa, applicants are required to demonstrate that they have enough money to pay for their tuition for a year. However, some participants discussed how this requirement can be misleading because it does not reflect the actual financial needs many students will face in Canada. This requirement suggests that financial support will only be necessary in the first year of studies and that international students will be able to support themselves financially once they are established. However, barriers to employment and restrictions on working hours mean that this expectation is not realistic. As a result, many students experience stress, anxiety, depression, and are at increased risk of dropping out due to inadequate financial resources. Indeed, the new and ever-evolving immigration policies in Canada are likely to increase the number of migrants falling into precarity. For

instance, some students have not adhered to the conditions of their migration status by deferring courses or working longer hours because they were struggling financially to pay their tuition. This situation is consistent with Kubal's (2013) concept of semi-legality, which offers an alternative view to the binary of legality and illegality. Interestingly, some participants had considered returning to their home countries due to the uncertainties surrounding their migration status and unemployment or underemployment, but chose to stay for various reasons, such as financial obligations to relatives back home or the desire to work towards their migration goals. Two of the three asylum seeker participants had entered Canada as students but fell out of status because of financial constraints and an inability to pay international tuition fees. This example illustrates how migrants can transition between migration statuses from legally recognized to becoming an illegal or non-status migrant, a phenomenon known as "befallen irregularity" (González Enríquez, 2013; Vickstrom, 2014). Previous research suggests that many non-status migrants in Canada were once status migrants who entered with a temporary work permit, student visa, tourist visa, or other authorization that eventually expired or was revoked, leaving them without legal status (Bhuyan et al., 2016; Bonifacio, 2017). Statistics Canada (2024) estimates that about 9% of precarious-status migrants arrived through the TFWP, 42% as students, and 44% as postgraduate work permit holders, students' spouses, or exchange program migrants. The remaining 5% comprised individuals whose asylum or refugee applications were denied, students whose permits expired, tourists who overstayed their visas, or temporary permit holders who changed employers (Alcaraz et al., 2021).

Some participants, especially asylum seekers waiting for the approval of their applications, had no access to health services in Alberta except in emergencies due to exclusionary health policies. This highlights how immigration status can act as a social

determinant of health. The lack of stability and predictability in immigration policies caused confusion, stress, and anxiety for some participants, as they could not plan for their future in Canada. Despite these challenges, some participants remained hopeful about their pathways to permanent residence and strived to navigate the evolving immigration landscape. Overall, precarious migration status also intersected with age, gender, cultural beliefs, discrimination, health status, health literacy, knowledge about immigration policies, exclusionary health policies, socioeconomic status, and social support networks to influence participants' health and well-being.

### **Age and Agency**

Some participants described their experiences with the “culture of silence” (i.e., where the oldest family member is always right) within their families and expressed frustration at their inability to freely express themselves or have open conversations with older relatives due to fear of disrespect. Others felt fortunate to have parents who encouraged open communication and discussions about feelings and opinions. However, the impact of a “culture of silence” varied among participants, with some experiencing more open family dynamics while others felt constrained by traditional norms.

*I feel like the culture of silence really messed up my emotional well-being because you cannot really express yourself anymore or come out as the person you are, or even express yourself because your parents are always considered right and they do not allow you to talk back or say anything which I didn't have the intention of talking back, but I had the intention of like coming out and telling them how I feel about certain things. For them, it doesn't really matter what matters is what they think about you and what they think for you (Ceeja).*

*A good example would be a child having a conversation with an adult, or not really a child, but as long as you're younger than the person you're having a conversation with, if there's something you disagree with or anything, you cannot object to what the older person is saying because they would see it as disrespect. Or you don't have manners, so you're not really free to express your opinion on something. Or give your advice or chip*

*in with your two cents, because it will be seen as disrespectful or as talking back (Talitha).*

*I did experience a culture of silence. I'll probably say more like maybe a little bit from my parents. Like, parents are always right. But I think they have tried to, like, accommodate our feelings. Also, we're trying to like, hear our points and also like communicate with us efficiently (Abira).*

Although she claimed to be fortunate to have understanding parents, Sheba explained how she endured the “culture of silence” until high school, when she was able to have an open conversation with her parents. However, her extended family continued to adhere to the “culture of silence” and expected her to remain silent.

*I would say that I'm fortunate that my parents had the culture of saying, “Tell us how you feel,” you know. But before I would say, like in Junior School, that silence, that code of silence, was there because they themselves, that mentality, they say that the elder is always right, was still there. But the minute that we are now in high school, you know, and maybe the things that are there are disparities between children and parents, right? You'll be able to, like, sit down and converse one-on-one with parents. Because there comes a point where, as a child, being told that you can't do this and there's no valid reason, it does not make sense when you're now older, right? Um, but I was lucky enough to have parents who were willing to discuss the reasons why. But I would say that's just my nuclear family. With extended family, I would say that it's still a bit apparent, you know, the silent Code whereby the talking eye, when the adults are conversing, you cannot say anything or contribute anything unless they say your name. So, I would say that culture is quite prominent. There is more of the code to say that once you reach a certain age, like in your 20s, then maybe you can start joining other conversations, but other than that, no (Sheba).*

It is worth noting that although some participants experienced a “culture of silence” in their countries of origin, interviews with participants showed that it was practiced to varying degrees in different family contexts. However, not all participants experienced the “culture of silence” in their families or home countries.

*I didn't experience any culture of silence back home. The family that I grew up in, like we were always heard, so we were a bit more progressive, I would say [laughing]. Then there are, like the older traditions. So, we were always heard, and we like discussions, so in my family specifically, I didn't experience that (Sunshine).*

Participants' age at migration and their credentials influenced their choice of migration route. Although they could have immigrated to Canada through the Federal Skilled Worker Program (FSWP), which involved longer processing times but guaranteed permanent residency, older participants with foreign credentials often chose the study route because it was the easiest and quickest option, despite the high cost of international tuition and the absence of a guaranteed pathway to permanent residency.

*I'm not a very young person. I'm 50. So, looking at all the options from his experience, looking at all the credentials that were available, he was the one who suggested that, as at that time, the study option was faster, the open work permit was there. I said ok! Why doesn't your wife process her, uh, uh, her second degree, like second first degree, because she has a Higher National Diploma (HND), and that one would be the easiest. That was how we took the education route. He was the one who helped me with all these schools in Canada, to make choices based on the course of study, one that will be easier (Samon).*

Many participants, especially younger ones, indicated that migrating to Canada exposed them to new rights and perspectives, such as the importance of consent, mental health awareness, healthcare access, and health insurance, which they were unaware of earlier in Africa. They valued the resources available for health education and support in Canada and recognized cultural differences in expressing opinions and seeking healthcare. The study showed that age intersected with education level, migration status, and culture to shape many participants' agency over their health and well-being both in their home country and in their new environment (Southern Alberta, Canada). While some experienced challenges due to stress from migration and adaptation, others gained new confidence and agency in prioritizing their health and adjusting to their new circumstances in Canada, while reflecting on past experiences and future goals.

*Besides being too young when I arrived in Canada, I was still being exposed to rights and having the, you know, the right to speak about something because back home in Africa, we can't really stand up and say, Oh, you are actually doing this to me. But the*

*fact that I had moved to a different place and I'm still getting to learn about my rights, and knowing that, um, color diversity and everything (Ceeja).*

*I'm also fortunate enough that there are a lot of resources available to me to know more about what consent is, for example. You know, cause back home people can hug whoever they know, and there's no issue. But here, if a person doesn't like being touched in a certain manner you can, they can obviously say that they did not consent to that. I'll say that has helped with age and um I would say that like being more vocal about it too, because you know, coming from a culture that is not like not vocal in terms of mental health and now coming to a place where it's like they are very proactive about it, I feel like that has helped a lot too with regards to that (Sheba).*

Although the culture of silence is less prominent in Canada, some participants who experienced it in their countries of origin reported that their pre-migration “culture of silence” had adversely impacted their ability to express themselves freely in social interactions.

*I feel like in Canada there is an open space to, there's space to express yourself freely. If you have an opinion, you are pushed to speak up. Um, I still do have challenges doing that. If someone older than me suggests something, I go with it. I still have challenges adding my own opinion in there or expressing myself. I just go with it, but there is, they do open up, it's a safe space to express yourself freely (Talitha).*

Additionally, some younger participants experienced challenges in asserting their ability to access and utilize healthcare services because their parents handled everything for them in their home countries, including booking medical appointments. As a result, the study showed that age interacted with health knowledge, as the older participants possessed more health knowledge and life experiences than the younger ones, who depended on their parents for everything, including health information.

*When I was still younger, I didn't really know about health insurance. I did not know about all that health stuff, and I did not know about therapy sessions. Um, you know all those things. But I'm now growing like this, I now know if I have anything going on, if I feel like there's something that's in my body that I don't feel is a normal thing, I have to take this to the hospital. I now understand what the coverage is, and like insurance, the insurance benefits that I get as a student, and things that I can get from the hospital (Ceeja).*

*My age back home definitely affected how I thought and how I perceived the whole health system, because I never really thought about it. I think that it has everything to do with*

*my age because coming here and now at the age that I am, five years later, I think more about my health, like a lot of times, because I feel like it's something important, and that is something I never definitely did because of my age back then. I was not mature enough to look at how some things were important to my health (Kamon).*

*As I'm getting older, I need to take care of my health because I haven't really paid much attention to my health, not giving myself that much time to talk to professionals about what I feel is beginning to have an effect on me. So, I want to use the good health facilities here to really ensure that I'm in a good state. I'll be visiting the hospital as soon as I get my health card. I heard they have a family doctor, so I want to get one whom I can talk to about my health and then get the necessary attention (Miss Brown).*

Marcus indicated that although he is getting older, he has not experienced the effects of aging on his health and well-being.

*My age has not impacted my health at all. Some of my Caucasian friends have been asking me that they can't believe how an African with that number of years on Earth is looking younger than them, looking younger than a 25-year-old Caucasian, you know, or probably a 27-year-old Caucasian. And I say, yeah, in Africa, we eat good food, Mehn. We eat, we eat, we don't, we don't eat all these things. But you know it is what it is because you're in the land, you know, you just have to live with it (Marcus).*

The study also showed that participants' age intersected with their migration status and level of education in Canada. Since there is no longer a clear pathway to permanent residency due to changes in Canadian immigration policies, older participants experienced more age-related precarious migration status stress than younger ones because of their heavy family responsibilities and their inability to reach their migration goals.

*There's too much stress. I remember like last year, winter. I was so stressed, and I was sick. Yeah, I was sick because. That was towards, I think, my kids needed to go to school, and I needed to send the money. My mom was sick, and I was struggling to get a job due to my immigration status, or just a bad time? It was not easy. Yeah, I think if you don't know, except that you are here, you will not understand. There's a lot of stress in this place, especially this period now. So, you can get sick because of the pressure and all the like. So, it's not easy (Johannes).*

*My age definitely impacts my health because um I've already done like seven years of tertiary institutions, two years in Polytechnic, I did five years in the university and I've already like completed my tertiary institutions but now because of PR in Canada I have to come back to school and start struggling too because I have not been studying for a while, now to start studying is a big task for me. So, it really does. It affected me a lot*

*mentally, and I won't say it's been easy going for me. It is not very easy going for me, actually (Timon).*

Additionally, participants' age interacted with gender, migration status, and a lack of family doctors to influence their health and well-being. For example, Sunshine mentioned that she could not plan to have another child because of the uncertainty surrounding her precarious migration status and the shortage of family doctors in southern Alberta.

*Thinking about getting older, I think maybe even just the whole migration thing, because you feel like you're starting over, right? But you are not 19 years old anymore. Like you need to do everything, and it needs to go faster than before. And you need to adjust better, so I think about my age and whether I will reach my own personal goals in the time that I have left, yeah. And now I'm thinking like, do I want to have another child or not? In terms of migration status, or the uncertainty, or I don't know, and biological clocks and stuff, but I don't know, yeah, what am I going to do? They stress me and affect my mental health (Sunshine).*

According to Ceeja, migrating at a younger age boosted her confidence. Interestingly, Ceeja, who moved to Canada at 15 years old to attend an international boarding school in Strathmore, Southern Alberta, reported that her confidence level improved through her interactions with other younger international students.

*Our school was quite an open school, and it had a lot of people from different countries, and it was an International School in Strathmore. There were a lot of people my age, even younger than me. It's something that actually boosted my confidence. I was kind of nervous at first when I was getting here. I'm like, oh, why did I decide to step out of my comfort zone so much? But when I saw these classmates of mine, Asian kids mostly come at a very young age, to the extent that they're in Junior School, and I'm in high school. So, I'm like, oh, this gives me a bit more confidence in myself (Ceeja).*

Participants arrived in Canada between the ages of 13 and 50 years old. Although the 'culture of silence' was experienced differently and practiced to varying degrees within families in their home countries, it adversely impacted the emotional health of participants who experienced it. For example, some younger participants felt unable to express themselves freely due to societal norms that dictated showing respect by staying silent during conversations with

adults and avoiding expression of disagreements or sharing their thoughts and emotions. As a result, some participants felt unheard and unsupported regarding their own needs and desires, while other younger participants reported open communication with their parents, where they expressed their feelings freely.

Participants' credentials and age at the time of migration influenced their choice of migration route. Even though they could have immigrated to Canada through the Federal Skilled Worker Program (FSWP), which required more processing time than pursuing a study permit and guaranteed permanent residency, some older participants with foreign credentials opted for the study route because it was the easiest and quickest option to gain entry to Canada, despite the high cost of international tuition and no guaranteed pathway for permanent residency. As a consequence, this choice impacted their health and well-being because the pursuit of expediency contributed to a prolonged state of precarity, immigration status stress, and uncertainty.

Participants' age at the time of arrival in Canada and their pre-migration cultural experiences (e.g., culture of silence) interacted to influence their health and well-being. Thus, although being in Canada provided younger participants with opportunities to learn and exercise their rights freely, including speaking up, understanding consent, and seeking healthcare when needed, their pre-migration experiences surrounding the culture of silence continued to impact their social interaction and expression of opinions in Canada. Additionally, some younger participants lacked health knowledge when they arrived in Canada because their parents had done everything for them back home, including booking medical appointments; managing things on their own was a new experience for them. However, the availability of health resources in Canada helped these younger migrants understand issues like health insurance and therapy.

The stress associated with migration and adjustment to a new education system in Canada (e.g., high international tuition fees) influenced some younger participants' mental health and personal goals. For example, one younger female participant found that her experiences with diversity in an international school setting in Canada increased her confidence, which in turn helped her deal with the difficulties of adjusting to a new place. However, some older participants also experienced stress related to the uncertainty surrounding their precarious migration status and their inability to achieve their personal goals (e.g., economic success) and meet huge family responsibilities (e.g., remittances to families in their home countries).

Overall, age as a social determinant of health intersected with culture, gender, personal goals, length of stay in Canada, health knowledge, and migration status to influence the health and well-being of participants.

### **Gendered Health Experiences**

All the participants came from traditional African societies where gender norms were maintained, reinforced, and enforced. These norms defined what is considered "masculine" or "feminine." Participants' gender norms were shaped through gender socialization from the family, peers, and media. Although traditional gender roles and norms were practised to varying degrees across different cultural contexts, many participants discussed how these norms influenced their perceptions of seeking healthcare and expressing emotions, which created challenges in discussing mental health, seeking help, and sharing feelings openly. In some cases, strict adherence to traditional norms was influenced by participants' social networks. Some men frequently struggled to communicate emotions due to societal views on masculinity, and as a result, internalized their struggles, hindering open dialogue and support systems. Additionally,

some women participants indicated that these gender norms and beliefs influenced gender disparities in their countries of origin, which, in turn, impacted their health and well-being.

*I think when I became... I think at the age of 18. When I started becoming sick, as a man, I mean, I had to, you mean, you need to stay quiet. You don't need to tell your friends or parents because you need to show you're a man. Yeah, and me being in Kenya, I will, when I fall sick, I won't, I won't let anyone know. I'll just go to a chemist and buy my drugs and take them (Caesar).*

*Yes, to be honest, traditional gender norms impacted my health because of the way I perceived such roles back home. But today, right now in Canada, that kind of perception has changed. I was socially constructed to act that way. Even in Ghana, we have this funny saying that men don't cry. Sometimes there are certain things, like your mental health. If I go and tell my fellow brother or like my colleague, Oh, that's what I'm going through and what the person will say, "You're a man, you have to move on." The person won't advise me to seek the services of healthcare professionals because they are not used to it. The people that I surrounded myself with were not used to that kind of, I mean, seeking help from mental health professionals or something (Sion).*

*Yeah, of course, my gender influences my health. Sometimes, yeah, as a man, with all the pressure on you as a man to provide for the home, and maybe you are not up to the task. Yeah. It's very stressful sometimes, as well as sometimes you see, it begins to affect you emotionally, and all kinds of stuff like that. So yeah, it influences my health (Johannes).*

However, Kamon reported that gender norms and beliefs have evolved in Kenya, especially among the youth, compared to years past.

*I'm a man, and I'm the provider, oh! Yeah, for sure, personally I do, and of course people do, but it's not a big thing, it's not like back in the days when, you know, men were the providers and only men could, you know, could feel the pressure of providing. In Kenya, it's not even a thing that people really talk about, especially young people, yeah (Kamon).*

The study revealed that gender disparity influenced some women's health and well-being. Some women shared how gender disparity in nuclear or extended family settings emotionally impacted their health and well-being.

*So, for me, the only thing I would think of, in terms of gender inequality, would be maybe like responsibilities at home, like spending more time juggling between, like household chores and taking care of a child, for example (Sunshine).*

*I experienced gender disparity, probably with extended families. Like, when I was out with my cousins, and then the girls washed the dishes, while the boys were playing games, or like on Xbox. Yeah, I think it's pretty unfair (Abira).*

Additionally, gender disparity was also experienced outside of family settings, both in nuclear and extended families. Some women participants shared their experiences of gender disparity in school.

*Well, I experienced gender inequality, maybe outside my family. Within the family, I didn't because I grew up in a family of all girls, so I didn't really experience any gender inequality. But outside in school, maybe the boys were kind of pampered, not really pampered as much, but they'll get work relating to how they're masculine. And then for us would get like feminine tasks. So, it was two different things (Ceeja).*

*Um, at home, I would say I did not experience gender disparity. My parents do try to make everything balance between male and female children, but at school, yes. I would say I experienced that. A good example would be that I was in boarding school. A good example would be how the laundry would be done for the male students, but for the female students, they would tell us to do it ourselves because we are girls. So, I feel like yes, we were, and another example would be that females had to clean their own dorms, but that would be done for the male students because they are boys, they can't do it. So that is quite something that happens a lot back home, yeah (Talitha).*

Some participants shared their experiences and understanding of traditional gender norms and beliefs, describing how parents and teachers directly or indirectly promoted and upheld these norms in their countries of origin, which impacted women's lives due to the culture of shame.

*We have chores that culture says only the girls need to do the chores, they need to take care of everyone, this and that, right while I have education going on. But my male siblings, whether older or younger, can also help; they were not, not to say not allowed, but they were basically ignored from the chore system, right? And to me, I was like, well, that's unfair because I'm also a student going to school, you know. Why can't we share this thing equally, right? And um that culture, like, even hearing from my mom when we will discuss it, saying that, oh, this is the system that we grew up in, you know, only the girls do the chores and the guys do, like, maybe they tend to the cattle when they are in the rural areas, right? I would say that that culture, that system, has been there for quite some time. And now there's slowly that awareness to say that no, it's not supposed to be like that, right? (Sheba).*

*I would say that even in the school system, right, it's like always the talk towards girls because I remember in a girls' school, like, there's always the teacher saying, you know, girls, you need to take care of yourselves, you know, all of these things. But then to hear*

*that all our guys are getting the same training, we don't; we barely hear that. Like, you know, it's never them being trained to say you should not look at a woman in a specific manner. You should not think in this way or in this sexual manner. But women, it's never those talks to them. It's always directed at women. You should cover yourself, you should clothe, but still, you hear cases of rape or this and that happening to women who were fully clothed. So that disparity, yeah, I would say it's annoying as you can hear from the passion of my voice (Sheba).*

Also, Sheba shared stories about how some young women lost their lives due to illegal abortions in Zimbabwe because of the strong culture of shame and stigma surrounding teenage pregnancy.

*I've witnessed, I would say, that there's this culture of shame that's there. If any woman, let's say, whether she was sexually harassed or abused or I don't know or got pregnant or impregnated by some guy, there's that strong culture of shame that's been there for a long time now, and making the woman inadequate or feel, you know, less of herself as a person or an important part of society. I'll say that has impacted a lot of them, has impacted their view of who they are, and I guess leading to hearing cases of women trying to abort their children, you know, in school properties or dumping their kids in the, I would say, in the dumpsters, you know. That culture has, I would say, slowly died down, but it has been there even when I was in high school. So, I would say that yes, to some extent, women could express themselves, but not as much as men (Sheba).*

*You know, pregnant teenagers trying to do, like, illegal abortions leading to health risks and hurting not only the child but themselves because they don't know the impacts of their own actions, right? And the culture of shame in the school society to say that, oh, look at this girl, she um, quote and quote like, I don't know, what are the words? She's very promiscuous, she's being a slut, etc. All of these connotations being marked on her right without hearing her story, I feel like it has influenced and impacted a lot of women (Sheba).*

It was noteworthy that Kamon and Ceeja discussed how men and women who sought formal support services (e.g., counsellors and therapists) were perceived as weak since they were considered strangers or outsiders in their culture.

*We had a therapist, which is not a common thing in schools in Africa. So, the fact that I actually feel like it's not common, it's something that actually drives me to think, is this necessary? Because no one prioritizes your mental health. You cannot really go and confide in someone and talk to them about your problems, because it's going to make you seem weak. Usually, those people are regarded as, like Oh, you're weak or you don't really know how to cope with your emotions, and you wouldn't want that label. So, you*

*have to actually act ignorant and make yourself look like you don't care; that's what keeps you going. And so, I never really confided in anyone (Ceeja).*

*Oh Yeah, well I think that is the thing that has the most influence because, yeah, I personally don't see myself the same as, you know, yeah maybe women not in a bad way but yeah it's harder for me to talk to someone than it is for maybe a girl, um you know, yeah it feels like just being weak when you have to go sit down and tell someone about your problems, which is easy for women to do, and I think it's naturally, it's easier for them and naturally, I think it's harder for men and yeah I think it's I think that's a contributor (Kamon).*

Additionally, Sheba shared her experiences and perceptions on why men often do not discuss their emotions and how she helped her men friends cope.

*I'll say that with regards to men in general, guys or men in general, they have this system of they don't talk, they don't vent. So, at times like you would have to probe if you had male friends, say, are you good? Are you OK? Is there something going on? I would say that some of them did like once, I would say we established that they were only purely platonic, we're just friends, a lot like the ones that I know that they did vent about what they were going through. But obviously some of them still like, you know, I'm, I'm OK. I'm doing well, you know, type of mentality too. So, it just had to depend on the person, varied from person to person (Sheba).*

Consistent with what Sheba said about masculinity and men's difficulty in coping, Caesar described how he coped with his challenges on his own without support from others.

*I will still consider myself a man, and I'll just be alone. I'll just be at home listening to some music, some I mean, there are some, this gospel music, which you listen to and you, you'll get, you get a little bit, how am I gonna put it? Lift um, you get a little bit of some courage, let me just say something like that, yeah. I think I will just be myself, I will also I'll be myself in my room. I'm someone, as I said, I'm an introvert. I'm an introvert, so I like being alone. I like solving my things alone (Caesar).*

However, some participants stated that traditional gender norms and beliefs did not influence their health and well-being because of their level of health knowledge.

*In Nigeria my gender never affected my, you see, it never affected me because like I said the level of awareness, like health awareness, they know in my house once you tell me you're not feeling well, I will say to you go and talk to the doctor, they say can't somebody buy something, I say, I'm not a doctor they know here and that is the same way I've always lived and that was even why what more um resulted in us having a private doctor that we could talk to (Samon).*

While some men participants retained their pre-migration traditional gender norms and beliefs in Canada, which influenced their access to and utilization of healthcare and often caused stress, many participants stated that exposure to Canadian culture had changed their perceptions on traditional gender norms and beliefs, as well as their attitudes towards seeking healthcare.

*I live by the rules in any society or in any area that I live in. I don't see barriers in anything. Yeah. It's a woman's environment. But one thing is just to live by their rules and avoid or stay out of trouble at every point in time. And that's what I've seen. One thing is the way, the way I might, I might take up a few challenges back home with a lady or probably any woman, is not the way I would have taken it here. That also helps me to train my mindset when he has to, when it has to do with women and having communication with them (Marcus).*

*In Canada, I've never heard anyone saying Oh, you are a man, so umm, for this particular issue, don't go and seek help or something. Rather, you will be encouraged to go and see a health professional. For instance, when it comes to mental health issues, they really take it seriously to the extent that nobody will advise you to do things on your own without seeking help from health professionals or health advice. So that notion that I was having, like maybe, oh, you're a man, it has really changed. I barely say this, even when I'm talking to someone back home right now. I don't really tell them to...oh.. You are a man. So, I factor in and take whatever they say seriously, and I will encourage them to seek help (Sion).*

It is worth noting that many participants who experienced gender disparity in their countries of origin mentioned that they had not experienced it in Canada. They perceived gender disparities as minimal or nonexistent in Canada, with an equal distribution of tasks at home and work. Some men expressed changes in their attitudes towards seeking healthcare due to exposure to more health information.

*I wouldn't say my family is set up anymore. Because, like in my house, like we all do something, like my brother and I, all to like take turns with the dishes (Abira).*

*I have not experienced gender disparity since arriving in Canada. Like the jobs that I was able to do, I did not see any form of gender disparity in terms of the distribution of work. It seemed quite, I'll say equal (Sheba).*

*So far, I haven't experienced any gender disparity in Canada. I do work in retail at the moment. I work in a clothing store, and I feel like females and males equally do the same thing. So, if, for example, I have a closing shift, if I'm sweeping today, tomorrow it could*

*be a male employee, or a male colleague sweeping or cleaning the bathroom, and we just change like that. It's, it's equal (Talitha).*

Some men participants stated that their gender norms and beliefs still influenced their attitudes and behaviors toward access and utilization of healthcare.

*Yeah. So even now, yeah, yeah, my gender beliefs and norms influence my attitude and behaviors towards access and utilization of healthcare because if I'm sick, for me, I don't know if I will even go to the hospital. I'll just go to the chemist and get some drugs and take my drugs at home and get well, and continue my daily activities (Caesar).*

Additionally, some men participants shared their struggles with traditional gender roles (e.g., meeting expectations to provide for families back home) and how they influenced their behaviour, responsibilities, and stress levels, as they navigated different gender dynamics in Canada.

*My parents are the kind of people who are very understanding, and they are very supportive. So, I know that they don't really care, that they just want the best for me, they just want me to do me, they want the best for me to be successful but, you know, even though they're not mentioning the fact that I actually like, I am the first male in my family so I know that I have some responsibilities even though I'm a student and I'm struggling to pay my tuition fee I still have the responsibility to support my family back home, so which I still do. And even last time, like two months ago, because things were difficult, I was thinking if things are still difficult like this, I might go back to Nigeria. So, all the funds I have acquired over time, I used part of them to get my mom a car. Yeah, because I felt like I needed to do something back home, because I've never actually been doing anything. So, my traditional gender norms and beliefs do affect me, yeah (Timon).*

*Yeah, my traditional gender beliefs and norms still impact me. Yeah, because sometimes they will just call you. Maybe they need something, and maybe you're still waiting for your payment. Or maybe like now, that job issue is a problem in this area; I don't know about other areas. Maybe you're still struggling. Maybe you lose one job, or you try, maybe you lose your job, or you try to get a good one. All that stuff like that. But they needed something for back home. Sometimes, they need money or something, and when they keep calling you, they cannot understand, but what they think is just the pressure; they cannot understand what you are going through. They just feel like no, everything is OK. But you, that is here, you know that it is not easy (Johannes).*

Sunshine also mentioned that her husband's participation in household chores has improved compared to when they were in Africa.

*I think my husband has actually been a bit more helpful since we've been here, it's been a bit better [Laughing], so I think in terms of gender, I think there's a slight improvement. So, for me, the only thing I would think, like in terms of gender inequality, would be maybe like responsibilities at home, like spending more time juggling between like household chores and taking care of a child, for example (Sunshine).*

Certainly, Caesar stated that, as a man, he did not feel comfortable being financially dependent on his parents all the time, even though he often received support from them.

*As an international student in Canada, I get to pay a lot, a lot of money as tuition fees per semester. So, I mean, I'll say I'm lucky, I also have a support system, my parents, who help me in that. But I mean, as a man, I always like to, I don't like to put everything on my parents. I also want to show my parents I'm a man. I mean, so I tend to also put a little tend to put a little bit in and not to put all the burden on him. I mean, like this semester, I can say boldly that I paid all my school fees by myself from the money I earned during the summer. So, I didn't put that burden on my parents, so yeah, that is it (Caesar).*

Interestingly, Samon reported he had moved away from traditional gender roles, and his family no longer uses terms such as “Head of the Family, Mother, or Father” but instead refers to it as “Household.” This, he claimed, meant that all family members participate equally in decision-making.

*I know this may not apply to too many people. I am in little bit lucky. I have a lucky family; I have an understanding family. And we don't have, we don't have, by the grace of God, we don't have health issues, everybody's going at their own pace, I'm happy with the children, they have integrated into the school fast. But in terms of Naira and Kobo, cents and dollars, that's the only variation is that everybody is aware now, the households. Here, the grammar is households, not father or mother or father & mother, it's a household. It's even gone beyond father and mother. So, that is one of the new cultures, and we have to abide by it. If we have to live optimally in this kind of environment, we don't have a choice. I would not be able to buy it if it were in Nigeria. I would have been thinking of how to buy a car for my son, or buy a car for everybody. Here, everybody will buy for themselves as long as they have reached the working age; the system must make it available for them to do so. So, instead, it tends to take some load off me, knowing very well that they understand. But like I said, I'm lucky they are, they are, they are, they understand the environment they are coming to, so that is the way it is (Samon).*

Gender norms are deeply embedded in culture and social structures, shaping how men and women behave in their interactions. These norms are behaviours or qualities considered

appropriate for each gender. As a result, women and men often think and act in ways influenced by feminine and masculine norms they encounter through interactions with parents, siblings, peers, and their culture (Courtenay, 2000). A woman participant mentioned that both parents and teachers played a role in constructing and reconstructing these gender norms, which in turn created and reinforced inequality between men and women within families and society. Although traditional gender norms vary across different cultural contexts, they influenced how some participants, especially men, perceived and addressed their mental health issues. Notably, men participants often found it difficult to express their emotions, likely due to the social construction of masculinity and the stigma linked to men seeking help. As a result, some men turned to informal support sources, such as family members, pastors, and friends, who were often ill-equipped to meet their health needs, which may have adversely impacted their overall health and well-being. As a man participant, Johannes stated, *“I had somebody like a pastor whom I would run to each time I had problems or challenges. I will run to him for advice, counselling, directives, and stuff like that.”* Similarly, a woman participant shared that seeking mental health help was viewed as a sign of weakness for both men and women in her country of origin, which acted as a barrier to accessing and utilizing healthcare services. She stated,

*“Because no one prioritizes your mental health, you cannot really go and confide in someone and talk to them about your problems. Because it's going to make you seem weak. Usually, those people are regarded as Oh, you're weak or you don't really know how to cope with your emotions, and you wouldn't want that label. So, you have to actually act ignorant and make yourself look like you don't care; that's what keeps you going. And so, I never really confided in anyone (Ceeja).”*

However, a Nigerian man participant mentioned the increasing awareness of the importance of seeking medical help regardless of gender in his home country, highlighting the role of health education and support systems.

Although gender norms are often portrayed as fixed, static, and unquestioned (Rwafa, 2016), some men participants moved away from traditional gender norms due to their adoption of Canadian societal norms and gender equality beliefs, indicating that gender norms or roles are fluid or dynamic. However, these gendered cultural expectations influenced how some men and women participants accessed and utilized healthcare in Canada to some extent. Studies conducted in Canada suggest that immigrant women are more likely than their men counterparts to access and utilize healthcare facilities due to socially constructed gender norms, which emphasize men's strength, resilience, and independence (Chen et al., 2008; Kirmayer et al., 2007; Turin et al., 2020). Courtenay (2000) and Williams (2003) have noted that there is a tendency for men to minimize pain and suppress the expression of need, resulting in men's lower rates of engagement in preventive health care visits.

Additionally, the traditional culturally-assigned breadwinner role continued to influence some men participants' mental health, often leading to stress, frustration, and depression due to their unstable migration status, unstable employment, and low income. Notably, some women participants emphasized the importance of gender-neutral roles within the household and the societal expectation of self-sufficiency in Canada, signifying a cultural shift in gender roles that has positively impacted their health and well-being. Although gender disparity was experienced differently among women participants, the emphasis on men's privilege, domination, and control over them in some cultural contexts placed them in a socially vulnerable and dependent position, which also impacted their emotional health and well-being at times.

Participants' gender, age, and immigration status intersected to influence their health and well-being. Consistent with previous studies, men and women participants experienced the impact of precarious migration status differently, particularly in terms of healthcare service access and utilization (Agadjanian & Yoo, 2018; Agadjanian & Zotova, 2019). For instance, a woman participant's precarious migration status, unstable employment, age, and lack of a family doctor collided, and she felt she could not plan for childbearing because she would not be able to access the necessary reproductive and sexual health services regularly. Overall, the study revealed that gender norms influenced participants' access to and utilization of healthcare. Interestingly, some men and women participants hesitated to seek help because they did not want to be labelled weak, or did not wish to seek help for their mental health issues because they considered them trivial compared to others. The women participants were more likely to seek help than the men participants. Gender as a social determinant of health intersected with age, socioeconomic status, migration status, and family responsibilities to influence the health and well-being of participants.

### **Transnational Experience of Discrimination**

Some participants described how racism, tribalism, and discrimination impacted their health and well-being by limiting or denying access to social and health services. Others explained that they did not experience these issues in their countries of origin, but acknowledged that they were common. Nevertheless, despite reports of racism, tribalism, and discrimination in their home countries, some participants denied their prevalence.

*Before coming to Canada, I lived in a neighborhood that was predominantly white African people, and I was basically not recognized by my neighbors because they were still sticking to the old ways. They would see you, and they won't greet you. So, you just have to, you know, that's life, and then love who you want to love and be how you want to be. I was saying I wanna leave, um, I wanna move to a place where my child can thrive, like that's one of the aspects. Because my husband is actually a Nigerian and so my*

*daughter's first name is not an English one, which is an easy-to-pronounce name. So, that's like one of the discrimination aspects, you know, because they'll judge you by your first name or whatever, because they cannot pronounce it, or you know, things like that, yeah, so yeah, so before coming here, definitely in parts. So, in the last neighborhood that I lived in, there was definitely discrimination, not blatantly, but like undertones, yeah (Sunshine).*

*Well, racism in South Africa is kind of different. I would say, like many other countries, because we have a past of apartheid and stuff. So, like, the schools were going to be like, even private schools. Like, I went to a private school with a majority of white kids. So, I guess everyone's still kind of adjusting to having black kids in their space, even if it's many years after, parents are adjusting because they lived in an apartheid state. So now having their kids interact with black kids, I feel like I did experience with teachers that treat us unfairly at my school, yeah (Abira).*

*It is something common that happens not only to my tribe but also to other tribes. All these stereotypes. Em!! Yeah, I come from a tribe where most of the people in the country are from that tribe. It's one of the major tribes in Kenya, and yeah, people from my tribe play a huge part in, you know, businesses in the country, like most businesses around, I'd say, people from my tribe that I come from. And from that, people have all these stereotypes about Kikuyus and money; you like money too much, sometimes people don't want, you know, associates too much with you if you have, and all the weird sayings, you might do anything for money, you know, but yeah but it's nothing major but yeah never bothered me (Kamon).*

*I didn't experience anything like racism or discrimination in Egypt, but it does happen in general in Egypt (Aaric).*

Participants' experiences of racism, tribalism, and discrimination in Africa were also influenced by their geographic location. For example, Raisa, who is from the Democratic Republic of Congo, did not encounter racism or discrimination in her home country but experienced these challenges during her stay in South Africa.

*Um, um, the one that I said I experienced was when I went to South Africa. Some of the things they said to me were racist. You understand? Like, this is not your country, go back home. Like, yeah, yeah, yeah. So, and kind of those things (Raisa).*

*Yes, some people are just disqualified from a job or something that they are qualified for, maybe based on either geographic location or something, or their educational background. But I didn't experience it myself (Aaric).*

*Discrimination is a norm in Nigeria. In the Nigerian structure, there's something called the quota system. The quota system in Nigeria, as it is today, is not defined. So, the*

*operator of the quota system, the administrator of the quota of an institution, brings the quota system into it, and so the issue of being denied, I'm talking about Nigeria. The issue of Nigeria, the issue of religion/culture, whatever discrimination exists, it has always existed. It is formal, it is in the constitution, it is documented, it's there. So, let nobody shy away from it. For instance, in the educational structure, some states are classified as Educationally Developed States, while others are classified as Non-Educationally Developed States. These are the 2 classifications. Aside from the issue of Educationally Developed and Non-Educationally Developed criteria, there is another one they call the Catchment Area. If you're not from the catchment area, even if you score 100/100, nobody will give you admission. I have experienced it because your question is, have I experienced it? It's discrimination I'm talking about, and that is your question; I have lived and experienced this discrimination all my life till I left. Discrimination exists in Nigeria (Samon).*

The transnational experiences of discrimination, racism, and tribalism among participants varied greatly based on their intersectional social location, country of origin, and their post-migration contexts. Some participants experienced discrimination across the transnational space, while others encountered it only in one location or sometimes not at all. However, when it was experienced, it significantly impacted their health and well-being, and sometimes limited their access to resources that support their health.

Although they did not experience overt racism in Canada, participants pointed out instances of indirect discrimination, unfair treatment (in workplaces, schools, and social settings), microaggressions, and systemic biases that impacted their sense of belonging and equality. They highlighted the subtle and complex nature of racism in Canadian society, ranging from feeling excluded in social settings to experiencing discrimination in employment. Some found it difficult to identify and address racism, while others confronted the issue head-on, advocating for equality and fairness.

*No, since I came to Canada, I have not yet experienced any racism. Yeah, no, no racism at all. But I've heard of those cases. But for me personally, I haven't come upon any, yeah (Darion).*

*Yeah, not directly, but I'd say yeah. I've seen some things happen where I feel like maybe someone treated me unfairly, and if I think about it, after maybe it hits me up to like two*

*days, and I'm like, oh yeah, I think that was racism, for sure. But I wouldn't say I've met someone who said stuff in my face, but I have experienced it, and I have seen it happening to other people, for sure. I used to work in a warehouse, and I saw that a lot. I started raising the issues. I don't know, it just became too much at some point because I saw it happening to me and the people who look like me, so yeah, I started getting mad, and I started complaining. Sometimes, when I apply for a job online and I don't know, I just have the feeling that [laughing] my name might affect whether I get the job or affect the kind of responses, the number of responses I get back. I wouldn't know for sure, but that thing is always there. But yeah, I've seen it even though indirectly. Oh yeah, where I used to work, they were just sending black people to work in a particular position more, you know, it was like a pattern. Like, you just notice it at some point, and there's no way I'd see it, and you'd see it, and five other people would see it, and it's not true. So yeah, we had a conveyor belt where there was a bottom and top, but they used to put us at the bottom, like you used to happen a lot, so yeah, that's for sure, being unfair (Kamon).*

*Sometimes, like in some places where we work, you will see how they prefer people from different races than us and there may be the position or the job they are supposed to give you, the hours you're supposed to work, they always give to other people from other race and how they would treat you at the job site, you would know that this thing is not right. But sometimes we don't have a voice. We just see it and we know it. We don't know what to do, so it's like that in Canada. The treatment they give you at their job site, and we see how they treat other people, maybe other people are white, and we see the difference. So, if you do something, how will they react to you, and if there's another person who is white doing the same thing, you see the reaction? If you're not very careful, they'll fire you and something like that. So, yeah (Johannes).*

Some participants compared their experiences of racism and discrimination in Canada to that of their countries of origin. They stated that, compared to their countries of origin, racism and discrimination in Canada are often subtle, which can make them difficult to detect or describe at times.

*I have not experienced it in school or at work, but like in public, yes. Um, one example I can think of is at my daughter's school. I tried volunteering, like you know, like parents volunteering for certain things, and I think a lot of the people here, I can't say, but maybe because the community is so tight-knit that everybody kind of knows everybody, or they went to school there. I don't remember what the actual story is, but when I went there, I was the only person of color to volunteer as a parent, and no one spoke to me for the whole time, not even treated well, and that made me feel like OK, that's weird, yeah. Um, I think it's very different here. I think in South Africa, people are more forthcoming with their racism. Like it's more, you know what, so you kind of not me necessarily, but in general, like you kind of know your place or you open your mouth. Also, if you feel like someone is like that, so we speak more, and like here it feels like we don't really speak about such issues, and so you can't be liking somebody else's hatred, right? And so you*

*kind of assume by the way they treat you, by the way they look at you, or so you're also making assumptions, and like, yeah. I feel like I will just like leave the place and forget about it, you know, and just move on instead of thinking about it in my head the whole time, because what am I going to do if someone told me you are not allowed to be here, go away. You know, he didn't say that like to my face, but then you read certain things online, like comments on social media things and then you actually see people's real feelings come out online sometimes. In South Africa, like I see it, it's more vocal. Here I see it, but it's not really vocal. It's like a passive kind of discrimination [laughing] I don't know how to say that. [Laughing] (Sunshine).*

*I'd say yes, I have experienced racism. I would say the racism that I experienced wasn't in terms of my education status or in terms of what you call it, health. But there's like this subtle racism that goes on, you know. They don't say it to your face, but you can tell with their eyes or their expression that they don't like you. You know, you see that, or if they see someone who's not the same skin colour as them, it's like they act in a certain type of manner. But I have, but the only time that I like remember seeing or like experiencing for myself, racism, I think I was waiting for the bus, right? I know for a fact the bus driver saw me, but decided to pass by me, and I was like, what? What is that? Like what? What do you mean? Like you, you could clearly see that I was at the bus stop. I'd say that, like I have not experienced much, but more of, like the instances that I've heard or seen, it's like a form of subtle racism that goes on. It's not like they're calling you out like, oh, you're a Negro, oh, this and that, or Nigger, all of that. It's not that, it's more like the subtle type of racism. I do not know how to explain it better, but yeah (Sheba).*

*Racism is part of their thing here, like the place of work. I've seen some level of racism, in which I just look at and try to overlook it as I see if I didn't see it. Obviously, um, it takes a toll on me, but sometimes you just let go like whoa, yeah. It is their country, I am here to just do what I need to do and just get going, you know? So that's what I just do. There are levels of racism. Sometimes, I try to call them cowards using that word because the racism in Europe is clear; they will tell you they are racist about it. Here, they will do as if they are joking and playing with you, but the level of racism behind it is massive. So, most times I just tell them, "You guys are cowards, come out straight and just tell me straight." Because we Africans don't put words back in our mouths. We say the way it is, this is the way I feel about you, and we move on with our lives. But it's pretty different here. Yeah, they will say nice things, but they're stabbing you heavily (Marcus).*

Other participants also questioned whether their experiences could be considered racism and discrimination (which some described as micro-aggressions), or whether it was simply a lack of understanding of what constitutes racism and discrimination in Canada.

*I will say, you know, sometimes we experience some things you don't know, whether it's racism, or it's a result of racism, or is it? I don't. I don't really know (Caesar).*

*It's probably just a microaggression, like racism. Um, I think it's hard to identify like racism here, especially if it's micro-aggression, because it's going to be like, especially at school, you're gonna be like, oh, the teacher is not letting me do it. Like redoing a test because I'm black. But it's really. It's like I don't know, I don't know how to explain it (Abira).*

*I cannot really say it's racism, but I feel like I was just immature about it [laughing] in high school. Um, so, I learned in, I can't really say all-white school, but it was. There were a few people of color. It was sort of like two or three people, which was a small number of people in the whole school. And in the class I was in, I was the only person of color, and everyone else was white, and my teacher was as well. So, there are certain poems and certain stuff that I would learn in school that made me feel a bit uncomfortable, and even for the teacher, I think it's because he was used to teaching white kids, and like white students, she didn't really consider me in that class. So, there were quite a number of things that she would say that felt like passive aggression to me, and I felt like it was an attacking thing. But overall, my grades are what would make me feel like, OK, there's nothing really going on. I'm being immature about it because whenever I would see my grades, I would still maintain a positive graph like the other kids. So, I was just like, OK, I don't really think it's attacking in a way, but it's something that made me feel uncomfortable in a class. So, I was just thinking 50/50, and I didn't want to play the race card, so that was it. So, yeah (Ceeja).*

*Yeah, not directly, but I'd say yeah. I've seen some things happen where I feel like maybe someone treated me unfairly, and if I think about it, after maybe it hits me up to like two days, and I'm like, oh yeah, I think that was racism, for sure. But I wouldn't say I've met someone who said stuff in my face, but I have experienced it and I have seen it happening to other people, for sure (Kamon).*

Experiences of racism, tribalism, and discrimination varied among participants. Some participants experienced them based on tribal affiliations and class distinctions, while others did not. However, when it was experienced, it had a profound impact on the participants' health and well-being, because it potentially limited their access to supportive health and social services and contributed to social and health disparities. Some participants discussed the prevalence of tribal stereotypes, prejudice in job opportunities, cultural clashes, and unequal treatment in schools, hospitals, and workplaces in their respective countries of origin. For instance, one participant described how people with private health insurance received preferential treatment in public hospitals compared to those with public health insurance. Additionally, another participant

discussed the impact of historical legacies like apartheid in South Africa on interactions with different races. Despite efforts to promote equality, many participants acknowledged that instances of discrimination based on race, tribe, and class were prevalent in their respective countries of origin, impacting access to social and health services before migration.

In Canada, studies indicate that immigrants contribute significantly to the economy through taxation, yet many immigrants, particularly temporary immigrants, do not benefit from the state they economically support (Caulford & D'Andrade, 2012; Chen, 2017), due to exclusive health and social policies and the constantly changing immigration laws and policies. Despite immigrants' significant economic contributions, there have been ongoing public debates about the unprecedented increase in the number of immigrants in Canada (Duncan & Caidi, 2018; Harris, 2018; Preston et al., 2022). Some of these debates have generated anti-immigration sentiments because of how immigrants have been portrayed as criminals, unwanted, illegals, outcasts, and aliens, particularly since 9-11 (Mogahed & Mahmood, 2019; Levin & Reitzel, 2018). Additionally, the rise of populist far-right ideologies in Canada has contributed to the politicization of migrants, portraying them as illegitimate intruders, threats to infrastructure, welfare programs, cultural homogeneity, and personal safety (Williams & Boyce, 2013). This promotes a hostile environment for immigrants, particularly precarious status migrants, who are often denounced and demonized by politicians and the general native population (Chavez, 2008; 2013). Many precarious status migrants internalize these messages, which adversely impact their health and well-being, and hinder their integration into the host society (González Enríquez, 2013). It is also worth noting that such anti-migration rhetoric and stereotypes about immigrants influence policymakers and politicians to develop and implement stricter federal immigration laws and policies that exclude precarious status migrants from fully accessing health and social

services (Golash-Boza & Hondagneu-Sotelo, 2013; Valdez et al., 2013). While these actions are often taken to prove politicians' toughness and position immigrants as criminals and lawbreakers, credible studies indicate that these portrayals do not represent the vast majority of immigrants (Sharpless, 2016).

Some participants experienced racial discrimination in Canada, which they often described as a subtle form of racism. Previous studies indicate that despite Canada's global reputation as an inclusive or multicultural society, its history as a white settler society is founded on a contradictory identity and evidence (Kihika, 2020). While Canada's multicultural policy promotes a sense of national "welcomingness," on one hand, its capitalist pursuit reinforces the construction of white privilege and exceptionalism on the other hand (Kihika, 2020). Some participants described what they experienced as microaggressions or patterns of discrimination, which were characterized by subtle and nonverbal interactions, and they often felt isolated or overlooked based on their skin color. Sue et al. (2007) have defined racial microaggressions as brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group. Despite variations in experiences, many participants experienced indirect or subtle racial discrimination, which made it challenging to address or identify clearly. These participants' varying experiences of racism and discrimination shed light on the complexities of racial dynamics and the impact of subtle racism in their daily lives in Canadian society. Notably, some participants expressed frustration at the lack of open dialogue about racism in Canada, contrasting it with more overt expressions in their respective home countries.

Some participants, such as asylum seekers, experienced healthcare discrimination due to exclusionary healthcare policy, which prevented them from accessing health and social services outside of emergency care while they awaited the approval of their asylum application and lacked Alberta health insurance coverage. Overall, participants described encountering racial discrimination in the workplace, educational settings, and in public interactions, where they felt excluded, unfairly judged, or treated differently due to their race. However, racial discrimination also intersected with other factors like ethnicity, stereotypes, exclusionary health policies, length of stay, and migration status to influence the health and well-being of participants.

### **Employment Opportunities**

Many participants shared their work experiences in Africa, highlighting varied financial situations, employment challenges, and family support. While some had well-paying jobs before migrating, others were either unemployed or had recently graduated. Despite economic uncertainties, family support played a key role in helping some participants manage stress and mental health issues, especially those unemployed in their home countries. Nearly all participants, including those with high-paying jobs, migrated to Canada seeking economic stability and a better future for themselves and their families.

*I was fortunate to be working in STEM, and maybe, like the software technology sector. So, I was fortunate to be in a company that is flexible with work conditions. So, I was actually working remotely from home and then in person as well, yeah. So, some days I think 3 days from home and I would meet the team and go on for two days in, in the actual office. It was just relaxed (Aaric).*

*When I was leaving, my financial status was good in the sense that I worked in a telecommunication company, which is a multinational industry, and I worked in the finance and Accounts Department, and my cost of living literally matched my inflow or the household income, which I think I was doing pretty well. Well, obviously everybody was also looking at it from the angle of what the future of the economy related to some things, and some of us decided to just take a bow out and probably look at what the West is like apart from getting the knowledge also, let's look at it from what the West is, what we can gain from the West and not sit in your circle, you understand (Marcus).*

*The truth, to be very frank with you, my brother, is that, back in Nigeria, too, I was not doing badly at all. Because at the time I took that decision, I was already doing my 22nd year in the bank. So, in addition to working in the bank, I had a business that I was managing. I have been in real estate, the financial services industry. I have grown my business a little; I wasn't just a young boy who just woke up from school and said I wanted to travel (Samon).*

According to Johannes, some jobs in Africa were physically demanding and tough, which often caused stress and other health issues. However, some people, including himself, took on those jobs to make ends meet when there were no other viable options.

*I was working there, and I had my own personal things I was doing for myself, yeah. Yeah, I think that the little thing you can get from the one I was getting from there was just to make ends meet, like taking care of myself, maybe sometimes my family. But sometimes it's not even enough. Yeah, I think in Africa, first, we get a lot of stress from doing physical work sometimes, yeah. So, also to the stress, we try to see how we can get something to take care of our families, and sometimes we get sick, and maybe not have a good medical system. And you are too stressed. Maybe how can I put it? But it's sometimes stressful back home, yeah (Johannes).*

Some participants stated they had limited or no work experience in their home countries because they migrated to Canada right after high school or were underemployed or unemployed. As a result, their parents provided financial support, which helped them cope with the challenges of unemployment.

*No, I didn't have a job in South Africa. My parents took care of me and paid for everything because I was still in school (Abira).*

*Finding work was really a challenge. You drop off resumes at companies, in restaurants, but they don't want to hire. Yeah, yeah, that's. Yeah, that's it, yeah. Yeah, I found a job after school, but they were just for a short while. So, finding work was a little bit of a challenge. Yeah, I had been doing some part-time jobs, yeah, and also my parents helped me a little bit. Like something like the rent, yeah (Darion).*

*When I finished school, I was employed for a while until the company had issues. So, after that, I wasn't employed. I was just floating around, going to cyber cafes, helping students to register for their tertiary institutions, and stopped doing and collecting some money, some peanuts from them. Because of the lack of employment and whatever things that place a little bit on your mind, but because you have your family, the support base, and everybody around you, so, you tend to continue with life over there, you understand?*

*Even if you are not good financially and economically, but you still have your family over there, and you're mentally you're good, yeah (Timon).*

Employment status intersected with age and social support networks to influence the pre-migration health and well-being of participants. For example, younger unemployed participants supported financially by their families did not experience as much stress related to unemployment as older participants with significant family financial responsibilities.

*Although I have my family around me, it's less, but it did because at some point when I started growing old, I knew that I had to, like, leave my father's house and then go for my own family and all that. So, all these thoughts played a big role. So, I was thinking more so that that was why my sister decided to help out, so she did, yeah (Timon).*

*I mean, it was, it was, it was, my health status was excellent until I started growing up, and then I started thinking of leaving my father's house, and then, because I was staying in my parents' house for a long time while I was unemployed. So, it's just really recently, and I started like I started thinking about it, and then started playing a role in my mental health, but throughout my entire life, my mental health has been excellent (Timon).*

While some participants had well-paying jobs in their home countries, once in Canada, they either worked part-time because of their temporary student status, held jobs below their qualifications due to unrecognized foreign credentials, or because their chosen field required advanced studies. Contrary to their pre-migration expectations, many found it difficult to secure employment upon arriving in Canada. Despite challenges with foreign credential recognition, some participants remained hopeful about future career prospects by pursuing additional education, exploring entrepreneurship opportunities in their fields, or choosing different career paths to improve their marketability. Limited job opportunities, part-time work, and transportation issues also increased stress and financial strain for some participants. They felt that priority in hiring was given to permanent residents, citizens, and refugees, making it harder for students and work permit holders to find employment; nonetheless, participants adapted by taking unrelated jobs in the hope of obtaining permanent residency.

*Right now, I am on a 3-month work probation period. So, before I came here, I was a microbiologist. I have a microbiology degree, and I am now working in community disability. In a way, I do feel that my potential is being underutilized, but also in another way, for me, I feel like I'm in a place where I'm choosing to do this work. So, I haven't purposefully gone out looking for a microbiology job. If that makes sense. Yeah, so I am kind of choosing also, like right now, not to do microbiology, but I have searched even though I haven't done applications, because I wanted to see, like, if I changed my mind, what the prospects are, and it's not looking good. I'm probably going to have to go and do a master's or something (Sunshine).*

*No, my qualifications do not match my job description here at all because I have a degree from Ghana, but it doesn't work here. Even with your degree, you still need to find a school, like going to school here, before you have access to those things, those work opportunities. So, now I'm just managing what I have, but it doesn't really match my qualifications. So, I'm looking forward to, like, getting more knowledge by going to school. However, because I'm an asylum claimant, it's hard for me to get enrolled in school (Miss Brown).*

*I'm not fully employed, yeah. Getting a job is not easy, and even if I get a job, I will get back to part-time work. To get a full-time job, it's not easy. So, all stuff like that stuff added to the stress. Coupled with the fact that I'm struggling to get a car because I don't have a car to get to work, as well. I lost a lot of jobs, also, maybe because I didn't have a car. It's also not easy to get the money to buy a car. Right now, I am in a healthcare job. That's what I do right now. Yeah, yeah. you see, it keeps fluctuating. Sometimes they will take you off shifts, sometimes they will increase it just like that. And sometimes they will give shifts to some people. We don't know why sometimes they take it from us. That's why right now I'm looking for another job, yeah (Johannes).*

Timon reported that he had difficulty securing full-time employment at one point because his study permit had expired.

*There was no job, only two days of job in a week, and I was looking for other jobs. I knew that if I applied for other jobs, they gonna ask me for my study permit, so I couldn't apply, so I would just hang in there (Timon).*

To improve his focus on academics during the fall and spring semesters, Caesar worked more hours during the summer break. Additionally, he had a secondary income from his business in Africa, which helped to alleviate part of his financial burden and maintain his sense of masculinity.

*No, right now I'm not employed because of school. But during summer, I work, yeah. Usually, during the summer, I get to work a lot. I mean, I save. I save a lot during the*

*summer. I get. I save a lot during the summer, and the money I get for the summer can really cover me until the next summer. And also, I mean, as a man, I also have the small things I do in Africa, which also gives me some money, and yeah (Caesar).*

Additionally, Darion discussed the strain of being a man with a low income who must rely on his sister for financial support because, as a man, he desired to be the one to provide.

*My work contract just ended. Doing a part-time job stresses me out. Yeah, yeah, it does. It stresses me out. Like, right now, I can't tell my parents that I am suffering from this. You don't want them to worry that much. Yeah, yeah, and I also don't want to worry my sister all the time because she's supporting me already. And I don't want to give her much pressure. Yeah, it's stressful, it stresses me a lot, yeah. It really stresses me out because I'm the man here. I want to be the one who's providing. Maybe even if it's once in a while, even though I haven't, because I have no job. It stresses me a lot (Darion).*

Interestingly, although they knew that the 40-hour-per-week employment was a temporary immigration program designed to address labour shortages during and after the COVID-19 pandemic, some student participants felt the federal government exploited and discarded them once they were no longer needed. For example, Talitha mentioned that the reduction in hours from 40 to 24 impacted both employers and students, as there were times when her employer needed her to work extra hours due to labour shortages, but could not do so because the new immigration policies limited her to 24 hours a week when school was in session. Additionally, some participants stated that certain employers did not hire them at all because of these policies, which restricted their working hours and, as a result, impacted their finances.

*They use them when they need them, and when they don't need them, they dispose of them. That is what they do. So, I think they should, if you're giving me the chance to work 40 hours when you need me, I think you should just run with it and not make changes when you don't need me anymore, because I need the money (Kamon).*

*You also have to be careful not to work more hours than you possibly can. The temptation that comes with your workplace looking for someone to cover a shift, to fill in a shift, and you are available, but you're unable to pick up that shift because you've already served your 24 hours for the week. Yeah, it is quite stressful (Talitha).*

Some temporary worker participants, including PGWP holders, also mentioned that securing full-time jobs with temporary status was challenging because many employers preferred migrants with permanent residency or citizenship. Kamon added that their difficulty in obtaining full-time employment was partly due to their identifiable African names and accents, which often created communication barriers between employers and immigrant employees. All these employment challenges influenced the health and well-being of the participants.

*Now the priority right now is for you know, permanent residents and citizens and refugees to get jobs, which makes it harder for students to get jobs or people with work permits like me to get jobs. I don't know, I feel like it just makes life way harder for some. So, yeah, I think they should make some changes. Sometimes when I apply for a job online, and I don't know, I just have the feeling that [laughing] I might, my name might affect whether I get the job or affect the kind of responses, the number of responses I get back. I wouldn't know for sure, but that thing is always there (Kamon).*

*Yeah, but luckily, I found a temporary work permit. Yeah, but when I came here, I really struggled getting work, and my first job was a three-month contract. Yeah, yeah, yeah. And the first thing that made me struggle with finding work was the communication with the Whites. I wasn't that comfortable with them. And um, yeah, that's the reason, yeah (Darion).*

Although some participants were dissatisfied with their current employment in Canada because it did not align with their foreign credentials, they perceived it as part of the immigration process, despite the negative impact on their health and well-being. However, other participants were content or indifferent about their job roles, even though they did not match their qualifications, because they still earned more than their counterparts in their home countries who held jobs suited to their credentials. For example, Samon intended to start his own business in the future instead of worrying about his current job that did not match his foreign credentials. Furthermore, Samon mentioned that even though he had a well-paying job in the corporate sector in Nigeria, he experienced more work responsibilities and enjoyed less family time than he does now in Canada.

*I'm working in a field completely unrelated to what I went to school for. It does affect me, but I'm working this job at the moment with the hopes of getting my PR. So, I'd say it's for the greater good. It's one of the things you have to go through as an immigrant. Yeah, but it affects me for sure, but I'm good with it (Kamon).*

*Although my job description does not match my qualifications, it doesn't affect me anyway. Do you know why? Based on my kind of person, my dream is not to work and work and work and work for people. You know, why? From what I see, in Canada is not going to be easy for me to get that kind of offer to start with. With regards to my qualifications, I've kept them, my dream is as soon as possible to be able to come up with a concept that is sellable here, that I will own a business for myself so whatever knowledge I acquire will be put even in my day-to-day work I put it into use whether the user recognizes it or not but whatever knowledge I have and put into use whatever work I do (Samon).*

*You can't use your qualification from Nigeria to work here unless you are extremely lucky. Talking about qualifications, even if I got a job in Nigeria with my qualifications, it still wouldn't be as much. What I earned from there still won't be much, compared to what I earn here in Canada, even though I am doing a job that does not match my foreign qualifications. So, it's really tricky. Do you understand what I'm trying to say? (Timon).*

Additionally, Samon stated that many immigrants are not securing jobs that match their foreign credentials because their skills or specializations are not in high demand in the Canadian labour market.

*When we came here, we discovered that general management was not really marketing. We now realize that the course is not that sellable here. That social work was more sellable. Now said, which course can we approach now that is marketable at the end of the program (Samon).*

While some participants held steady jobs in their home countries, others were unemployed because they were younger, recent high school or college graduates, or struggled to find full-time work. However, the impact of unemployment on health varied among participants, influenced by age, family financial support, and family responsibilities. Consequently, some unemployed participants, especially younger ones, did not experience severe adverse effects because they received financial support from their families. In contrast, older participants often experienced more intense financial hardship due to significant family responsibilities, including

expectations to be breadwinners, without additional family financial aid. Therefore, family financial support played an important role in helping some participants manage their financial challenges both in their countries of origin and after migration. Stressful work environments, unemployment, difficulty finding jobs, financial challenges, and lack of support systems influenced some participants' decisions to explore opportunities in Canada. This highlights the importance of financial and employment stability, as well as family support, at different stages of life.

In Canada, the Employment Equity Act (1995) was enacted to promote equality and address the disadvantages experienced in employment by marginalized groups such as Indigenous peoples, people of colour, immigrants, and persons with disabilities in the workplace. However, some participants felt discriminated against by employers due to poor recognition of foreign credentials, unequal distribution of work, difficult accents, identifiable African names, and hard-to-pronounce names (Employment and Social Development Canada, 2019). They also experienced inadequate understanding of the labour and health systems (Bajwa et al., 2018; Yanar et al., 2018; Hall et al., 2019), and limited social support (Doki et al., 2018), all of which contributed to stress, frustration, anxiety, and depression. Nearly all participants had precarious employment, such as part-time, temporary, or contract work, largely due to their migration status. Precarious employment describes "a sense of lack," including unstable working conditions, unstable income, lack of social and employment protections, vulnerability to wrongful termination, absence of security, limited career advancement, and other factors associated with unfavourable employment conditions (Bajwa et al., 2018; Kalleberg, 2009, 2014; Rönnblad et al., 2019). Some participants viewed precarious employment not just as a loss of income but as a failure to achieve their migration goals, which often led to thoughts of return migration and

feelings of frustration, stress, and depression. The psychological impacts of precarious employment varied depending on factors like family financial support (from parents and siblings) and cultural and migration backgrounds and needs (Shen & Kogan, 2020). Older participants felt these effects more acutely as they struggled to meet multiple family responsibilities, placing them in a socioeconomically disadvantaged position. Additionally, some participants' job roles did not align with their qualifications, motivating them to pursue alternative careers, further education, or nationally recognized certifications after obtaining their permanent residency. However, other scholars have noted that even recertification in the host country might not be sufficient to secure employment matching their qualifications, due to prejudices, biases, and racial discrimination by employers (Coates & Carr, 2005). Despite these challenges, many participants remained hopeful and resilient in their pursuit of career goals.

### **Money Matters**

Some participants reported that they were well-established and earned enough income in their countries of origin to meet their social and health needs, such as access and utilization of healthcare, while others only earned just enough to cover their basic needs or were unemployed or students living with their parents and had no living expenses. The study findings also showed that some participants' incomes in their countries of origin did not align with their qualifications.

*When I was leaving, my financial status was, um, was good in the sense that I worked in a telecommunication company, which is a multinational industry, and I worked in the finance and Accounts Department, and my cost of living literally matched my, matched my inflow or the household income, which I think I was doing pretty well (Marcus).*

*My income, without mincing words, my brother, and my income influenced my health very positively. If I didn't have that income, I wouldn't have been able to do my annual check, and I would not have been able to have a private doctor (Samon).*

*I was a full-time worker back home, but my expenses were more than my income. Very low income (Miss Brown).*

Sion mentioned that low income or poverty influenced his use of traditional or alternative medicine because he was unable to make ends meet.

*Low income was one of the challenges that I personally faced back home in Ghana. Because what you work for is not how much you earn at the end of the month. The job that I was doing and the salary I receive every month do not correlate. And my salary wasn't even meeting my expenditures in Ghana, so it was very tough for me. Poverty plays a major role because the reason why I'm saying this is. First of all, I was really educated because I went to school, and I really know how important Western medicine is, but then sometimes you can't afford it. I won't develop a love for something that I can't afford. Therefore, I developed a love for local medicine, because I didn't me much or anything. Sometimes I would just pack up and go to the farm and just get some, I mean, local medicine, come home and put it on fire and just drink it (Sion).*

Because they earned lower incomes, some participants reported that their parents' financial support, including free accommodation, sustained them in their countries of origin.

*Um, I really didn't have many expenses considering how I was still living with my parents while I worked. So, to get the extras that I needed, my income was, it was OK. It could have been better for the job that I was doing because I was, I was, um, I was an assistant in an office area. I was a secretary, so it could have been better, but considering how I was living with my parents, I didn't really have many expenses like rent or utilities to pay. So, it was ok, yeah (Talitha).*

Some participants earned enough to make ends meet, while others reported that the rising cost of living made it difficult for them to cover their expenses with their low incomes. Although some participants admitted that their income in Southern Alberta did not match their foreign qualifications and could have been much higher, they were not overly concerned by this because they either saw it as a necessary part of the migrant experience, and it was still higher than what their counterparts earned in their countries of origin, or because their families financially supported them. Importantly, despite income disparities, some participants found comfort in benefits like free healthcare, which minimized or alleviated financial stress.

*Um, my parents support me as well as some of the money that I get, but generally, my salary cannot meet all my needs (Ceeja).*

*So, in terms of net income, I do not see myself as doing badly at all because by the time I sum up what I earn gently, if care is taken, I may be able to get up to 17-18 dollars after tax from both jobs. Which is, if I want to say OK, I'm zeroing it only on the bank. So, in terms of Naira and Kobo, I'm not feeling shortchanged (Samon).*

*I still earn more than what I would have earned in Nigeria doing jobs related to my field of study. I earn more here doing jobs that are not related to my field of study than what I would have earned doing jobs related to my field of study in Nigeria (Timon).*

Some participants' health and well-being were adversely impacted by low income because they had no alternative sources of financial support.

*Right now, my income and my expenditures don't match. My expenses are way higher than my income. It's really draining me because right now I feel like it's very tough, it is really, the journey has been so tough (Sion).*

*I would say, yes, low income is one of my challenges. Because coming from the summer, where I could work as many hours as I possibly could, 40 hours or more. Um, and then having to come down now to a limited 24 hours, the change in income. So now the budget is tighter. And we know that tuition is a lot. It is really a lot. So, just having to balance the financial part of things with the limited hours that I can work, I would say it is quite challenging a bit (Talitha).*

Despite earning less than what she was qualified for, Miss Brown was okay with it because she did not have to pay for access and utilization of healthcare in Canada, unlike the high costs of healthcare in Ghana.

*Although my income does not match my qualifications, it does not bother me because I don't need to pay anything when I go to the hospital, and that alone relieves that stress or burden off me. I don't need to think about paying for hospital bills, you know. When I'm sick, I'm free to walk to any clinic and get my health checked, so I think it's not a burden for me here (Miss Brown).*

Due to their financial challenges, other participants reported that they relied on the financial support of their sponsors (such as parents and relatives) for everything, including financial statements needed for their visa applications.

*Many people, like in my area, especially I in my area, a lot of people struggle a lot. So, there's no financial means, it's really hard for them, they really find it hard to meet the expectations of coming here. Yeah, but for me, I got lucky because my sister kind of sponsored me to come here (Darion).*

*Yeah, in Nigeria, I was going through financial issues, financial problems, you know, there is no job, so that affected me mentally (Timon).*

In Southern Alberta, some participants indicated that the challenges of finding jobs, the high cost of living, underemployment (such as reduced work hours for students), low income, high international tuition fees, and lack of financial support all intersected to influence participants' health and well-being. Some students also experienced financial challenges due to changing financial circumstances of their sponsors, which disrupted their studies and impacted their immigration status because they had to drop out of school.

*Um, my parents pay off like, everything I need to get (Abira).*

*I'd say paying school fees (tuition) was also a huge, huge problem for me, and I think it still is for a lot of people. You're paying three times the amount that domestic students are paying. Yeah, it's not easy, it's not easy. I know we have sponsors, we have people who are paying for our school fees from back home, but yeah, sometimes things change, and the money is no longer flowing like it used to, and yeah, that can be a challenge for international students, which I was a student for four years (Kamon).*

It is worth noting that not all participants experienced financial challenges. Some reported less stress from financial challenges because their parents or siblings provided them with financial support, compared to others who did not receive such support from their social networks.

*Yeah, so far, yeah. I can say that because you know, I'm not, even if I have no employment, my sister houses me, and she feeds me. Yeah, so, for me, I'm good, yeah (Darion).*

*Even though you are not good financially and economically, you still have your family over there, and you're mentally, you're good, yeah (Timon).*

Some participants who were previously students reported that they dropped out of school to seek asylum due to financial challenges. Others took a break to work over the maximum 24 hours per week new immigration policy (during the school semester session) because they could

not afford the high international tuition fees, which adversely impacted their health and well-being.

*I came here to study, but things didn't turn out the way I wanted due to financial challenges. So, I had to pause my schooling for now. My uncle paid most of the money, but after getting here. He was supposed to pay my fees, and then one or two things happened: my dad also fell sick, so because of these things, I couldn't, like, start school. But unfortunately, as things happened, he got angry and said he wasn't going to pay my fees again (Miss Brown).*

*But you know, when I came here, I really understood my uncle because he actually supported me with the visa application fee, everything like my flight ticket, just that tuition fee, he paid the initial deposit, and he told me when I came here, he would pay the rest. So, when I came here, I started school alright, but the money wasn't coming, and I couldn't force my uncle to send me money because, at the end of the day, it's my dad's responsibility. He was doing that because of like he was very sympathetic about it, and he was actually doing that even though it wasn't his responsibility to do that (Sion).*

It is well recognized that financial challenges due to a low socioeconomic status and the inability to make ends meet can lead to stress and cognitive load, which in turn influence poor physical and mental health outcomes (Clark et al., 2021; Woolf & Braveman, 2011). Many research studies suggest that individuals' physical health and quality of life are influenced by their ability to afford safe housing, high-quality healthcare, and nutritious food (U.S. Department of Health and Human Services, 2020; Woolf & Braveman, 2011). Therefore, people with lower socioeconomic status are more likely to experience poor health than those with higher socioeconomic status. Before migration, some participants had a good financial standing because they had good-paying jobs in sectors such as the technology industry, a multinational telecom company, or a financial institution, which positively influenced their access to and utilization of health and social services in their home countries. Some younger participants had no income, but they were financially supported by their parents or siblings, and were often included in their health insurance coverage, which positively impacted their health and well-being. However, others struggled with low income in their home countries, hindering their access to and

utilization of health and social services, and access to holistic health and well-being.

Consequently, low income influenced some participants to use alternative or herbal medicines due to their inability to afford allopathic healthcare costs. As one participant stated, *“If you don't have money, you go for traditional medicine. It helps because most people cannot afford to buy drugs or to go to the hospital.”* These patterns emphasize the significant relationship between low income and access and utilization of health and social services, and their associated adverse impact on participants' health and well-being in their respective countries of origin.

In Canada, precarious status migrants are more likely to live in poverty due to low income associated with unstable employment, adversely impacting their health and well-being since employment and income are well-documented as social determinants of health (Craig-Neil et al., 2023; Liang et al., 2021; Patel et al., 2018; Tibber et al., 2022; World Health Organization, 2007). Many of the participants earned low income, including those who had previously earned higher incomes in their home countries, because of their precarious employment conditions characterized by low minimum wage, unemployment, underemployment, restricted work hours, lack of stable employment, lack of recognition of their foreign credentials, and a lack of health benefits beyond universal coverage. In addition to influencing their access to income, participants' precarity also often contributed to adverse mental health outcomes, including anxiety, stress, frustration, and depression. Several studies in Canada suggest that racialized minorities, such as immigrants (particularly recent immigrants), are more likely to earn less income and experience more precarious employment than native-born Canadians due to many reasons, including non-recognition of their foreign credentials and a lack of Canadian training or work experience (Reitz, 2007a; Shen & Kogan, 2020). Furthermore, studies also suggest that while socioeconomic disparities or gaps between native-born Canadians and immigrants may

close over time, equity may never be fully achieved (Reitz, 2007b). Consequently, prolonged periods of low income may worsen the financial status of many participants, thereby creating financial barriers to accessing primary healthcare and widening health access disparities.

Due to their low income, some participants frequently struggled to meet their basic needs and fulfill their financial obligations to their families, such as caring for sick loved ones in their home countries, which had a potential impact on their health and well-being. The extended family pressure or expectations to contribute financially to support their non-immigrant family members, the high cost of living, precarious employment, and high international tuition fees, combined with the psychological impact of their precarious immigration status, led to stress-related illnesses such as anxiety and depression. This financial shortfall often persisted despite participants holding multiple jobs to make ends meet. Additionally, their low income prevented some participants from seeking help from some health experts or professionals, including therapists and counsellors, who required out-of-pocket payments

One international student participant discussed how the financial situation of many international students, like himself, was thrown into greater precarity in the face of changes to Canadian government policy that restricted the maximum number of hours they could work each week to 24 hours, down from the previous maximum of 40 hours per week. Consistent with scarcity mindset theory (Liang et al., 2021), this financial struggle and preoccupation with costs and trade-offs impacted these students' cognitive abilities, made it hard for them to concentrate in class, and sometimes led some of them to put off their studies:

*“Sometimes they go to lecture halls, unhappy because they feel like Oh! I have bills to pay. How am I going to pay my bills? So, while at the lecture hall, he or she will be*

*thinking about his bills, so at the end of the day, is she focusing on his studies or not? He's not focusing. He's thinking about his bills (Sion)."*

Overall, the impact of low income or no income was experienced differently by participants based on their age, family financial responsibilities, and the family's financial support. This illustrates the complex financial realities participants experienced in different situations and how their low incomes influenced their access to and utilization of health and social services.

### ***Life Course Backsliding***

One potentially useful theoretical perspective to examine the impact of financial precarity on health and well-being is that of life-course (McDaniel and Bernard, 2011). The life-course perspective, according to McDaniel and Bernard (2011), is based on four fundamental tenets: (a) our everyday experiences create a trajectory that starts at birth and continues until death; (b) life-course development involves multiple interconnected domains, including physical, cognitive, emotional, and social aspects; (c) social bonds formed throughout our lives impact our life course and that of others; and (d) life-course development is shaped by several contextual factors (both local and national), such as culture, family, socioeconomic status, and historical events.

Some participants, particularly older ones, who had stable employment and well-paying jobs in their home countries before moving to Canada, experienced some life-course backsliding in the post-migration period because of their unstable employment, unfavorable living conditions, and uncertainty about their future in Canada. In other words, they experienced a loss of previously achieved life-course milestones, which resulted in a sense of backsliding in terms of their progression towards their goals (McDaniel and Bernard, 2011). Their precarious migration status affected their access to, and use of, health and social services, which they never

lacked in their respective countries of origin due to their previous privileges, age, social status, financial status, and access to social networks. One participant stated:

*“The truth, to be very frank with you, my brother, is that, back in Nigeria too, I was not doing badly (meaning he was doing well). Because at the time I took that decision, I was already doing my 22nd year at the bank. So, in addition to working in the bank, I had a business, and I have been in real estate and the financial services industry. I have grown a little, I wasn’t just a young boy who just woke up from school and said I wanted to travel (Samon).”*

While some older participants experienced life course back-sliding, some younger participants who were unemployed, employed part-time, or students in their respective countries, who migrated to Canada to continue their educational career, could be viewed as a life course development because they were in school, continuing their educational career (which was their main reason for migrating to Canada). While some were unemployed, employed part-time, or students in Canada, a few participants were financially supported by their social support networks (e.g., parents and siblings), enabling them to progress towards their life course goals despite encountering these structural barriers.

### **It takes a Village to survive**

This theme captured the importance of community (such as extended family members, neighbors, teachers, community leaders, and community resources) in providing a network of support, guidance, and resources that help shape an individual’s physical, mental, emotional, spiritual, and social well-being. Navigating the challenges associated with migration and establishing yourself in a new country requires the collective effort of many supporters along the way and a strong sense of community. Participants shared their varied pre-migration social

support network experiences, highlighting the importance of family, friends, and community for emotional and sometimes financial support in maintaining well-being. Many participants felt well-supported by a close-knit network, while a few participants described their varying levels of support based on cultural norms and individual circumstances. Participants' strong pre-migration social support positively influenced their health and well-being.

*I grew up in Cairo, it is a big city where people mostly don't leave. So yeah, I just like we grow, we grow up all together in the same kind of city, like, we are two hours away because it's a big city. But we are, yeah, yeah, we are just growing up together. So, my friends from elementary school up to high school and college, we're all like connecting all the time, and family as well (Aaric).*

*My social support network back home was good. I think the closer I was living to them, like it's obviously easier to access and have access to everyone. But when you move away from your family, like I mentioned, the last neighborhood that I lived in was a bit farther from my family, but not that far. It was about a 25-minute drive, and you know, back home, a 25-minute drive feels far compared to when you are here (Sunshine).*

*My social support was and is still amazing. My family, friends, yeah, yeah. I have a great dad, grandparents, you know, aunts and uncles, who are very supportive of me. The community that I have back home, and yeah, just the community, friends, family, and how people socialize back home, which is very easy to, you know, talk to people, whether you're on a bus or you're just walking down the street. I would say that helped me do well mentally (Kamon).*

However, the composition of participants' social support networks varied. Thus, while many participants included family members, friends, and neighbors as their social support networks in their countries of origin, some participants had only family members as their social support networks due to strict parental and family beliefs.

*Social support system, I will say, I mean, friends, not really. I will say maybe in the family, like with my uncles and aunts, yes. I can always go to them if I have any problems. But for friends and so no, I don't, I don't really think so (Caesar).*

*I grew up with parents who were very strict, and they just made my network very small. So, the people I would get along with or people they'd introduce me to would be, um, their sisters, their siblings, and maybe my grandma and my grandfather. But I didn't really have a lot of connections with my whole family (Ceeja).*

Interestingly, according to several participants, the ability of the individuals who formed a person's social support networks, especially their financial ability, determined how strong those networks were in their home countries, which Samon described as the “Pyramid of Look.”

*Social support in terms of government is zero. Social support in terms of family, friends, well, we'll say average, because the way it works in Africa is this. There's this “the pyramid of look.” [Laughing loudly]. What this means is that the man looks at you and says, “This one will be able to help me.” You look up and say the other man will be able to help me in terms of assistance, and so on. So, like I said, an average person is not very high up there and not very low down there. So really, apart from moral and information support, which I cannot deny because, like I told you, my clique influenced and eased my migration decision. That's when they were all moving, they would tell me, Samon, “I'm relocating now,” and I would ask them, “Where are you going?” And so that social support in terms of family and friends does exist (Samon).*

*I had family and friends, I could rely even like neighbors, um, because of like the community that we stayed, we could like, you know, even rely on neighbors and friends to say oh maybe let's say we hear that there were thieves in the neighborhood and then there's like a neighborhood watch that's there to make sure that the whole neighborhood is safe. Even with family, if we needed anything, we could just call and rely on them when we are in an emergency. So yeah, I will say I had quite a diverse network, but it depends on the needs that I had at that point (Sheba).*

*Yeah, reliance on family and friends, but it depends on the context of reliance we are literally looking at. If it has to do with, um, because we are communal in a sense, we tend to enjoy ourselves every weekend. You know, despite the fact you go through stress at work and everything, you know, you have one or two things, but when it has to come to the weekend, we try as much as possible to also enjoy the bit of what we've worked for over the week. But when it comes to relying on friends and family for money, there is what we call OYO back home, which is an acronym for “On Your Own,” meaning you're on your own. So, when it comes to finances, you need to literally depend on yourself and probably your nuclear or probably extended family on this (Marcus).*

After migration to Alberta, all participants continued to maintain strong relationships with their pre-migration social support networks (e.g., family members and friends) due to the continued practice of a culture of collectivism, lack of strong post-migration social support networks, and being far from home. Many participants maintained strong transnational ties with their home countries to help them cope with their post-migration challenges, such as a lack of sense of community, as they sought to form new social support networks in their new

environment. Some participants drew strength from participation in cultural and church activities and groups, family, or formed meaningful relationships to combat feelings of isolation and homesickness. Others expressed disillusionment with the limited social support in Southern Alberta. The contrast between the communal values of their home countries and the more individualistic nature of Canadian society was highlighted as a significant adjustment for many.

*There's not that big a sense of community here. It's this whole image of yourself if that makes sense. Like, I know in Africa, there's this whole thing that says it takes a village to raise a child. Here, there's like, there's no sense of that village. It's like a one-man show, like, each man for himself, God for us, all types of mentality. You know, like, I don't know how to explain, I think if that makes sense (Sheba).*

*Social support network in Canada, I won't say it's excellent or good. I'll say it's OK. Because I remember, like last year, when I had a problem. I was expelled from work, and it's my uncle who helped me. So, I think that was my biggest challenge in Canada because at that time, I remember I got to work, and after two weeks, I was gone. I was told to leave, and my car broke down. I didn't have anything. So, it's my uncle who told me to just come to Edmonton, to his place. And yeah, he gave me some advice. So, I think, yeah, my uncle is one of my biggest social support networks. And then again, maybe in Lethbridge, I will say a few friends, whom I have. Because, I mean, I won't always go to Edmonton. But yeah, you can't compare this to one I have back home. Back home, I'm with my parents (Caesar).*

*Here in Canada, it's like I'm all by myself because my sister has her husband, and they have kids, so they are on their own. Sometimes, I wouldn't even speak to her for weeks. It's just that I usually get calls from my mom and my dad back home. Yeah, in Nigeria, I was going through financial issues, you know, there was no job. So, that affected me mentally. But in Canada, because there is actually no one around, it's worse because you are lonely; there's this social environment that we've created for ourselves in Nigeria that is not available here. Everybody's working somewhere and nobody has time, you understand, so it's difficult here than in Nigeria currently. Yeah, mentally it is more difficult here than it was in Nigeria (Timon).*

Sadly, some participants reported they did not have any social support networks in Canada.

*I don't have any family members here. And I don't even have friends here. So, no, I don't have anyone I can rely on (Miss Brown).*

*No, I don't have any social support network here. It's only me here (Raisa)*

Some participants talked about the composition of their social support network and experiences in Canada, which was consistent with what Samon had previously described as the “Pyramid of Look.”

*Yeah, I have a brother, yeah. He is also in Lethbridge, but he has a family. Yeah, so I don't really, I don't really include him in the finance things. Yeah, because I'm used to my sister. Because she lives alone. She doesn't have much to do, yeah (Darion).*

*I do not really have a social support network in Canada. Not really. The one thing I've noticed in this country is that people can support you to some extent. Yeah, maybe I've not met one. Yeah, there are kinds of support people can give you. I have people who can advise you when you are going through something; you can talk to them, and they will tell you what to do or just give you a hint (Johannes).*

Contrary to his initial perception of Canadians as individualistic, Samon reported that although he had a stronger pre-migration social support network, he had managed to form a strong social support network in his community in Lethbridge because his neighbors welcomed him and helped him integrate well, resulting in a cultural shock.

*My social support network in Canada is fine. Yeah, like I said, this community, I joined the church too, so I'm a little bit active in church. I don't feel isolated at all, that's just the truth, yes. When we came to the neighborhood where we got our accommodation, it reminded me of the true African extended way of Life. It reminded me of how we lived in the village, how I could go to my neighbor's house to get fire. Because our neighbors would check on me, give me things. Luckily, I know it doesn't happen very often in Canada, in this place where we are, we do this annually like the beginning of summer, they share, one family, takes it upon themselves, will share letters with everybody, we should just come out and anything you have, bring it and if you don't have anything, just come, let us know our neighbor. That's what we do here. I've spent this second year here now, and we have done it twice. Told them we were new in Canada, in fact, they checked on us, so I felt at home. So that cultural shock that we were expecting, or “Oyibo” (meaning a Caucasian in Nigerian dialect), don't talk to people, “Oyibo” live their own lives, we have never experienced it yet in my community. I don't know about other people, but that is my experience, I'm telling you (Samon).*

*When I was looking for a job, I could just see my neighbor parking, I ran to him and I said, Please, I'm looking for a job and it actually helped. Even if I didn't pick up the job, at least to have taken my resume to somebody who would invite me for an interview, at least they have done their bit, right? At least I was well-received in this community, and I'm very happy about that. I thank God for that (Samon).*

Some participants indicated they experienced homesickness due to the absence of their pre-migration social support networks.

*So, it's like you're now trying to find that sense of community again. But like I said, as a Zimbabwean, you barely find a lot of Zimbabweans, or they're doing different things. You can't rely on it, like forming a community with people back home. So that's trying to find that sense of belonging in a new environment, trying to make a new home in a place that's originally not your home. I'll say that that's the biggest challenge, and also coping with homesickness (Sheba).*

Interestingly, Sunshine indicated that while there were not many South Africans in Lethbridge, she also did not want to associate with those who are here due to her experiences of racism in South Africa.

*Lack of community or people that's from the same place as I am. There aren't a lot of South Africans here, and the people who are, you know, are the people who discriminated against me back home. So, those are not the people that would want to gravitate towards [laughing](Sunshine).*

Sadly, Kamon shared how he lost some African friends in Lethbridge, which he partly attributed to a lack of a strong pre-migration social support network, and how some Africans often ignored mental health issues.

*I wouldn't say they were close friends, but they were people I talked to. And yeah, we used to hang out, but I wouldn't call them my close friends. Um, I wouldn't say that. One of them had an overdose; that's how he died. He was homeless at some point. And yeah, he had his closest family members in America, I think, but in Canada, he only had friends, and I think neighbors from back home. And the other one I knew had some mental problems as well, and he recovered, and then after that, yeah, he had an accident driving. I think he was drunk. Um, yeah, I'm not sure, but I think that's what happened, and yeah, yeah, they had friends (Kamon).*

An individual's social support refers to the network of friends, family, and neighbors who assist or comfort them to help cope with challenges or stressors (Garcini et.al., 2021), and the strong relationship between social support and improved overall health and well-being of immigrants is well documented (Lin et al., 2020). Many participants had strong pre-migration social support networks, primarily comprised of family, close friends, and community, and they

emphasized the tight-knit community bonds in their respective countries of origin. These social support networks played an important role in participants' lives because they provided them with resources, such as financial and emotional support, which positively influenced their health and well-being. However, before migrating to Canada, some participants only had their immediate family as social support due to strict parenting, family beliefs and norms, or financial constraints. Additionally, other participants reported that the degree and availability of financial or emotional support from family, friends, and neighbors varied depending on the circumstances of individuals who formed their social support networks, which one participant described as a "Pyramid of Look." The "Pyramid of Look," according to this participant, means that one should know the capabilities of individuals in their social support network and categorize them before approaching them for any kind of assistance, including financial assistance, because it makes things easier and saves time.

Some participants migrated to Canada because of their already established social support networks (Siblings, uncles, and friends) in Canada, which supports previous studies that immigrants are more likely to migrate to countries where they already have established social support networks (Koser,2007). This helped them navigate challenges in their unfamiliar environment and assisted their integration into Canadian society. However, many participants felt the loss of their pre-migration social support networks in Canada, which made it difficult to find a sense of community and navigate challenges in their new and unfamiliar environment. The loss of social support due to migration adversely impacted some participants' mental and emotional health; however, some participants relied on family in Canada or a few close immigrant friends from their home countries for support. Alternatively, participants formed new connections through churches or Canadian friends, which offered them opportunities to adapt to their new

environment and fostered a sense of community through meaningful and productive interactions with their physical and social environments. This highlighted the importance of having some form of social network in Canada, even if not as strong as in their home countries.

Interestingly, although one participant reported a stronger pre-migration social support network, he had formed a strong social support network in his community in Lethbridge. His neighbors were welcoming and helped him integrate well, which was surprising to him because he initially perceived Canadians to be individualistic. Some studies have suggested that sustaining transnational ties could hinder some immigrants from developing strong social networks in host countries since maintaining friendships in countries of origin may lead to retreating from friendship networks in host countries, which could cause migrants to become more isolated and could contribute to them integrating into marginalized groups in a fragmented manner (Verdery et al., 2018). Although not as strong as their pre-migration social support networks, some participants were able to establish effective social support networks in Canada, but this was not the universal experience for all participants. The reasons for this disparity in experience are not clear. Perhaps some participants' difficulty in finding social support was related to their preconceived notions that Canadians are individualistic and distant, or perhaps these challenges were partially informed by Canadians' misconceptions about immigrants. Certainly, some Canadian communities have observed people coming together to support those in need in a variety of contexts, including to support recent immigrants; however, more research exploring the disconnect between immigrants and Canadians would be beneficial.

## Chapter 8: Navigating Challenges

This sub-theme, “Navigating Challenges,” captured participants' coping strategies to navigate their post-migration challenges, which were often influenced by their pre-migration coping strategies. These included maintaining open communication and finding emotional support, seeking guidance and peace from a higher power, pursuing self-care, and remaining hopeful and resilient.

### **Maintaining Open Communication and Finding Emotional Support**

Following migration to Alberta, many participants continued to use their informal support services in their countries of origin to cope with their challenges because they felt comfortable sharing their struggles with loved ones, including mothers, relatives, and friends, for varied perspectives and advice. Additionally, some participants indicated they did not often seek the help of health professionals when needed because they did not have family doctors to do the referrals and lacked the financial resources to pay for those private healthcare services. A few participants indicated they used both formal support services (such as counsellors and therapists) and informal support services (such as family members and friends). Building a strong network of supportive relationships was essential for coping with stress and finding comfort after tough days. This helped them to maintain an open communication with their inner circle, navigate difficult challenges, and find emotional support.

*Even just talking to friends who can relate helped a lot. Or calling up, just checking up on friends, to see that, oh, I saw that you're not feeling good today - are you OK? You know, those types of network systems really helped a lot. So, say for me coping there's either talking to a lot of friends who know about this situation or are related to it, or sometimes even asking advice from my mom, even though she might not have like she might not be well versed in the area, but just hearing from a grown up's perspective, I would say that also it kind of helps you too in a sense (Sheba).*

*I do talk about it with my friends here. Also, I do talk about it like with my family back in Egypt. Like calling them. Um, I did like yeah, one time, I did talk with social workers as*

*well, like in my appointments, during one of my appointments. So, that was also helpful. Like they're just talking, uh, with them, like they would just like help me explore some things. Um, so yeah, I'd say I can get support using the healthcare system and friends as well (Aaric).*

*Here in Canada, I met a friend here in Canada. Yeah, and we normally spend a lot of time together, so I really talk to him a lot when I'm going through something. Yeah, we normally talk a lot. He also shares his struggles and those kinds of stuff. I don't really see much help from the therapist. I don't think they help me that much, according to me. So, I just prefer talking to a friend. OK, yeah. Because where I'm from, like in Kenya, I'm not used to such stuff as therapists. Yeah, so we are used to talking to friends. We talk about our struggles, yeah (Darion).*

Participants' social support system played a significant role in their promotion and maintenance of health and well-being by providing them with emotional support, assisting them in coping with stressful situations, giving them a sense of social and personal control, and providing social meaning to their migration experiences. Many participants relied on their informal support system (e.g., parents, pastors, and close, trusted friends) for emotional support and help-seeking because of the familiar bond they shared with them. Participants' informal support system instilled a sense of hope and optimism in them by sharing words of encouragement, showing empathy and care, and providing guidance. This fostered a healthy environment for emotional expression and venting, making them feel emotionally supported and comfortable sharing their challenges. Additionally, the emotional support, advice, and encouragement provided by the participants' informal support system also motivated some participants to seek or access formal support services, thereby using both formal and informal support systems. However, some participants did not seek help from their informal support system, such as friends, due to concerns about privacy, feelings of shame, fear of being judged and ridiculed, and concerns that others may lose respect for them. Some other participants did not seek help from formal support systems due to a lack of knowledge about available resources and services, a lack of transportation, not perceiving their problems as serious, use of alternative

medicines, financial constraints, a lack of Alberta health insurance, and a lack of family doctors for referrals.

### **Seeking Guidance and Peace from a Higher Power**

Participants from diverse cultural backgrounds shared their beliefs in a higher power to help them navigate their post-migration challenges. Living away from home, participants highlighted the importance of prayer. Therefore, some participants turned to prayer as their primary coping strategy, followed by seeking solace in friends in the absence of parents for support, signifying the importance of emotional connections and faith in navigating the challenges of separation and distance. Raisa, Ceeja, and Talitha highlighted the importance of faith and prayer in dealing with life challenges, seeking guidance and peace from a higher power during challenging times.

*I'm a Muslim, so I believe in praying. We pray six times a day. I pray to God that if I'm sick, God helps me to feel better. And uh, just like that, for my family's sake, I pray for them. God help them to feel better. Yeah, I believe in God. I believe that God is the one who does everything. Even if I go to the hospital and if it wasn't meant for me to live, even though the doctor could try, and if it was my time to pass, I would still pass. But if it wasn't time for me and God didn't want me to pass, I'd still live a life. So, actually, for me, before I go to the hospital or if I'm sick and need to go to the hospital, I always pray first before I go. Yeah, I believe in God [Laughing] (Raisa).*

*I also pray about it because my parents are not here, so I have to just pray about the situation. I just never grew up in an environment where I would go to a therapist, and it just gave me the mentality that I don't think I can or I may need a therapist anytime soon because I went through all those problems in Africa. But I'm still OK. So, yeah (Ceeja).*

*Um, my parents happen to be leaders in our church. So, that narrative of mental health, they tell you it's all in your head, just pray. If you claim you're depressed, they tell you it's all in your head, just pray about it. There's no need to seek therapy, there's no need to go and see a psychologist. There's no need to seek people who are in that industry. All you have to do is pray. So, that narrative was also pushed quite a lot, religiously (Talitha).*

Notably, some participants often used the phrase “*By the grace of God*” to demonstrate their reliance on God to navigate challenges.

*“The rules keep changing. We don't know, and you are basically just living by the grace of God every day (Sunshine).*

*“By the grace of God, I have a very, very, conscious life. You know, you can't separate, um, my existence from my religious beliefs” (Samon).*

Religion and spirituality played significant roles in the lives of many participants, particularly in relation to health and healing. This, in turn, influenced their attitudes and behaviors toward healthcare access, health service utilization, and overall identity formation, as well as their personal views and lifestyles. Some participants prayed, attended church and mosque services, listened to sermons, listened to religious music, joined and participated in religious group activities, sought advice from pastors, found peace in prayer during challenging times, and stayed connected with their supreme being. Participation in religious activities provided participants with a sense of belonging, trust among members, and solidarity, which was lacking in mainstream approaches to navigating post-migration challenges associated with their precarious reality (Agyekum & Newbold, 2016; Joly & Reitz, 2018; Vang et al., 2019). Participation in religious activities also enabled them to heal emotionally, physically, mentally, and spiritually by connecting them to their cultural community, other immigrants of diverse backgrounds, and a higher power, by enhancing psychological stability and improving their social integration into the community (Koenig et al., 2012; Tegene, 2018).

Many participants emphasized the importance of faith and prayer in navigating life challenges. Consequently, many participants turned to spirituality and sought guidance from God as their go-to source of support to navigate challenges. Interestingly, one participant felt that her religious beliefs and spirituality were strengthened because her pre-migration social support networks were absent in Canada.

Overall, belief in a higher power and the hope it fostered helped many participants to navigate challenges, including sickness. Belief in a higher power fostered trust that God would intervene on their behalf and helped participants feel less alone in dealing with the challenges they faced. Thus, religion and spirituality provided participants with tools for understanding life's challenges, a sense of meaning, social support, and coping mechanisms that promoted resilience.

### **Pursuing Self-Care**

Each participant had unique coping mechanisms for managing stress, from seeking social support to self-soothing practices. In pursuit of self-care, some participants preferred solitude and reflection over social gatherings to combat idleness. Some participants talked about finding peace in prayer, regularly visiting the family back home, listening to music, and keeping busy, while others mentioned the importance of socializing for mental well-being, even though it's tempting to stay isolated. Some participants also mentioned self-medicating for common illnesses instead of visiting hospitals and relying on home remedies for ailments like malaria.

Living away from home, participants highlighted the importance of support from non-migrant families, words of encouragement, and a good support system from friends as valuable coping mechanisms. Although seeking professional help was considered important, many participants did not seriously pursue it due to financial constraints or a lack of private health insurance to cover the costs. Pursuing self-care was a key theme for coping with stress and emotional distress independently or with the help of close friends and family, rather than seeking professional help. Some expressed intentions to access professional assistance once they have the necessary resources, such as having health insurance.

*Anytime I'm stressed, I just call some of my friends. The first thing is, we either plan to go to the gym, play table tennis, play games, or try to just hang out, you know, talk about it,*

*and laugh about it. We express some concerns about how we could improve it, you know. We chill, you know, we eat together. Those are the things we do. It makes life better than, you know. Obviously, sometimes, people at home might not understand what you're going through, especially when it comes to this side of the world, you know. They might use the perspective of whom to judge your situation, you, when you have discussions with them. But here it's pretty different because you need to have someone who is probably within the same circle that literally understands where the shoe pinches. So, that's what we do (Marcus).*

*I feel like it's so important in the way that we cope and handle things, you know. Just being a one-man island, you can't survive within this, I'll say this system. You need people, you need a culture of people who know you, love you, and support you dearly to help you through it. And I feel, um, like that's what has been helping me to cope, you know. And also like, pray and support from family back home who are cheering you on, saying we're proud of you, you know. And like, letting them know to say that, yeah, I know that you're proud of me, but sometimes, hey, man, I'm going through it, you know. And here, like you know, I know, you're going to get through that. Those words of encouragement, those prayers, and just the good support system from your friends, I feel like have been very helpful in a way. And also, just being able to, like I said, going to church, and I'll say hanging out with friends when we can, has helped me a lot in these years that I've been here (Sheba).*

*I was just trying to be myself, trying to um, socialize just to make, um, sure I'm OK. That is when I get home, even though at a point it's made me feel like staying home, not going out, to meeting people or socializing. But I also thought that was going to affect me pretty much, so I have to just get myself relaxed, try to socialize, sit somewhere, go to a spot or a bar like someplace where they play music, sit there, and just you know, have fun. So, that was the only thing I could do to make sure I'm OK or get myself calm down, apart from that, I didn't really see a medical doctor to talk about. I only have, I only take Tylenol when I have any umm body pain or something, but when I feel emotionally stressed, like when I feel down, I just relax, sleep, that's all. I don't consult any health professionals here in Canada, but I want to start doing that as soon as I get my health card (Miss Brown).*

*I'm like an introverted person, a very quiet person, and you know. As I said earlier, like being a man in control, I mean, when I have a problem, I'll just sit quietly in my room and just be reflecting on it. Yeah, I won't say anything to anyone, because I'm a very quiet person. I don't like going to the hospital, I mean, that much. I believe if you have the drugs at home, why not just take the drugs at home rather than going to the hospital? Because when we fall sick, we know it's malaria, so we won't go to the hospital. So, we just go to the chemist and get some malaria drugs and just drink them. And in two days you are OK. And nobody knows [laughing] you continue your life. Yeah (Caesar).*

Although some participants considered seeking professional help when needed, they preferred to cope independently with their emotional distress or with the support of their social

support networks (e.g., close and trusted friends and family members). In pursuit of self-care, participants adopted several strategies, including socialization, distraction, acceptance, courage, and appreciation.

**Socialization.** Participants engaged in activities with other immigrants that helped them build a social support system, develop a sense of community, and connect with others in ways that reduced loneliness, homesickness, and feelings of not belonging (e.g., playing sports with friends, going to the gym with friends, organising and attending social events, participating in sports, and joining ethnic associations). As one participant stated, *“Anytime I’m stressed, I just call some of my friends. The first thing is, we either plan to go to the gym, play table tennis, play games, or try to just hang out, you know, talk about it, and laugh about it (Marcus).”*

**Distraction.** Some participants engaged in distracting activities that diverted their attention from their challenges (e.g., listening to music, staying busy, working multiple jobs, participating in social activities, and visiting home countries regularly). As one participant stated, *“I keep myself busy, like when you’re busy, you don’t have time to think about all of these things (Miss Brown).”*

**Acceptance.** Some participants accepted their precarious migration status conditions, which helped them maintain a sense of satisfaction and a positive mindset. As one participant stated, *“I’d say it’s for the greater good. Ah!! It’s one of the things you have to go through as an immigrant (Kamon).”*

**Courage.** Despite the uncertainty about their fragile migration status, many participants showed a level of bravery that motivated them to cope with hardships or challenges. As one participant said, *“The purpose, the reason behind my being here, hasn’t been accomplished. So,*

*going back is not the best decision for me. So, I thought about it because if I go back, that means I am a failure. So, I decided that, OK, I will face the battle (Sion)."*

**Appreciation.** Many participants expressed gratitude for what Canada has provided them. As one participant stated, *"I really want to also give back to the country, like for the opportunities it gave me, like for the education and so on (Aaric)."*

As seen in previous studies, participants often preferred to cope with their mental health issues privately due to the influence of stigma, stereotypes, discrimination, prejudice, and negative labels attached to mental health (Witt et al., 2011). According to Fung and Wong (2008), this may explain the differences in attitudes and behaviors surrounding mental health help-seeking between immigrants and native-born Canadians. Some participants turned to introspection, religious music, and solitude as coping mechanisms to unwind and maintain emotional equilibrium. Some participants used religious music as a spiritual expression and a means of connection to improve their overall health and well-being. Religious music centers around elements of hope, optimism, love, and peace; therefore, listening to religious music enhanced some participants' psychological well-being (Aldridge, 1995). Additionally, listening to religious music can assist in spiritual development, which is an essential component of complementary and alternative medicine (Ellison, Bradshaw, & Roberts, 2012) and part of a "holistic approach" to health (Micozzi, 2010). Some participants listened to religious music to focus their thoughts and energies on the positive and healthy aspects of life rather than the negative and unpleasant ones. Additionally, listening to religious music helped some participants to relax and feel calm, fostered a deeper relationship with God, provided a sense of strength and purpose in the face of adversity, and filled a significant vacuum in their lives, particularly the absence of pre-migration support networks. Listening to music has been linked to several

positive health outcomes, including decreased anxiety (Evans & Rubio, 1994), increased life satisfaction and a sense of escape from life's challenges (Hayes & Minichiello, 2005), decreased anger and antisocial orientations (Krahe & Bieneck, 2012), decreased depressive symptoms and other psychopathological manifestations (Erkkila et al., 2011), and the activation of the brain's pleasure and reward circuits (Koelsch et al., 2006).

While participants in this study emphasized the benefits of self-care, it should be noted that some studies suggest that self-care may cause additional stress as it can be demanding and exhausting for the individual (Berterö & Hjelm, 2010). Additionally, stress can negatively impact an individual's health by triggering physiological systems and encouraging unhealthy behavioral coping mechanisms; therefore, some self-care strategies may not always be helpful and constructive (Cohen, 2004) and an individual's stress levels can either increase or decrease depending on their experiences and the type of social support system they have (Stenberg & Hjelm, 2024).

### **Remaining Hopeful and Resilient**

This theme captured the connections between hope and resilience. Some participants shared their experiences of adapting to a new system and coping with uncertainties. They emphasized the importance of understanding and complying with policies while navigating challenges with hope and striving for a better future, such as obtaining necessary documents for better opportunities. Hope and perseverance were emphasized as important in dealing with the constantly evolving immigration policies. Despite these challenges, remaining hopeful and resilient were important themes in overcoming obstacles and working towards personal dreams and goals.

*Well, right now I psyche my mind that OK, now I've lived in Ghana, this is how things work in Ghana, I'm here, things work differently here. I have to really understand how*

*things work here and cope with it, follow the system, and at the end of the day, things will get better in the next, in the future. Right now I feel like I'm here to live life like, OK, even if I have to begin from scratch, I'm still doing it because I know that this is a new system that I have to follow, and everybody here has actually followed, they've paid the price and now they are at the level that they are now. So, I have to actually also follow the route, take things slowly even though it's tough, but it's gonna get better in the near future (Sion).*

*Well, the only way I cope is to remain hopeful. When my friends ask me how I am, I tell them, "I'm fine and hopeful." So, this is the way. In fact, I remember, my friends say, this is your hopeful thing. It's a new thing, but that is the way it is. It is hope that keeps me going. Whatever the challenge is, I believe that once I'm able to run through my migration process as fast as I can, and certainly I will live my life the way I want, as in being able to live my life like averagely. Thus, be able to get the basics of life, and that is my dream (Samon).*

To minimize the adverse health effects associated with their precarious immigration status and resettlement difficulties in Canada, some participants maintained optimism and hope for a better future. As one participant stated, *"It is hope that keeps me going, whatever the challenge is, I believe that once I'm able to run through my migration process as fast as I can, and certainly I will live my life the way I want to."*

Participants believed resilience to be one of the most effective strategies for dealing with the stress associated with their precarious situation. Resilience refers to an individual's ability to effectively adjust to their surroundings or living circumstances when faced with hardship (Garcini et al., 2021). According to resilience theory, individuals can prevent, lessen, or eliminate the adverse effects of stress by tapping into their resources and assets (Fergus & Zimmerman, 2005). According to Fergus and Zimmerman (2005), resources refer to beneficial social and environmental elements outside of the individual, while assets are positive abilities within the individual that they can use to manage stress. Although navigating challenges associated with precarious migration status and resettlement was difficult, it motivated some participants to build

resilience as they considered such challenges to be an integral component of their overall migration experience.

## Chapter 9: Potential Policy Pathways

This sub-theme captured the participants' recommendations to improve health and well-being among precarious migrants, including implementation of fair immigration policies (e.g., restoration of 40 hours of work a week and discontinuation of ELP test as a requirement for PGWP), elimination of employment barriers (e.g., the recertification process), investment in alternative medicine, and investment in healthcare professional education (e.g., scholarships and grants for students enrolled in health-related programs).

### Implementation of Fair Immigration Policies

Some participants, particularly students, expressed concerns surrounding the Canadian immigration process, including lengthy migration application processes, unnecessary English language proficiency tests, the impact of changing immigration laws, and the limitations on working hours for study permit holders. Suggested recommendations included more flexibility in the number of work hours permitted for students, better monitoring of students' progress, consideration of students' financial situations, and the implementation of fair policies that support students' academic success and well-being. Importantly, there were calls for more accessibility with immigration services and fairness in immigration policies.

*I would say, in terms of the changes in the system with regard to the application of work permits or giving special recognition to specific students in their programs, I feel like that should not be the case. You know, everyone, despite whatever program or major that they're doing, should have equal prospects in getting a job, you know, if they decide to stay, you know (Sheba).*

*To me, it doesn't make sense. Someone who's taking a master's and Ph.D. can bring their partner, but someone who is doing their undergrad cannot. It doesn't make sense, and there's no logic behind it. Yeah, people bring their sponsors for support, you know. This makes it easier for you when you have someone supporting you. I think it's really inconsiderate to do that, and I honestly think if they can't just treat immigrants well, they shouldn't even give them their visas to come here. It's not easy, especially right now with students, you probably don't have money coming in from home, maybe something*

*happened and you're not getting access to money to pay your school fees, and you have to get a job (Kamon).*

*I know they have their rules and regulations, and they keep changing. Like today, you will seek asylum with someone, or someone will seek asylum before you, or you will seek asylum before someone, and the person will have their hearing before you, and stuff like that, at the same time, at the same place. Every time you see, you see different changes. And sometimes we wait until maybe they forget about us. My lawyer has been writing them for a couple of weeks now. They keep telling him that he should wait. Some people get theirs faster. I don't know what's happening (Johannes).*

Some participants recommended that IRCC should be easily accessible because it was difficult to contact them for information regarding immigration application processing updates.

*The IRCC should be more accessible, especially to those who are within this space. I don't know if I have become obsessed with this comment, 'they should be more accessible.' Yeah, even because when you call IRCC now, the person you are talking to says, "I cannot give you this information," it is only the information that you have that I have after spending so much time to be able to get through to the person. So, they should be more accessible and a little bit more definite. I don't know, I read because they have a lot of backlog. I don't know what they can do to really be able to speed up their process, but they should be more accessible (Samon).*

Additionally, some participants advocated for the cancellation of the English Proficiency Test as an eligibility requirement for the Postgraduate Work Permit (PGWP) because, according to them, it does not make sense for an immigrant who has completed a tertiary education in Canada and paid high international tuition fees to be subjected to such tests. They perceived the English proficiency tests as financially draining, robbery, unfair, and discriminatory.

*The ELP test could be financially draining. These tests are expensive, and they are not subsidized in any way (Aaric).*

*I recently heard that if you want to apply for a postgraduate work permit, you need to do an English Language Proficiency Test, IELTS or CELPEP, or something now. So, after you finish school in Canada, studying in English, you need to do an English test to prove that you can work in Canada. So, you know, things like that, or when for certain courses that you apply for at the colleges, you need to do an entry test as well, that's testing your English or your math skills, or whatever you are doing. Yeah, it's like, hey, you forgot to speak English after two years of being in an English-speaking country (Sunshine).*

*I'm so sorry. That's to me, not to be rude, that to me sounds like a lot of nonsense. Because for me to be able to do the bachelor's degree, right? We needed to speak in English. I qualified for the degree program, and I even graduated, which means that I'm fluent and proficient in English. Even though it's not my first language, it's not my native tongue, right? To then demand that students do that, to me, seems like a form of discrimination, because you're clearly saying that international students do not know English when we clearly do. I'm sorry [sighs high] that I'm infuriated after hearing that. That is very frustrating for them to be able to do their studies and to be at those specific levels. Of course, I'll say that maybe they learned, even if they learned in their native tongue, for them to come and do their degree, it means that they know English. I don't want to assume that they don't. For them, being able to get to that degree program means you know English. You are fluent in that, so to let them write an English Language Test is unfair and discriminatory. For me, it's a form of robbery of money, like you're trying to rob students and people of their money (Sheba).*

Furthermore, many participants suggested that the new immigration policy changes should have targeted the new temporary immigrants, not those already in Canada.

*I think the people who are already here, like people who came like say, for example, you came here as a student, and when you came, certain rules applied when you were here. So, like for the people who are here, keep those rules the same, and then implement them (the new rules) when that person's term is over. Does that make sense? So yeah, new people coming in, apply whatever you are changing, make it apply to those people. Because you come in with these other rules, this is what you're told, this is what you are buying into, right? So, I feel like whatever the person came in with, just implement your new rules when that person's term is over (Sunshine).*

*For me personally, in terms of immigration, firstly, the changes in immigration laws like each year. I believe you can change the immigration law each year, but it shouldn't affect everybody. And for me, it should affect just those coming in the current period of time in which you are announcing your laws. It shouldn't affect those who have previously been here. I don't know if you understand. Yeah, because I mean I also came, maybe last year, we came, we were working 40 hours a week. And now we work 24 hours. It's normally for me, if they had to change that, it should have affected maybe those who came this year, without affecting those who came in before. Yeah, and also financially in terms of tuition fees, we see, I think the university also increases fees each year or so. For me, if they will increase fees, it shouldn't affect everyone. It should affect those who are going to start at that time, as they're increasing the fees. Because why will I leave my country knowing I'm supposed to pay \$21,000 per year, and because I'm doing maybe a four-year course in my third year, I see myself paying 25,000 or so, like it's not normal (Caesar).*

Also, many participants recommended that the IRCC should partner with institutions to monitor international students' academic performance to determine who should work 40 hours and who should not.

*Make work hours flexible for students. Mandate every institution to monitor every international student's progress, and anyone who is not doing well should be flagged up or see what remedy they can use to actually assist the person, rather than using one jurisdiction to judge all others. Now, there is an extreme shortage of services presently in virtually all organizations. But because students are constrained to 24 hours. You don't want to jeopardize the rules, you don't want to go against their rules, you know. So, you just have to work on it. It is what it is (Marcus).*

*They changed from 40 hours to 24 hours. I felt it wasn't good enough because it was just a disadvantage for some students. I feel that what they should have done was that they should have said, OK, if you want students to concentrate on their studies, right? OK, after each semester, they should bring their report from the school. Anyone who failed any course, you understand, should not work the following semester, you understand what I'm trying to say? So, that would have made students sit up, whether they were working 40 hours or 24 hours. Because you want to pass, you will sit up and study very hard, you understand? I felt that it would have been a better policy, instead of just switching from 40 to 24 hours, which is now affecting students. So, if you want students to be serious, you should just introduce that (Timon).*

Many participants, both students and non-students, called for the reinstatement of the previous 40-hour weekly work policy for students because of the high cost of living and high international tuition fees.

*I would recommend that they increase the student working hours because the income from 24 hours a week of work is not enough to meet the high cost of living (Sheba).*

*I think something should be done about it because I'm leaving here, it's not easy, so paying fees and at the same time paying bills comes with a lot of responsibilities. You need money to do all that. So, if you don't work, how do you pay for all those things? I think something should be done, 24 hours a week cannot help them to pay their bills, and not to even talk about paying their fees. I think they should be giving the free will to live, like giving the students more hours to work like before (Miss Brown).*

*I think there should be a better way to attend to those things. I know what they said is that students are abandoning their courses. Let it be that they have a better relationship with the school, to know the performance of the students, and they should know what to do about that. But in the current 24 hours, anybody, any student who's in school and thinking of meeting their needs with it, it's not practical. I pray and hope that the*

*authorities will come to realize that a lot of students, as much as they want to acquire the knowledge, equally want to use that knowledge in an environment where it will be appreciated. Because the essence of any man is for him to have a quality of life that he or she will appreciate (Samon).*

According to Abira, some students may experience mental health issues if they can only work fewer hours or limited hours when school is in session, considering the high cost of living and high international tuition fees.

*In terms of student hours, I'd say more like mental support because I like, especially international students, they only have like 24 hours a week of work, which is nothing considering the high cost of living and international tuition fees (Abira).*

Kamon, a PGWP holder participant, made an interesting statement about how the reduction of students' work hours per week from 40 hours to 24 hours seemed to indicate they were being used and disposed of. He recommended that the government restore it to 40 hours a week, using a spousal divorce analogy argument to support his recommendations.

*They use them when they need them, and when they don't need them, they dispose of them. That is what they do. So, I think they should, if you're giving me the chance to work 40 hours when you need me, I think you should just run with it and don't make changes when you don't need me anymore, because I need the money. Like the concept when people get married and you marry someone who has money, and now you're divorced and you're arguing in court that your partner was used to, you know, this lifestyle. So, they are entitled to getting money from you to maintain that lifestyle because you've more money than they do. So, you end up paying alimony. Yeah, it's the same thing. Now I'm used to working 40 hours a week, and I'm getting all this money, and everything is easy for me, and out of nowhere, you cut it short. I think that makes life difficult for some (Kamon).*

Additionally, Johannes, an asylum-seeking participant, argued in his recommendations for the government to increase the number of hours students are required to work during school hours due to the high cost of living, using the example of his sister, a student, who was experiencing financial challenges. For someone like him, also going through immigration status challenges, to make a case or a plea on behalf of his sister, who was struggling financially due to high international tuition and the rising cost of living, is worth noting.

*They have their rules and regulations, but we are just pleading on this issue with students and their hours of work right now. And I don't know how they're coping because some of them are really, they're really going through a lot. Because they have to pay their bill, though I know that before they came here, they proved to the government that they have money. I know, but looking at what's ground now? It's not easy for them. It's all I can say (Johannes).*

Demonstrating his level of legal consciousness, Marcus made an intriguing argument that Canada shouldn't enact new immigration restrictions simply because other countries, like the UK, are.

*Now, there is an extreme shortage of services in virtually all organizations. But because students are constrained to 24 hours, you don't want to jeopardize the rules, you don't want to go against their rules, you know. So, you just have to work on it. It is what it is. We are students in these nations, but the policies are too stiff for us. It's trying to block one loophole and leaving the others widely open, which I think is not fair to me. Just because the UK has done something of that sort, or probably Australia has done something like that, does not mean you have to copy them. You just have to work with facts, go around, and don't use one province to judge other provinces. I think that's what has happened (Marcus).*

Many of the participants advocated for the development and implementation of fair federal immigration laws and policies that could support and potentially improve their health and well-being, including ensuring equal processing times of applications for all immigrants without discrimination, the cancellation of English language proficiency tests as requirement for PGWP application, restoring the previous 40-hour maximum hours of work for study permit holders, and providing easier access to IRCC officials. Participants suggested that IRCC partner with tertiary educational institutions to monitor international students' academic progress and that they only limit the number of weekly working hours for students who fall below academic standards. Many participants were upset by the English language proficiency test requirement for the PGWP application after completing their tertiary education in English, and felt it was discriminatory, stressful, and financially draining, especially considering the high costs of international tuition fees. According to Australian studies, language proficiency tests used to

evaluate prospective immigrants' ability to make critical migration decisions give these tests undue influence and exert a significant effect on immigrants' well-being (Hoang & Hamid, 2017). In Canada, an immigrant must demonstrate their English proficiency through their citizenship in a major English-speaking country, such as the United States or the United Kingdom, or by passing a standardized English language test, such as the IELTS or CELPIP (the general option), which is approved by the IRCC (Hoang & Hamid, 2017; Merrifield, 2012). Studies have revealed that immigration authorities in countries such as Canada, Australia, New Zealand, and the UK have justified the use of language proficiency tests because they viewed them as a mechanism to also assess immigrants' ability to integrate into society, the workplace, and participate in their community's activities (Merrifield, 2012). Interestingly, a 2022 survey in Canada revealed that many Canadians would not pass the language proficiency and citizenship tests that immigrants must pass before their immigration applications are approved (Kelley, 2023).

Overall, these study findings revealed that the current restrictive immigration laws and policies also adversely impacted participants' health and well-being because they potentially limited their access and utilization of health and social services due to the perpetuation of their precarious migration status. However, the impact of recent immigration policies was experienced differently depending on participants' age, gender, social and financial support, family responsibilities, length of stay, and course of study. Depending on the duration of residence in the country, these constantly changing immigration laws and policies could negatively affect migrants' health and well-being, especially among those with precarious status (Torres & Young, 2016).

## **Elimination of Employment Barriers**

Many participants recommended that employers be encouraged to hire temporary permit holders since they were often discriminated against in the hiring process due to their precarious migration status.

*Now the priority right now is for you know, permanent residents and citizens and refugees to get jobs, which makes it harder for international students to get jobs or people with work permits like me to get jobs. Ah!!! I don't know, I feel like it just makes life way harder for some. So, yeah, I think they should make some changes (Kamon).*

*The government can actually talk to the employers to encourage them to hire students, because sometimes students will go to a company and they will tell them, Oh, because you are working 24 hours, we cannot hire you. Otherwise, it will increase the unemployment rate among students. So, it's having an impact on even job searching (Sion).*

Stricter immigration policies aimed at regulating migrant entry and legal status have led to a notable increase in the number of precarious status migrants and those experiencing precarious employment in Canada (Goldring & Landolt, 2013; Hari & Liew, 2018). Over the past three decades, complicated austerity measures and neoliberal restructuring have made work in Canada more unstable (Goldring & Landolt, 2013; Hari & Liew, 2018). Some of these measures have included a sharp reduction in public spending, the imposition of social responsibility on individuals and small groups, deliberate efforts to criminalize labor organizing to reduce its power (Harrison & Lloyd, 2012), and the financialization of state assets, such as bonds and pensions (Whiteside, 2013). Even though some workers have greater flexibility in their work arrangements, including the ability to work remotely and collaborate across time, space, and cultures, the recent trend toward more unconventional work arrangements (such as contract, part-time, and seasonal jobs) is rapidly replacing full-time direct employment, and has marginalized some worker groups, particularly precarious status migrants (Hoffman et al., 2020). Therefore, participants advocated for equal employment opportunities for all, regardless of their

temporary immigration status in the Canadian labor market and suggested that employers should be encouraged to hire qualified temporary status migrants without discrimination based on their migration status, accents, and identifiable African names. In response to the undervaluation of international qualifications and experience, one participant suggested that professional competence recertification could be carried out in the participants' home countries to lessen the financial burden on new immigrants upon their arrival in Canada. He felt it could be accomplished by collaborating with some well-known organizations or tertiary institutions in Africa. Additionally, another participant recommended that immigrants study courses or programs that would make them more competitive in the Canadian job market.

### **Improvement in the Living Conditions of Precarious Status Migrants**

Some participants advocated for a reduction in international tuition fees, more job opportunities, better wages, and affordable housing to help with the rising cost of living, since temporary immigrants find it difficult to get financial support from financial institutions in Canada.

*I think that, um, umm, let me just say, the way they made education expensive for foreigners is very annoying at times because you're paying like five times more than the citizens and the PRs. So, I feel that it needs to change, at least maybe twice more, but paying five times more is ridiculous. That means that we register for each course, maybe like 2300 per course, and they're just paying 500. And sometimes they get loans, and all these things are not available to foreigners. So, I do feel like, policy-wise, they should change. And they're making life difficult for international students (Timon).*

*And also, this issue of jobs, if they can look into it and provide jobs for us. I think that would be good. And the rent, because the way the rents are increasing, prices are increasing, foodstuffs are increasing. And the salary or wages. What the employer does is, they pay people, and your take-home pay can't meet your bills. Like the rent, your stuff, you go to groceries, you see how expensive all those things are, and you see that at the end, you have nothing left. That's why sometimes you see people trying to get jobs, trying to change jobs, or trying to get more than two or three jobs because of the increase in prices of the kinds of stuff. And to even get good jobs, it's not easy (Johannes).*

Furthermore, to lessen the financial burden on new immigrants upon their arrival in Canada, Timon suggested that professional recertification be completed in the countries of origin of immigrants through collaboration with certain well-established institutions.

*If they want to make it easier for foreigners coming in, they should make sure that they actually passed the professional board certification from back home. For example, if you're like a computer science student, there should probably be an exam that, after passing the exam, automatically you can get a job in Canada, but from back home, you understand, that would be very good (Timon).*

Samon, who came to Canada on a spousal work permit, recommended that it is good for immigrants to do courses that will make them more competitive in the Canadian job market.

*When we came here, we discovered that the general management course that the school offered my wife was not really marketable. So, I inquired which course she could take to make her marketable at the end of the program. We discovered that social work was more sellable. So, she is now taking a BSc. Social Work (Samon).*

The health and well-being of participants were impacted by their poor access to resources in Southern Alberta. Limited hours of work, limited access to health and social services, discrimination or unfair treatment in the labor market related to poor recognition of foreign credentials and experience, inadequate housing, and low income were all identified as challenges by participants. For example, the Canadian government has cited inadequate housing as one of the reasons for capping the number of foreign students admitted to Canada. This largely political decision, informed by society-wide reports of limited housing availability, is partially supported by several studies suggesting that precarious status migrants are more likely to experience challenges finding accommodation. This challenge further intersects with other environmental and resource challenges to influence health and well-being, such as harsh weather conditions, low income, unemployment or underemployment, exploitation by employers, no employment benefits or compensation in the event of an injury, discrimination, and limited access to health

and social services due to a lack of private health insurance, and exclusionary health policies (Brabant & Raynault, 2012; Fasani & Mazza, 2020; Willen et al., 2017).

To address these identified challenges, some participants advocated for a reduction in international tuition fees, greater access to jobs without unnecessary barriers, better wages, free healthcare for students, and access to affordable housing to help with the rising costs of living. Support in the area of financial well-being is particularly needed because it is difficult for temporary immigrants to qualify for loans or receive financial assistance from financial institutions in Canada.

### **Investment in Alternative Medicine**

The study findings indicated that some participants continued to use traditional/alternative medicine or combined it with Western medicine due to cultural beliefs, low income, limited healthcare access, the shortage of family doctors, and inadequate cultural competence among many healthcare professionals. In this regard, some participants recommended that the government invest in both traditional and alternative medicine to meet their health needs.

*Regarding the health policy, I would say improving wait times for referrals. That's a big challenge. Oh! I didn't mention that earlier, but yes, so one of the challenges that I faced as well was longer referral times, especially like, yeah, I have some health problems and one specialty (Aaric).*

*I would also recommend that they expand the insurance coverage of students when it comes to medical care, because the insurance coverage is not helping in any way. Sometimes, if you want to get a prescription for medication from the hospital or anything and ask them to check what insurance coverage they can get from their Alberta health card, it's not enough (Ceeja).*

*I think some of the recommendations are to increase investment in the healthcare system, probably in the doctors and nurses, to reduce the unnecessary time wasting for people sitting in the hospital. So, that can also reduce, um, stress and also encourage people to go to the hospital, rather than using other um alternatives. Also, other alternatives are also good depending on the usage, like for us, the African brothers, some of us would do*

*if I had the opportunity to get some of those leaves back home, I don't mind. I will just boil it and you're good, you know. But I believe the country could also do better, and probably just for them to keep investing in the health sector (Marcus).*

### **Investment in Healthcare Professional Education**

Some participants also suggested that the government offer scholarships to both domestic and international students enrolled in health-related courses to make it more attractive to meet the high demand for medical professionals and improve wait times for referrals and direct care in emergency rooms, and expansion of health insurance coverage for students to ease their financial burden with the high cost of living and international tuition.

*The government should invest heavily in health and probably give a scholarship to both local and international students to study more health-related courses. I think I heard in New Brunswick or Nova Scotia, or Newfoundland, if you have to do, I think it's Newfoundland, that you have to do nursing or probably do something, the government pays you, you don't even need to pay for school fees. The government pays you to go to school to become a nurse. So, that makes you literally focus than you have to go to school and hustling for money for your school fees. And you know, you are also constrained to 24 hours. So, there are a lot of challenges for international students. But if this can also be adopted within our context, I think it will go a long way (Marcus).*

The provision of insufficient or delayed services to treat a health concern typically results in unmet healthcare needs (Chowdhury et al., 2021; Wu et al., 2005). Studies suggest that more than 11% of Canadians, including immigrants, have unmet health needs and do not seek medical attention when they believe they need it (Statistics Canada, 2017). However, studies suggest that the risk of unmet healthcare needs is far greater among minorities, such as migrants (Wu et al., 2005; Sou et al., 2017). Subjective factors, including individuals' perceptions about available care and help-seeking behaviors, which are often influenced by their socio-cultural concepts of health and disease, household income, personal ideologies, and a lack of knowledge about the Canadian healthcare system, can result in unmet healthcare needs and health disparities between

migrants and native-born Canadians (Chowdhury et al., 2021; Nelson & Park, 2006; Sou et al., 2017; Wu et al., 2005).

Recently, there has been an increasing awareness of complementary and alternative medicine (CAM), and it has become an integral part of some patients' medical care in Canada (Canizares et al., 2017). However, the use of CAM has come under public health scrutiny because some argue that some alternative or traditional remedies may contain toxic compounds that could adversely impact an individual's health. Additionally, many conventional physicians are uncomfortable with the use of CAM because they believe that there is a lack of knowledge about it and scant scientific empirical support for the effectiveness or safety of many alternative therapies (Canizares et al., 2017; Wiles & Rosenberg, 2001). Moreover, there is often a power struggle in many situations, including public popularity, laws and regulations, and consumption patterns and rates (Canizares et al., 2017; Wiles & Rosenberg, 2001). In Canada, herbal medicines, dietary supplements, food supplements, and herbal remedies are all classified and regulated by the Natural Health Products (NHP). As a result, they must prove their safety and effectiveness to receive a license before being placed on the market (Government of Canada, 2022), which has influenced their use in Canada in recent years. Understanding the shifts in CAM and conventional care utilization trends is crucial for planning and improving the healthcare system and medical education.

Many participants accessed CAM, including traditional African medicines based on cultural beliefs, and because of financial and structural barriers to accessing conventional health care. Consequently, some participants recommended that the federal government invest more in research and that it support the use of alternative medicine to meet their unmet health needs. Additionally, to address the shortages of healthcare professionals, some participants suggested

that the government increase investment in medical professional education by offering grants and scholarships to students, including international students enrolled in health-related programs, which would encourage or attract more people into the medical profession because of the high costs of tuition, particularly for international students.

### **Specific Actionable Policy Recommendations**

Considering the general recommendations suggested by participants for improved health and well-being, I have identified some specific policy proposals that I believe are practical, locally relevant, and feasible to implement in Lethbridge, Southern Alberta, to support African immigrants with precarious migration status. These policies or programs take into account provincial dynamics, municipal authority, and the capacity of local institutions to intervene, even if the federal government holds jurisdiction over immigration status.

### ***Housing***

The housing crisis in Canada has been presented as the rationale for recent immigration policy reforms that have reduced immigration targets and significantly decreased the number of study permits issued to international students. In addressing the housing availability and affordability crisis, it is important to first recognize that this situation is likely the result of a complex collision of issues, rather than the result of the increasing international students and immigrants alone. Inflation, rising interest rates and property prices, allocation of properties to online rental through sites like Airbnb and Vrbo, increasing building material costs, real estate sales patterns, the need to rebuild a credit history after migration, housing discrimination within a very competitive market, and many other factors are likely playing a role in the housing shortage, rental availability, and affordability. Therefore, a comprehensive strategy to address housing availability and affordability is needed not only for immigrants but for many different

groups in Canada that are facing housing barriers. Consequently, there is a need to examine the factors contributing to housing barriers in different jurisdictions, including Lethbridge, Alberta and the surrounding area, and develop local strategies to address the unique conditions in that context. Lethbridge and other municipalities could explore public-private partnerships with builders to ensure the mix of single dwelling homes and multi-family properties meets the housing needs of each community, with adequate numbers of affordable entry-level rental properties available. Development of affordable housing programs like expanded rent supplement or subsidy programs may support wider economic priorities by supporting the availability of employees for local businesses. Creation of grants or tax credits to incentivize landlords to develop and offer rental properties at more affordable prices may improve availability of housing for multiple marginalized groups. Development and enforcement of bylaws to address housing discrimination towards precarious status migrants or other racialized or intersectionally marginalized groups may also discourage landlords from engaging in housing discrimination or imposing unrealistic requirements on potential renters. Funding housing support workers to help new immigrants and others locate suitable housing would also be very beneficial, especially for new arrivals without adequate language competency or knowledge of Canadian systems.

### ***Enhancing Access to Culturally Safe Primary Health Care***

Access to primary health care and affordable mental health services is a major issue for many Canadians, but there are often even greater access challenges for new immigrants, especially when they hold precarious immigration status. Although some "uninsured primary care" clinics are already operating in certain Alberta cities, the creation of a "no documentation required" mental health walk-in service would greatly reduce barriers for precarious status

migrants. Supporting the training and employment of peer navigators from African communities and developing standards for hiring African-identifying mental health counsellors could also facilitate access and utilization of mental health services by African immigrants. Indeed, access to African-identified mental health practitioners may be enhanced by overcoming existing barriers to credential recognition, as many trained African health professionals are not being utilized effectively because of these barriers. In addressing the expansion of healthcare services as recommended by participants, Alberta Health Services can support the establishment of more local health programmes that provide culturally safe and free basic medical care, prenatal and maternal health services, and mental health counselling, with wrap-around interpretation services.

### ***Addressing Employment Discrimination***

Regarding employment discrimination, exploitation, and abuse, Lethbridge can collaborate with the province of Alberta to enforce the "Fair Labour Protection Program," especially in labour-intensive industries, agriculture, and caregiving, where many of these abuses occur partly due to employment-related immigration status. This could be achieved through increased labour inspections in sectors hiring immigrants with precarious status, anonymous reporting mechanisms, and penalties for companies that mistreat or withhold salaries from precarious migrants.

### ***Demystifying Immigration Processes***

Given the difficulties identified by participants related to contacting IRCC and understanding the shifting landscape of immigration laws and policies, Lethbridge could provide additional support to individuals with work permits and residency pathways. This could potentially be achieved through subsidizing free or low-cost immigration law support, working

in partnership with the University of Lethbridge to access their expertise to support policy advocacy, and potentially by providing seminars on work permit eligibility, restoring immigration status, and pathways to permanent residence.

### ***Overcoming Employment Barriers***

Barriers to employment can be reduced, but perhaps not eliminated, as the participants suggest. The City of Lethbridge and local industry partners could potentially partner with the University of Lethbridge, Lethbridge Polytechnic, and other educational providers to support credential recognition. This work could potentially be supported by municipal or industry-specific grants to help with document translation, credential assessments, English Language Proficiency evaluations required for PGWP, and the provision of bridging training programs to lower employment barriers, such as the underemployment of skilled African migrants due to non-recognition of foreign credentials.

### ***Fostering Peer Support in Immigrant Communities***

Since many participants rely on their communities for support, Lethbridge institutions could collaborate with African organizations to support the training and employment of community leaders, including religious leaders, as cultural brokers, interpreters, health system navigators, and legal support guides. This strategy could reduce systemic barriers, foster trust, and promote their successful integration into Canadian society.

### ***Immigrant Success Leads to Societal Success***

While each of these policy proposals potentially requires financial investment by federal, provincial, or municipal government in partnership with local industry, it is important to recognize that facilitating immigrant success will likely generate significant economic benefits, increased tax revenue over time, and reduced expenditures related to negative health and social

outcomes that will inevitably emerge if nothing is done to support groups such as African immigrants with precarious status. Abdicating responsibility and ignoring these problems does not make them go away; it merely transforms these problems into bigger issues over time. Therefore, taking decisive policy actions and engaging in strategic investment will likely result in better health, social, and economic outcomes for both immigrants and the communities they occupy.

## **Chapter 10: Conclusion**

This chapter discusses the unique findings in this study, limitations of the current study, makes recommendations for further research, discusses the significance of these study findings and their implications for practice, articulates a knowledge translation plan, evaluates the utility of the intersectionality framework as a theoretical lens in this context, and discusses my reflexivity in the context of this research.

### **Unique Findings**

The study's analysis addressed three main research questions: 1) How do African immigrants with precarious immigration status perceive and define health and well-being? 2) What migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious immigration status in Southern Alberta? 3) What coping strategies do African immigrants with precarious immigration status in Southern Alberta employ to navigate their precarious circumstances? Additionally, the study contributes to filling a gap in existing literature by providing the following unique findings.

First, the study revealed that some international student participants dropped out of school and sought asylum due to financial constraints caused by the continually changing migration policies, such as limited work hours and new eligibility criteria for the PGWP program. The course eligibility under the new immigration policy for the PGWP includes STEM (Science, Technology, Engineering, and Mathematics), Healthcare, Trades, Agriculture, and Transport for undergraduate students. Therefore, all undergraduate international students not enrolled in these programs are currently ineligible for a PGWP. Furthermore, according to the new immigration policy, qualified candidates must have achieved at least a level 7 in each of the four General Training English Language Proficiency Test (Canadian Language Benchmark

[CLB]) domains (Reading, Writing, Speaking, and Listening) for university graduates and a minimum of level 5 for college graduates. Notably, the Language Proficiency certificate expires after two years. Unfortunately, the IRCC requires students to take the General Training English Language Proficiency Test even if their Academic English Language Proficiency Test results are still valid. Since the test costs between \$330 and \$350 before taxes, many participants view this as unfair, discriminatory, a scam, and a financial burden after paying high international tuition fees for years. Additionally, there is the challenge of finding a job that matches one's qualifications to qualify for permanent residence (PR). As PR depends on the Point System, earning a minimum of 5 or 7 CLB levels may not guarantee application eligibility, and failing to secure a matching job makes one ineligible for PR. Therefore, a higher point score increases an applicant's chances of obtaining PR. The concern is how international students who completed coursework in English at a Canadian college or university, completed assignments and tests in English, and perhaps took English courses during their studies, are subjected to this unfair requirement. Interestingly, a refugee or PR applicant married to a Canadian, with little or no English or French background, is exempt from the English Language Proficiency Test requirement. Indeed, Canada's new and shifting immigration policies are likely to increase the number of migrants facing precarity. For example, some students did not follow the conditions tied to their migration status by deferring courses or working longer hours because they struggled financially to pay tuition. Two of the three asylum seeker participants had entered Canada as students but had fallen out of status due to financial constraints and inability to pay international tuition fees. This highlights how migrants may shift between migration statuses, from legally recognized to undocumented or non-status. Additionally, the new immigration policy states that undergraduate students cannot bring their spouses, while graduate students can. This was seen as

discriminatory because spouses provide essential financial and emotional support. The absence of these support systems often leads to stress, anxiety, and depression.

Second, when applying for a Canadian international student visa, applicants are required to demonstrate that they have sufficient funds to cover their tuition for a year; however, some participants argued that this requirement could be misleading because it does not reflect the real financial challenges many students will experience in Canada. This criterion suggests that financial support is only needed during the first year and that international students will be able to support themselves later, but barriers to employment and restrictions on work hours make this unrealistic. As a result, many students experience stress, anxiety, depression, and a higher risk of dropping out to engage in semi-legal activities due to insufficient finances. Many participants also suggested that the new immigration policy should focus on new temporary immigrants, rather than those already in Canada.

Third, the concept of “life-course backsliding.” Some participants, especially older ones who had stable employment and well-paying jobs in their home countries before moving to Canada, experienced some degree of life-course backsliding due to unstable employment, challenging living conditions, and uncertainty about the future after migration. In other words, they experienced a loss of previously achieved milestones, experiencing a setback in their progress towards their goals (McDaniel and Bernard, 2011). Their precarious migration status influenced their access to and utilization of health and social services, which they had previously not lacked in their countries of origin because of their privileges, age, social status, financial situation, and social networks. While some older participants experienced this life course backsliding, some younger participants, who were unemployed or students in their home countries and migrated to Canada to continue their education, could be seen as experiencing a

form of life course development, as they were in school and pursuing their educational goals (the main reason for their migration). During their time in Canada, some were unemployed, employed part-time, or students, and a few received financial support from their social networks (e.g., parents and siblings), helping them progress towards their life course objectives despite these structural barriers.

Fourth, contrary to the idealized dream, some participants experienced feelings of failure, hopelessness, and the desire to return to their countries of origin due to the uncertainty surrounding their precarious migration status and their inability to achieve their migration goals. Therefore, it is also possible that some immigrants in host countries encounter a similar “nerve syndrome” after migration when they start to see migration as no longer beneficial due to the constantly changing immigration policies that shift them from one form of precarity to another, making their path toward permanent residence more difficult.

Fifth, some student participants felt exploited and abandoned by the federal government because, during COVID-19, students were allowed to work 40 hours a week due to a labour shortage. Although it was a temporary policy, many believed they could work 40 hours a week for over two years without it impacting their academic performance. Therefore, they argued that it was unreasonable for the government to use academic performance as a reason to cut their hours. They pointed out that if domestic or local students can work full-time while maintaining good grades, why shouldn't international students? As some participants argued, the government should have collaborated with universities to allow students with good grades to continue working full-time instead of applying the rule to everyone.

Lastly, the “Pyramid of Look.” This term was coined by one of the participants to describe the structure or makeup of a social support network. It suggests that individuals should

understand the capabilities within their social support network and categorize them before seeking help, including financial aid, as this approach makes things easier and saves time.

These unique findings demonstrate how precarious migration status significantly impacted the health and well-being of participants by intersecting with other socioeconomic factors that compounded stress, anxiety, frustration, and depression. As participants experienced these challenges and sought ways to survive, new immigration policies and a shifting socio-political environment disrupted their pathways to success, forcing them to explore other options, both legal and illegal. These detours could increase the risk of unlawful acts, such as employer abuse due to their employees' vulnerable status or students abandoning their education. As one participant stated, “It's trying to block one loophole and leaving the others widely open, which I think is not fair for me.”

### **The Significance of the Study and Implications for Practice**

There was a greater representation of international students and temporary foreign workers in my sample. Therefore, these findings are especially relevant for these groups and may not fully represent the experience of all African immigrants with precarious status because there is significant intersectional diversity within this umbrella title of precarious status. Nevertheless, these findings represent an important contribution given the large number of international students in Canada and the changing government policies that are likely to push more of these students from one form of precarity to another. Studying African immigrants with precarious migration status in Lethbridge provided valuable scholarly and practical insights because their perspectives reflected the realities of the participants in the unique context of a small conservative city in southern Alberta.

First, this study addresses a significant knowledge gap by offering new, localized data for a region largely absent from national migration research. Most Canadian migration studies focus on large urban centres such as Calgary, Edmonton, Toronto, Vancouver, and Montréal, leaving the experiences of precarious-status migrants in smaller cities like Lethbridge underexplored. Hence, this study offers place-specific evidence on intersecting factors like gender, racism, discrimination, service gaps, and employment in Lethbridge. This challenges the idea that African immigrants with precarious status experience similar challenges in large urban centres and smaller communities.

Second, the research provides a detailed understanding of precarious status as a social determinant of health. While participants' migration trajectory conditions intersected to influence their health and well-being, precarious migration status notably constrained their access to healthcare, especially mental health services, and impacted the stability of their employment and income. Nonetheless, the effects of precarious migration status varied among participants, intersecting with factors such as age, gender, social support networks, employment, discrimination, and length of stay. Using data from Lethbridge, Southern Alberta, this study advances our understanding of intersectionality and health disparities.

Third, the study contributes relevant evidence for policy in Lethbridge, a city that is underfunded in terms of immigrant support services yet is becoming increasingly diverse. It highlights policy gaps at municipal and provincial levels, including the lack of targeted initiatives for African communities and specialized settlement programs for immigrants with precarious immigration status. Lethbridge's social and economic policies, Alberta Health Services planning, and settlement initiatives, like job programs for immigrants with uncertain immigration status, could benefit from this research.

Fourth, despite significant variation within the population of immigrants with precarious status, this study uncovered new insights into the unique challenges experienced by African immigrants in non-metropolitan regions of Canada. These immigrants encounter different obstacles compared to those in larger cities, such as smaller labour markets and a scarcity of culturally appropriate services.

Fifth, the research provided participants with a platform to share their lived experiences, illustrating how their migration trajectory conditions overlapped and influenced their health, well-being, and coping strategies like community support and resilience. This study amplifies the underrepresented voices of African immigrants with precarious status in Lethbridge. This vulnerable group is often missing from Canadian datasets because they are reluctant to participate in research due to fears of detention or arrest, rendering them socially invisible in policy discussions. As a result, this research enhances scholarly understanding of this group and could influence immigration policy.

Sixth, this research may contribute to the national debate on immigration issues, such as the rights of migrants with precarious status or temporary residents, labour exploitation, healthcare access for uninsured individuals, and pathways to permanent residence for African migrants.

Seventh, the study promotes methodological innovation in researching marginalized and racialized groups with precarious status, serving as a guide for building trust with immigrant communities, recruiting difficult-to-reach populations, and applying culturally sensitive qualitative approaches.

Eighth, these findings could inform the development of surveys to assess health challenges and service needs before and after migration among this at-risk group in Alberta or

across Canada. This could foster collaborations among researchers, community groups, and policymakers to develop and evaluate culturally appropriate policies that support the integration of precarious status immigrants into Canadian society.

Finally, healthcare providers can also use these findings to inform their clinical assessments and deliver appropriate care for African immigrants with precarious status in Alberta or Canada, many of whom may experience stress, frustration, anxiety, and depression related to their immigration circumstances.

### **Key Takeaways**

The key takeaways from this research are as follows: First, the study revealed that precarity had a larger impact on individual migrants than I initially expected. For example, two students transitioning from one precarity (student status) to another (asylum-seeking status). Participants' precarious migration status significantly influenced their access to and utilization of healthcare, including mental health and social services in Lethbridge. However, the participants experienced the effects of precarious migration status differently because they each possessed a unique intersectional social location informed by their age, gender, social support networks, employment, and income. In a small community like Lethbridge, where specialised immigrant services are scarcer than in larger urban areas, the encountered structural barriers may have been felt more acutely by some participants.

Second, the study showed that many participants often neglected their mental health. Uncertainty about their migration status frequently caused stress, anxiety, depression, and emotional exhaustion. Despite these issues, many participants either did not access or accessed mental health services at an inadequate level due to stigma, lack of culturally safe support,

limited health knowledge, absence of family doctors, religious and cultural beliefs, and financial barriers.

Third, although they cannot fully replace formal supports, the study revealed that participants' community and informal support networks, such as churches, ethnic associations, extended families, and peer groups, played a vital role in helping them navigate their challenges by providing emotional support, encouragement, hope, and resilience. The participants demonstrated resilience, courage, and hope through strategic navigation of their limited economic, social, and health resources.

Finally, the study highlighted the need for improved access to primary care, mental health services, employment protections, and clear pathways to permanent residency. The effectiveness of service interventions is limited if the legal precarity at the heart of many issues is not addressed.

### **Strengths and Limitations of the Study**

The study revealed the following strengths: First, using intersectionality theory as a theoretical lens helped me explore and better understand the overlapping social identities and migration trajectory conditions which interacted to influence the health and well-being of African immigrants with precarious migration status in Lethbridge, Southern Alberta. Second, these findings have the potential to be transferable in multiple ways consistent with qualitative research methods. First, they resonated with the participants through member checking (Smith, 2018). This was achieved by member checking with six participants from diverse backgrounds, who affirmed that these results reflected their realities or perspectives as African immigrants with precarious migration status in Lethbridge, Southern Alberta. Third, by interviewing 18 eligible participants, data saturation was reached as evidenced by data redundancy without significant

new data emerging in later interviews. Transferability was further enhanced through a thorough description of the research setting, participant demographics, methods, and processes, all of which assist in decisions regarding transferability because the findings can be applied to similar settings (Holloway & Wheeler, 2010; Smith, 2018).

This research study also revealed certain limitations. First, although the study aimed to capture the broad experiences of a diverse group of African immigrants with precarious status in southern Alberta, my sample had a greater representation of international students and temporary foreign workers. Therefore, these findings are especially relevant for this population, which makes a significant contribution, given the number of international students in Canada and the changing government policies that are likely to increase the number of students in precarious status. Second, the study partly relied on snowball sampling to recruit participants, which may have introduced self-selection bias by including those more eager to share their stories or more engaged with the subject (Meyer & Wilson, 2009). Snowball sampling may have also contributed to the greater representation of international students and temporary foreign workers in the sample, as initial contacts likely had more connections with individuals who shared similar experiences and social backgrounds. Additionally, snowball sampling might have biased my sample and underrepresented this vulnerable group, as initial voluntary participants could have protected others by not referring them (Erickson, 1979). Despite these limitations, snowball sampling proved to be the most effective method for reaching this hard-to-access population. Third, most participants identified as Christians, with very few Muslims, unintentionally excluding immigrants of other faiths (e.g., African Traditional Religion). Fourth, all participants held at least a diploma from their home countries, inadvertently excluding those with limited or no formal education. Fifth, the study involved only participants who spoke and understood

English, thereby excluding those who could not communicate well in English, despite potentially holding valuable insights. Sixth, the brief duration of interactions with participants means the study may not have captured all relevant overlapping migration experiences influencing their health and well-being. Seventh, men outnumbered women in the study, which may have influenced perceptions regarding how gender impacts overall health and well-being. Eighth, my pre-existing knowledge of the study topic might have influenced my methodology, data collection, analysis, and interpretation; however, I tried to reduce this bias by maintaining reflexivity throughout the research process. Ultimately, despite efforts to minimize bias, I also acknowledge that, consistent with social constructivism, all findings ultimately represent some degree of co-construction between myself and my participants. Lastly, my African background could have influenced participants' responses, with some withholding key information, perhaps thinking I should already know certain details as an African. This is reflected in a quote from a man participant: "You know Africa is Africa," meaning nothing has changed there.

### **Recommendations for Future Research**

Considering the limitations of this study, I recommend the following for future research aimed at understanding how migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious migration status in Lethbridge, Southern Alberta, Canada. First, I suggest that future research expand upon this study by including participants from all African countries, including speakers of different languages, to gain a broader range of perspectives on the phenomenon under study. Although this may be challenging, I believe it can be achieved through dedicated effort and collaboration with translators or researchers skilled in other languages. Second, future studies should include participants with low or no educational background to better understand the diverse and complex

intersectional migration trajectory conditions influencing their overall health and well-being. Third, due to time constraints, I recommend conducting a longitudinal or ethnographic study with sustained engagement, allowing researchers to spend more time with participants, build trust, and collect richer data. Fourth, I propose that future research aim for a more balanced gender representation to better explore how gender influences the health and well-being of African immigrants with precarious migration status. Finally, I suggest adopting a mixed-methods approach to explore this complex issue, providing a deeper understanding and increasing validity and reliability. Combining multiple research methods can help reduce limitations and biases associated with a single approach. These recommendations could help policymakers develop a more comprehensive understanding of the research area, enabling more informed decisions and the design of effective interventions based on a thorough grasp of the issues.

### **Knowledge Mobilization**

These study findings were presented at the Medical Microbiology class on November 22, 2024, at the Immigrant Mental Health Symposium organized by Lethbridge Local Immigrant Partnership on January 24, 2025, and at the Border Studies Research Group Conference on Thursday, June 12, 2025. I plan to publish at least one manuscript in a peer-reviewed journal, such as the *Journal of Ethnic and Migration Studies* or the *International Journal of Migration, Health, and Social Care*, which would be suitable venues. I also intend to present these findings at conferences, like the Metropolis Conference of Canada in 2025. A copy of the thesis will be available at the University of Lethbridge Library and the ProQuest Thesis Database to contribute to the existing body of knowledge in related fields. Additionally, I aim to share the findings with stakeholders, including religious and community leaders of African immigrant communities and

healthcare providers. Sharing these results with such groups could help improve understanding of the migration trajectory conditions that intersect to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta. Moreover, these findings could benefit immigrant organizations and professionals working with immigrants across Alberta and Canada.

### **Evaluation of the Theoretical Framework**

As a guiding theoretical framework for this study, the theory of intersectionality helped me to explore the overlapping identities and migration trajectory conditions experienced by my participants, such as age, gender, income, employment, and religious and cultural beliefs, and how they intersected to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta. The intersectionality framework revealed that the participants' complex social locations and access to power and resources influenced their perceptions and definitions of health and well-being, their experiences, opportunities for success, and the strategies they used to navigate adversity.

The theory was ideal for this study because it helped me analyze participants' diverse perspectives, views, and experiences of precarious migration status, and provided a deep understanding of how their migration trajectory conditions and social identities intersected to influence their health and well-being. It also illustrated how their unique intersectional location informed how they navigated these challenges and proposed solutions to improve their overall health. Additionally, using intersectionality as a theoretical framework illustrated how participants with higher social status in their home countries, who maintained contact with friends of similar social strata, experienced privilege in transnational spaces and preferred healthcare services in their countries of origin. Conversely, these same participants experienced

subordination in Canada because their precarious migration status limited their access to health and social services. This aligns with intersectionality theory by illustrating how some individuals can simultaneously experience privilege and subordination (Crenshaw, 1989, 2003; Hankivsky, 2014).

Overall, these study findings revealed that precarious migration status intersects with overlapping social identities and migration factors such as age, gender, income, employment, healthcare access and utilization, and utilization of alternative medicine to influence the health and well-being of the participants. This aligns with previous research indicating that immigration status as a social determinant of health should not be viewed as a standalone factor but rather as one intersecting with other factors like age, gender, income, race/ethnicity, discrimination, health status, education, health policies, and employment to shape the health and well-being of immigrants (Ellis & Stam, 2018; Hatzenbuehler et al., 2013; Phelan & Link, 2015; Villegas, 2015). Therefore, legal migration status may not serve as the sole protective factor for immigrants, particularly for marginalized and racialized groups, as it can interact with issues like racism and discrimination (Flores & Schachter, 2018). Additionally, through the lens of intersectionality as a theoretical framework, the study revealed that participants with higher social status in their countries of origin and maintained connections with friends from similar social strata experienced privilege within their transnational spaces. Consequently, these participants preferred healthcare services in their countries of origin but also experienced subordination in Canada because their precarious migration status or circumstances limited their access to health and social services. This aligns with intersectionality theory by demonstrating how individuals can simultaneously experience privilege and subordination (Crenshaw, 1989, 2003; Hankivsky, 2014).

## Reflection

I learned a great deal from conducting this qualitative research study. The interview guide played a key role in contributing to the success of this research. The interviews allowed me to gain a deep understanding of the research problem, as participants shared valuable insights based on their diverse views, perspectives, and experiences, despite the brief and limited time available. The study revealed that the challenges experienced by participants were more extensive than I had expected. For example, some international students had abandoned their studies to seek asylum due to issues such as financial constraints.

Despite the success of this research study, I encountered some challenges. First, rescheduling interviews was necessary when some participants had to cancel due to other commitments or poor audio recordings. For example, I had to reschedule an interview because the initial recording was unclear due to internet fluctuations. Additionally, another participant neither showed up nor returned my call on the scheduled day. Second, my limited time with participants was influenced by the constraints of the research timeline. According to Liamputtong (2013), longer engagement with participants can significantly impact findings, as it allows the researcher to explore sensitive issues and gather valuable information that might not emerge in a shorter period. Third, capturing and interpreting nonverbal communication, such as body language and gestures, was a challenge. Although time-consuming, transcribing data and generating codes, categories, and themes enhanced my research experience. Fourth, separating my beliefs, values, and gender biases from the data collection, analysis, and interpretation was challenging. However, I actively reduced my biases by keeping a reflexive journal and consistently referring to it (Liamputtong, 2013). The credibility of the data was further strengthened through my supervisor's support and member-checking with some participants.

Lastly, I noticed that African immigrants with precarious migration status in Lethbridge, Southern Alberta, were often reluctant to share knowledge, especially regarding immigration rules and procedures. For instance, some participants lacked awareness of recent immigration policies because they did not follow the news or their immigrant associations did not communicate such information effectively on their platforms.

Based on the findings and the valuable information shared by the participants, I believe that, as a researcher, I owe them the responsibility of translating the study's findings to policymakers, rather than simply adding to the body of knowledge. This is because, according to participants, nothing is being done to promote the health and well-being of immigrants with precarious migration status in Canada. In doing so, I believe this could potentially lead to discussions, development, and implementation of policies that address the health and social needs of this vulnerable population.

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## Appendices



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### Appendix A: Participation Invitation Letter

To the Executives,

Subject: Invitation to participate in a study titled “Exploring how migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta.”

Dear President and Executive Members:

I am Emmanuel Ato Moses Desbordes, a Ph.D. candidate in Population Studies in Health, in the Faculty of Health Sciences at the University of Lethbridge, Alberta. I am undertaking this research that seeks to explore migration trajectory conditions (i.e., pre-migration, migration, and post-migration) that intersect to influence the health and well-being of African immigrants with precarious migration status in Southern Alberta. Precarious-status migrants by definition, include but are not limited to temporary-status migrants such as temporary workers, international students, refugees, asylum seekers, and migrants whose visas or work permits have expired. I would like to partner with your organization to help me recruit African immigrants with precarious migration status in Southern Alberta. I am inviting African immigrants with precarious migration status in Southern Alberta to voluntarily take part in the study. Your assistance in sharing information about this research and recruitment materials with immigrant groups through your bulletin boards, social media platforms, or meetings would be greatly appreciated.

It is intended that documenting participants’ migration experiences will generate valuable knowledge that may inform policy and advocacy efforts to support African immigrants with precarious migration status in Southern Alberta. Participation is voluntary, and each participant has the right to withdraw from the study at any point in time, for any reason without any penalty or consequence. Participants who choose to withdraw from the study will have all their information destroyed to protect their confidentiality.

Participants who may be interested in contributing to the study can contact me via any of the contacts provided below. I will contact any potential participant and schedule an interview for approximately 45-60 minutes on Zoom or in person. An informed consent form and a demographic information form will be emailed to the participants to read, fill out, and sign before the interview date. All the participants' concerns and questions about the research study

will be addressed before the interview date. Participants will be interviewed separately at a mutually agreed-upon location that provides safety, security, privacy, and confidentiality. If participants consent, these interviews will be digitally recorded to capture the individual's migration trajectory experiences with as much accuracy as possible. Participants have the right to turn off their cameras during the interview session if they wish to be interviewed with the camera off or do not feel comfortable being interviewed with the camera on. The collected data will only be shared with my thesis committee members. Participants will be reimbursed for costs incurred (e.g., transportation, childcare, and parking) in the study.

Data, including digital recordings and any notes, will be encrypted, and saved on a password-protected computer. Hard copies of the data will be kept in a locked filing cabinet in a locked room at the Faculty of Health Sciences, University of Lethbridge. Research data will only be accessible by the researcher and the research supervisors. Digitally recorded interviews and all other documents will be destroyed after 5 years. All participants will receive a \$20 gift card as a show of appreciation for their participation, which they may keep even if the participant decides to withdraw from the study. These study findings will be shared with your organization and participants if they so wish. A copy of the thesis will be made available through the University of Lethbridge Library and ProQuest Thesis Database to add to the already existing body of knowledge in related areas of study.

I kindly ask that the leaders of this organization help me to share the nature, purpose, procedures, expectations of participants, and the risks and benefits of this study with this vulnerable and hard-to-reach group in ways that ensure that potential participants do not feel any coercion to participate.

This study has received ethical approval from the University of Alberta Human Participant Research Committee – Ethics ID # Pro00144998.

If you have any questions about this study, feel free to contact me via email: [e.desbordes@uleth.ca](mailto:e.desbordes@uleth.ca), or my thesis supervisor, Dr. Peter Kellett (email: [peter.kellett@uleth.ca](mailto:peter.kellett@uleth.ca)) at the Faculty of Health Sciences, or the Research Ethics Office, University of Alberta (Phone: 780-492-2615 or email: [reoffice@ualberta.ca](mailto:reoffice@ualberta.ca)). Thank you.

Yours faithfully,

Emmanuel Ato Moses Desbordes



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## Appendix B: Participant Recruitment Poster

**Would you be willing to participate in a research interview?**



*Exploring how migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious immigration status in Southern Alberta.*

### **Eligible Participants must:**

- a) identify as an African immigrant with precarious migration status (i.e., those with temporary immigration status such as international students, temporary workers, refugees, asylum seekers, migrants with expired visas or work permits) living in Southern Alberta communities and not in detention centers.
- b) be 18 years of age or older
- c) be able to communicate in English
- d) have lived in Southern Alberta for at least a year
- e) be able to provide informed consent

The interview will take 45-60 minutes on Zoom or in person. You have the right to turn off your camera if you do not want to be interviewed with the camera on. Each eligible participant will receive a \$20 gift certificate

For further information, contact Emmanuel Ato Moses Desbordes via email:  
e.desbordes@uleth.ca or Cell: 587-821-5087

*This study has received Ethical Approval from the University of Alberta Human Participant Research Committee – Ethics ID # Pro00144998*

## Appendix C: Demographic Information Form

Participant ID: \_\_\_\_\_

I would like to begin by asking you some basic information about yourself.

1. Please indicate your gender.
  - Man
  - Woman
  - Gender Diverse
  - Prefer not disclose
2. Within which age range are you?
  - 18-25
  - 26-35
  - 36-45
  - 46-55
  - 56-65
  - 65 or above
3. At what age range did you migrate?
  - 18-25
  - 26-35
  - 36-45
  - 46-55
  - 56-65
  - 65 or above
4. What was the reason for migration?  
\_\_\_\_\_
5. Do you have children living with you?
  - Yes
  - No
6. Do have any social support network in Southern Alberta?
  - Yes
  - No
7. What best describes your marital status?
  - Single, Never Married
  - Married
  - Common Law
  - Separated
  - Divorced
  - Widowed
8. What best describes your level of education?
  - Elementary School
  - High School
  - Some college education
  - College diploma

- Some University education
  - Bachelor's degree
  - Postgraduate degree
  - Other (Specify) .....
9. How long have you lived in Southern Alberta?
- 1-2
  - 2-3
  - 3-4
  - 4-5
  - 5 and more
10. What best describes your employment status?
- Employed full-time
  - Employed part-time
  - Not employed
11. What best describes your Immigration Status?
- Temporary resident (e.g., international student, temporary worker, and visa holder,)
  - Refugee
  - Asylum seeker
  - Non-status
12. Are you able to access and utilize healthcare in Southern Alberta?
- Yes
  - No
13. What do you do when you fall sick?
- See a physician
  - Resort to alternative medicine
  - Self-medication
  - Consult a physician in your home country
14. What best describes your economic status?
- Less than \$800 per month
  - Between \$2000 to \$3000 per month
  - More than \$3000 per month
15. What best describes your religious affiliation?
- Christian
  - Hindu
  - Buddhist
  - Muslim
  - Other.....
16. Will you incur any costs to partake in this study?
- Transportation
  - Childcare
  - Parking
  - Other .....
  - Not Applicable

## Appendix D: Interview Guide

### **Part 1: Introduction**

Thank you so much for taking the time out of your busy schedule to talk with me today. This research is about exploring how migration trajectory conditions (i.e., pre-migration, migration, and post-migration) intersect to influence the health and well-being of precarious-status migrants in Southern Alberta. There are no right or wrong answers to any of my questions since the objective of this interview is to seek your perspectives on the topic of today's discussion. These data will be kept safe and used for this research only. I will use a pseudonym to protect your identity in these data and maintain confidentiality. Is there any preferred pseudonym you would like to use, or do you want me to make one up for you? Please let me know if any questions make you uncomfortable; feel free not to answer. Do you have any questions before we begin?

1. What was the reason for your migration to Canada?
2. At what age did you migrate?
3. How long have you been in Southern Alberta, Canada?
4. Were any other people (e.g., family, friends, neighbours, and smugglers) involved in your migration decision?
5. Is it common for people who identify with your gender, age group, ethnic group, friends, and family members in your community or home country to migrate?
6. Before leaving your country of origin for Canada, have you ever applied for a visa to travel to any other country? Is Canada your first destination from your country of origin?
7. Was your decision to migrate to Canada influenced by your post-migration social network, such as family members and friends in Canada?
8. Why did you choose to migrate to Canada?
9. Before migration from your country of origin, did you have any pre-migration expectations of Canada?
10. How did you hear about the opportunities in Canada (e.g., social media, friends, family, or smugglers)

### **Part 2: Pre-migration conditions**

1. How did you define health and well-being before migration?
2. How would you describe your pre-migration health status?
3. What were your home country's pre-migration circumstances/conditions (e.g., wars, persecution, torture, mismanagement, corruption)?
4. What pre-migration condition(s) influenced your decision to migrate?
5. What pre-migration experiences/challenges influenced your health and well-being?
6. What was the healthcare system in your country of origin?
7. How did you access and utilize health and social services in your country of origin?
8. What barriers, if any, did you experience in accessing and utilizing healthcare in your country of origin?
9. What pre-migration challenges/experiences influence(d) your health and well-being in your country of origin (e.g., age, gender, cultural/religious beliefs, geographic location, racism/tribalism, discrimination, employment, income, education, health

literacy/knowledge, social isolation/exclusion, competence of healthcare professionals and quality of healthcare, and doctor-patient relationship, access to health and social services (e.g., any experience of inadequate, unsafe, and affordable housing etc.)?

10. Did you resort to alternative medicine, traditional medicine, or home remedies when you were sick in your home country?
11. Were you confident in the healthcare system in your country of origin?
12. How did you cope with health issues?

### **Part 3: Migration conditions**

1. How did you facilitate your journey (e.g., visas, travel documents (fake or genuine), financial support from family, friends, and smugglers)?
2. How easy was your journey, or did you have trouble getting the visa or permit (safe or unsafe routes, legal or illegal points of entry)?

### **Part 4: Post-migration conditions**

1. Has your pre-migration perception and definition of health and well-being changed after migration?
2. Has your immigration status changed since you arrived in Canada?
3. How do you see your current health status compared to your pre-migration one?
4. What are your views on the pathways to permanent residency in Canada? Do you think they are guaranteed?
5. How does your precarious immigration status affect your mental and physical health?
6. What are some of your post-migration challenges or experiences?
7. What post-migration conditions influence your health and well-being (e.g., age, gender, cultural/religious beliefs, geographic location, racism/tribalism, discrimination, employment, income, education, health literacy/knowledge, social isolation/exclusion, competence of healthcare professionals and quality of healthcare, and doctor-patient relationship, access to health and social services (e.g., any experience of inadequate, unsafe, and affordable housing, etc.)?)
8. Are you concerned about the current changes to immigration policy?
9. Does your precarious migration status hinder you from accessing healthcare?
10. What are some of the challenges you encounter or have encountered in accessing and utilizing healthcare in Southern Alberta?
11. What healthcare services do you pay for out of pocket, and what do you want to see changed?
12. To what extent does your precarious immigration status limit the ability of your children, including Canadian-born citizen children, to access the services to which they have rights?
13. How do you cope with health issues in Canada (e.g., self-medicating, using false documents, or delaying the use of essential healthcare, including ante and post-natal care or immunizations)?
14. Do you resort to alternative medicine, traditional medicine, or home remedies when you are sick?
15. Do you contact any physicians from your country of origin when you are sick?
16. Have you ever been arrested, detained, and deported from Canada or any other country?

17. Has your initial reason for migration changed with time?
18. Do you intend to return to your country of origin permanently someday?

### **Part 5: Conclusion**

1. In your opinion, what migration trajectory conditions (i.e., pre-migration, migration, and post-migration) intersect to influence your health and well-being?
2. How do you cope with the migration trajectory conditions that intersect to influence your health and well-being?
3. What changes in policies and practices (e.g., health, employment, immigration, etc.) would support your health and overall well-being?
4. I don't have any more questions. Is there anything you want to add or need clarification on before we officially end this interview?
5. Can I please contact you again if there is/are any responses that need further clarification?

**Thank you so much for your time and for providing this valuable information**



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## Appendix E: Informed Consent Form

**Title of Study:** Exploring how migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious immigration status in Southern Alberta.

### Principal Investigator:

Name: Emmanuel Ato Moses Desbordes  
Affiliation: University of Lethbridge, Alberta, Canada  
Email: [e.desbordes@uleth.ca](mailto:e.desbordes@uleth.ca).

### Supervisor:

Name: Dr. Peter Kellett  
Affiliation: University of Lethbridge, Alberta, Canada.  
Email: [peter.kellett@uleth.ca](mailto:peter.kellett@uleth.ca)

You are invited to participate in this research study voluntarily. Before you take part, we are available to explain the project, and you are free to ask any questions about anything you do not understand or that needs further clarification. You will be given a copy of this form for your records.

### Why am I being asked to take part in this research study?

You are being asked to voluntarily participate in this research study. Your valuable information will help us explore how migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious immigration status in Southern Alberta.

Precarious-status migrants per definition, include but are not limited to temporary-status migrants such as temporary foreign workers, international students, refugees, asylum seekers, border crossers, and migrants whose visas or work permits have expired. Following migration to Canada, precarious-status migrants experience migration trajectory conditions that intersect to influence their health and well-being.

### What is the reason for doing the study?

The purpose of doing this research study is 1) to explore how African immigrants with precarious immigration status define health and well-being; 2) to explore how migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious immigration status in Southern Alberta; and 3) to explore what coping strategies African immigrants with precarious immigration status in Southern Alberta use to navigate their precarious circumstances.

**What will I be asked to do?**

In addition to the informed consent form, a demographic information form will be emailed to you to read, fill out, sign, and email back to me before the interview date. We will address all your concerns and questions about the research study before the mutually agreed upon interview date. You will be interviewed separately. Virtual interviews utilizing Zoom software or in-person face-to-face interviews will be used for data collection. In either case, you will be interviewed for approximately 45-60 minutes in a natural setting that preserves your confidentiality, possibly including your home (if you live alone), or any chosen place of convenience outside your home, that provides the safety, security, and confidentiality needed to engage in the research interview. The interview will be scheduled at a mutually agreed upon convenient time. A password waiting room will be utilized during virtual interviews to enhance the security of the interview and confidentiality. If you agree, the interview will be digitally recorded and transcribed verbatim by me. You have the right to turn off the camera during the interview session if you wish to be interviewed with the camera off or do not feel comfortable being interviewed with the camera on. The collected data will only be shared with my thesis committee members. You may be contacted again to ensure I have correctly understood what you have told me.

**What are the risks and discomforts?**

There is minimal risk with participating in this study (that is, within acceptable minimum daily risk). Although some of the questions may be sensitive, which may lead to emotional and psychological distress as you recount your migration experiences, we will apply the principle of 'non-maleficence' in research to ensure that your physical, emotional, and social well-being is maintained and that you are not adversely affected by taking part in this research. A list of counseling services in Southern Alberta will be provided if you experience emotional and psychological distress and wish to access additional support (see Appendix I: Counseling services). You have the right to skip questions that make you feel uncomfortable or stop the interview if you do not feel comfortable to continue. Please note that while it is not possible to know all of the risks that may happen in a study, we have taken all reasonable safeguards to minimize any known risks to a study participant.

**What are the benefits to me?**

While there may not be any direct benefit to you, results from this study will be beneficial to both the immigrant communities, precarious-status migrants, and agencies that interact with them, to broaden their understanding and knowledge of how migration trajectory conditions intersect to influence the health and well-being of African immigrants with precarious immigration status in Southern Alberta, Canada. In addition, it could potentially inform policymakers to develop comprehensive policies that address the health and social needs of this vulnerable migrant group. Finally, it could lead to further future research that benefits this migrant population.

**Do I have to take part in the study?**

Being in this study is completely your choice. If you decide to be in the study, you can change your mind and stop being in the study at any time without any consequences. You have the right to skip questions or refuse to answer questions that you are not comfortable with. There are no consequences if you do not answer a question or if you decide to stop the interview. You may ask questions at any time. You can also take a break, stop the audio recording, or withdraw from the

study for any reason. If you withdraw, the interview recording will be stopped. Even if you remain in the research study, you may choose to withdraw some or all of your responses by contacting me within two months after the interview. You will have two months after the interview to contact me to request that your transcript and demographic information be destroyed. We will be unable to remove your responses after that time because they have become part of the data set and data analyzed.

### **Will I be paid to be in the research?**

As a show of appreciation, you will receive a \$20 gift certification which you may keep even if you decide to withdraw. This should not be perceived as an inducement of any kind of participation. In addition, you will be reimbursed for costs incurred (e.g., transportation, childcare, and parking) in the study. If you choose to withdraw from the study partway through participation you are entitled to this incentive.

### **Will my information be kept private?**

During this study, we will do everything we can to make sure that all information you provide is kept private. No information relating to this study that includes your name will be released outside of the researcher's office or published by the researchers unless you give us your express permission. However, under Alberta law everyone has a mandatory obligation to report any revelation of potential crimes such as child abuse, or elder/vulnerable adult abuse, to appropriate authorities (e.g., law enforcement); or 2) you disclose information that places your safety or the safety of others at risk.

To further ensure your privacy and confidentiality, the interview recordings will be saved on a password-protected computer. The data collected from you will be shared with only my supervisor. I will transfer the digital audio file after each interview to an encrypted folder on my password-protected computer. All hard copies of data including handwritten notes, transcribed data, external drive (USB) key, and other all documents bearing the names of participants will be kept in a safe and secure filing cabinet, for confidentiality reasons and will be used only for this research. These data will be saved on a password-protected computer and encrypted electronic files. I will utilize pseudonyms to protect your identity, especially during the analysis and write-up of findings. All raw data both hard copies and digital files on the digital recorder, and my computer/digital storage will not only be deleted but digitally shredded and disposed of in the Faculty of Health Sciences confidential shredding after 5 years.

### **What if I have questions?**

If you have any questions about the research now or later, please contact me at [e.desbordes@uleth.ca](mailto:e.desbordes@uleth.ca) or my supervisor, Dr. Peter Kellett, Faculty of Health Sciences (email: [peter.kellett@uleth.ca](mailto:peter.kellett@uleth.ca)).

If you have any questions regarding your rights as a research participant, you may contact the University of Alberta Research Ethics Office at [reoffice@ualberta.ca](mailto:reoffice@ualberta.ca) or 780-492-2615 and quote Ethics ID Pro00144998. This office is independent of the study investigators.

There are no identified conflicts of interest since this study is not funded by any organization.

**How do I indicate my agreement to be in this study?**

By signing below, you understand:

- That you have read the above information and have had anything that you do not understand explained to you to your satisfaction.
- That you will be taking part in a research study.
- That you may freely leave the research study at any time.
- That you do not waive your legal rights by being in the study
- That the legal and professional obligations of the investigators and involved institutions are not changed by your taking part in this study.
- That you agree to the data being stored as part of a data repository (where applicable)

**SIGNATURE OF STUDY PARTICIPANT**

\_\_\_\_\_ Pseudonym (if necessary)  
Name of Participant

\_\_\_\_\_ Date  
Signature of Participant

**SIGNATURE OF PERSON OBTAINING CONSENT**

\_\_\_\_\_ Contact Number  
Name of Person Obtaining Consent

A copy of this consent form has been given to you to keep for your records and reference.

## **Appendix F: Member Check Guide**

1. Is there any part of the study findings that does not accurately reflect or represent your views?
2. Do you want to further develop, clarify, or change any part of the study findings?
3. Is there anything in the study findings that stands out for you?

### Appendix G: Budget

<b>RESOURCES</b>	<b>AMOUNT (CAD)</b>
Transport Expenses	\$200
Stationery/Printing	\$100
Communication - (phone & internet)	\$200
Digital recorder	\$100
Flash drive	\$40
Transcription software	\$100
Snacks & Drinks for participants	\$100
Transportation, Parking, and Childcare costs	\$360
Gift certificate	\$500 - \$600
Dissemination of Findings	\$200
<b>In-kind Resources</b>	
Use of the University computer	
Use of NVivo 15 QSR software	
<b>Total</b>	<b>\$2000</b>

### Appendix H: Study Timeline

<b>TASK</b>	<b>ACTIVITY</b>	<b>MONTH</b>
Thesis Proposal	Submit the thesis proposal to the committee	July 2024
Thesis Colloquium	Committee to approve thesis proposal	August 2024
University of Lethbridge Human Subject Research Committee	Submit an application to the Ethics Review Board for approval	August 2024
Recruitment	Recruitment of participants	September 2024 – February 2025
Data Collection	Review of Literature & Interview of participants	September 2024 – February 2025
Data Analysis	Rigorously analyzing the data	December 2024 – March 2025
Thesis Results and Discussion	Writing Results and Discussion	February 2025 – September 2025
Thesis Final Draft	Submit to Committee	October 2025
Thesis Defense	Defense	December 2025

**Appendix I: Community Mental Health Services Provided by: Alberta Health Services -**

**South Zone**

**Alberta Health Services Mental Health Clinic – 403 329 4775**

**Bow Island Provincial Building**

802 6 Street E, Bow Island, Alberta T0K 0G0  
403-529-3500

**Brooks Health Centre**

440 3 Street E, Brooks, Alberta T1R 1B3  
403-793-6655

**Cardston Provincial Building**

576 Main Street, Cardston, Alberta T0K 0K0  
403-653-5115

**Crowsnest Pass Provincial Building**

12501 20 Avenue, Blairmore, Alberta T0K 0E0  
403-562-5040

**Fort Macleod Health Centre**

744 26 Street S, Fort Macleod, Alberta T0L 1Z0  
403-553-5340

**Lethbridge Provincial Building**

200 5 Avenue S, Lethbridge, Alberta T1J 4L1  
403-381-5260

**Medicine Hat Provincial Building**

346 3 Street SE, Medicine Hat, Alberta T1A 0G7  
403-529-3500

**Oyen Community Health Services**

315 3 Avenue E, Oyen, Alberta T0J 2J0  
403-529-3500

**Pincher Creek Provincial Building**

782 Main Street, Pincher Creek, Alberta T0K 1W0  
403-627-1121

**Raymond Health Centre**

150 N 4 Street E, Raymond, Alberta T0K 2S0  
403-752-5440

**Taber Health Centre**

4326 50 Avenue, Taber, Alberta T1G 1N9  
403-223-7244

**Mental Health Helpline**

**Toll-free line: 1-877-303-2642.** For available translation services.

**Call Toll-free line: 1-888-594-0211.** For information and referral Specialists.

**\*If you are in immediate danger, call 9-1-1**