

**IMMIGRANT WOMEN'S ACCESS AND UTILIZATION OF PERINATAL HEALTH
SERVICES IN SOUTHERN ALBERTA**

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Abstract

Immigration is widely recognized as a defining characteristic of Canada (Immigration, Refugees and Citizenship Canada, 2024). Disparities in access to quality healthcare emerge when gender, ethnicity, and race place individuals at a social disadvantage, increasing risks of stigmatization, discrimination, and unequal treatment (World Health Organization, 2018). Women who receive early and consistent prenatal care typically experience improved health outcomes. However, multiple studies have repeatedly demonstrated that women from refugee and migrant backgrounds encounter significantly poorer perinatal outcomes (Heslehurst, 2018; Väisänen, Remes, & Martikainen, 2022; Sturrock et al., 2020; Behboudi-Gandevani et al., 2022). Over the past fifteen years, the migration of women of reproductive age to Canada has doubled, demonstrating the need for targeted investigation into their healthcare access and utilization. Therefore, this study aims to improve understanding of the perinatal experiences of immigrant women in Southern Alberta and contribute to the expanding literature on this subject.

This research employed an exploratory qualitative design utilizing an interpretive approach, which was guided by intersectionality theory as the theoretical framework. Semi-structured interviews were conducted with seven women from immigrant backgrounds. Braun and Clarke's thematic analysis (2022) was applied to examine the data and identify key themes.

The study's findings expanded understanding of the perinatal experiences of immigrant women in Southern Alberta and reveal intersecting factors that facilitate or hinder access to essential health services. Sharing these experiences may inform the development of policies and interventions that aim to improve the level of care and healthcare utilization within this population.

Ethics Statement

Work described in this thesis received research ethics approval from the University of Alberta Research Ethics Board, Project Name “Immigrant Women’s Access and Utilization of Perinatal Health Services in Southern Alberta”, Protocol number: Pro00150987, March 25, 2025.

Use of Generative AI

The use of AI-assisted tools in this thesis was strictly limited to Grammarly for refining sentence structure, improving clarity, and providing proofreading for grammatical errors, typos, and spelling mistakes. AI was not used to generate any content or ideas in any capacity. All interpretations and conclusions are entirely my own.

Acknowledgement

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"A mother's love for her child is like nothing else in the world. It knows no law, no pity, it dares all things and crushes down remorselessly all that stands in its path." — Agatha Christie.

Table of Contents

Abstract.....	iii
Ethics Statement.....	iv
Use of Generative AI.....	v
Acknowledgement.....	vi
Table of Contents.....	viii
List of Tables.....	x
List of Figures.....	xi
CHAPTER 1: INTRODUCTION	1
Background	1
Female Migrants to Canada.....	3
Rationale.....	4
Study Purpose/Aim	5
Research Question.....	6
Significance of the Research	6
CHAPTER 2: LITERATURE REVIEW	8
Canadian Healthcare System - Overview.....	10
Maternal and Perinatal Health.....	12
Migrant and Refugee Women Health Status	15
Barriers & Facilitators to Accessing Maternal Healthcare.....	17
Internalized Oppression.....	20
Theoretical Perspectives.....	23
Summary	25
CHAPTER 3: METHODOLOGY	26
Study Design	26
Positionality/Reflexivity.....	26
Theoretical Approach.....	28
Research Setting.....	30
Participant Recruitment.....	30
Data Collection and Procedure.....	33
Data Management Plan	35
Data Analysis	36
<i>Scientific Rigour & Trustworthiness</i>	38
Ethical Considerations.....	41

Summary.....	43
CHAPTER 4: STUDY FINDINGS	44
Demographic Information of Participants.....	44
Description of Themes	46
Theme 1: The Village Navigating Support Networks.....	47
Theme 2: Velvet Rope System.....	56
Theme 3: Hitting A Wall: The Living Toll.....	63
Summary	78
CHAPTER 5: DISCUSSION OF FINDINGS.....	80
Overview of the Inquiry	80
The Village: Navigating Support Networks.....	81
The Velvet Rope System.....	85
Hitting A Wall: The Living Toll	88
The Convergence of Inequality in Perinatal Care	93
Strengths of the Study.....	94
Limitations of the Study	95
Reflexivity.....	97
Recommendations for Future Research	100
Significance of the Study and Implications for Future Practice.....	102
Knowledge Mobilization.....	104
Conclusion.....	105
References	107
APPENDICES	124
Appendix A: Participation Invitation Letter.....	124
Appendix B: Organization Permission Form.....	126
Appendix C: Recruitment Poster.....	128
Appendix D: Participant Consent Form	129
Appendix E: Research Question	133
Appendix F: Interview Guide.....	134
Appendix G: Analytical Progression.....	136

List of Tables

Table 1: Demographics summary.....45

Table 2: The themes and subthemes.....46

List of Figures

Figure 1: Age and Gender Pyramid, as of July 1, 2003, and 2023, Canada.....	9
Figure 2: Total Population vs. Recent Immigrants (2016 to 2021)	9
Figure 3: Diagram of the Role of APOs in the Pathogenesis of Cardiovascular Disease.....	14
Figure 4: Mechanisms of Oppression.....	21
Figure 5: Levels on which Racism Exists.....	22
Figure 6: Phases of Reflexive Thematic Analysis.....	38

Chapter 1: Introduction

Background

A migrant, as defined by the UN Migration Agency (IOM), is an individual who has crossed an international border or relocated within a State from their usual place of residence, irrespective of their legal standing, the voluntary or involuntary nature of the movement, the reasons for the migration, or the duration of their stay. Migration generally implies the *voluntary* movement of a person across a border, often for better economic opportunities (United Nations High Commissioner for Refugees [UNHCR], 2016). This is not the case for refugees.

Immigration has long been considered the defining feature of Canada (Immigration, Refugees and Citizenship Canada [IRCC], 2024). Immigrants contribute to the economy by joining the labour force, paying taxes that fund public services, and supporting our aging population. Canada has four categories of immigrant admission, including *economic immigrants*, *family-sponsored immigrants*, *refugees*, and *other immigrants* who were granted permanent resident status outside of the previously mentioned categories (Statistics Canada, 2022c, 2023b). An *economic immigrant* is an individual who has been chosen based on their capacity to enhance Canada's economy through the fulfillment of provincial or territorial labor market requirements. A *family-sponsored immigrant* is an individual who has been sponsored by a Canadian citizen or permanent resident and has obtained permanent resident status through familial ties, such as being a spouse, partner, parent, grandparent, child, or other relative of the sponsor. The *refugee* category comprises immigrants who have been granted permanent resident status due to being displaced and fearing persecution if they were to return to their country of origin. The *other* category of immigrants comprises individuals who have obtained permanent resident status

through a program that is distinct from those outlined in the preceding categories (Statistics Canada, 2023b).

The main international instrument of refugee law is the 1951 Geneva Convention. According to the Convention, a refugee is an individual who is unable or unwilling to return to their country of origin due to a justified fear of persecution based on criteria such as race, religion, nationality, membership in a specific social group, or political beliefs (UNHCR, 1951, p.3). Although the Canada UNHCR office opened in 1976 (Global Affairs Canada [GAC], 2024), Canada has participated in the UNHCR Executive Committee since 1958 and has worked to safeguard the rights of people forced to flee conflict and persecution (UNHCR, n.d.). As of June 2024, the UNHCR mid-year trends report indicated that 122.6 million individuals have been displaced globally due to persecution, conflict, violence, human rights violations, or events severely disrupting public order (UNHCR, 2024, p.2).

The term “migrant” is frequently used to refer to individuals who fall within any of the four immigrant classifications. Nevertheless, the UNHCR (2016) advised against this practice, due to the possibility that this may lead to confusion that could potentially jeopardize the well-being and security of refugees. It is important to note that Canada has a longstanding history of accepting refugees, having welcomed more than 1.5 million individuals since the year 1980 (UNHCR Canada, n.d.). In 2022, Canada achieved recognition as the leading resettlement nation worldwide by welcoming over 46,500 refugees from a diverse range of over 80 countries. (IRCC, 2023, p.33).

The researcher acknowledges that there is a diversity of gender presentations, and that being biologically female, or intersex with the ability to get pregnant, does not necessarily equate with gender identification as a woman. However, the participants in this study were all

biologically female and all identified as women, so in this study the terms female and woman are used interchangeably.

Female Migrants to Canada

Female migrants and refugees account for 135 million, or 48.1 per cent, of the global international migrant number (United Nations Department of Economic and Social Affairs, Population Division, 2021; Global Migration Data Analysis Centre [GMDAC], 2023). Among displaced populations as of 2022, 51% of refugees were women and girls (UNHCR, 2023). Global Affairs Canada (2017) reports that women and girls shoulder a heavier burden of care for both families and the community at large when humanitarian crises hit. Furthermore, women and girls face a heightened risk of exploitation, abuse, and violence, including sexual violence, with estimates suggesting that one in five refugee or displaced women have experienced sexual violence (Global Affairs Canada, 2017). In 2024, Canada welcomed a total of 49,285 resettled refugees, of whom 22,915 were female (IRCC, 2025).

A United Nations (UN) report indicated that pregnancy-related problems and maternal health issues such as high rates of stillbirth, infant mortality, and inadequate or absent antenatal care were common among immigrants throughout the European Union countries and Asia (UNHCR, 2018). In high-income nations like Canada, migrant and refugee women have access to equivalent services as native-born women. However, they exhibit lower utilization rates of preventive gynecological services, experience higher rates of complicated pregnancy outcomes, and face an elevated risk of adverse perinatal outcomes (Schmidt et al., 2018; Fellmeth et al., 2017; Almeida et al., 2013). A study conducted by Khanlou et al. (2017) supported these results, in which they found that a higher incidence of complications related to pregnancy, childbirth, and the postpartum period was seen among migrant women.

Disparities in access to quality healthcare arise when factors such as gender, ethnicity, and race place certain individuals at a social disadvantage, leading to increased risks of stigmatization, discrimination, and unequal treatment (World Health Organization [WHO], n.d.-a). Multiple studies have consistently shown that women from refugee and migrant backgrounds experience significantly poorer perinatal outcomes (Heslehurst, 2018; Väisänen et al., 2022; Sturrock et al., 2020; Behboudi-Gandevani et al., 2022). The past fifteen years have seen a doubling in the migration of women of reproductive age to Canada. This underscores the necessity for a targeted investigation into the utilization of healthcare and access to healthcare services for women from refugee and migrant populations (Khanlou, 2017).

Rationale

Alberta's population continues to experience exponential growth. According to the Government of Alberta (2024), the population of Alberta grew by 204,209 individuals, representing a 4.4% increase between July 1, 2023, and July 1, 2024. This growth rate is higher than the 3.9% increase observed between 2022 and 2023. International migration is the primary driver of population growth in Alberta. In the first quarter of 2024, Alberta experienced a net gain of 32,893 residents due to international migration (Rodrigues, 2024). To put this into perspective, while Alberta's growth rate remained elevated at 1% in the second quarter of 2024, Canada's growth rate was 0.61% in the second quarter of 2024 (Government of Alberta, 2024). According to the data presented, migration remains a key driver of population growth in Alberta. According to the Business Council of Alberta (2023), females accounted for 52.3% of permanent residents in Alberta from 2016 to 2021. In addition, approximately 54.2% of the permanent residents who arrived in Alberta between 2016 -2021 were females aged 25 - 44, slightly surpassing the national average of 52.4%. These figures underscore the significance of

prioritizing the health of immigrant women, particularly their maternal health and healthcare utilization.

Research indicates that the experience of displacement, migration, and resettlement can further widen existing health disparities among women originating from migrant and refugee communities (Boyle et al., 2018; WHO, 2017). These women often have limited or no access to healthcare prior to migrating to the host country (Boyle et al., 2018). Moreover, migrants and refugees frequently possess a restricted understanding of the healthcare infrastructure in their newly adopted nation, leading to potential challenges in accessing and utilizing healthcare services. Further, Coleman (2018) identified that insufficient prenatal care among pregnant refugee women can exacerbate the risk of pregnancy-related complications. Factors that can heighten susceptibility and hinder access to and utilization of healthcare services include, but are not limited to, language barriers, healthcare provider attitudes, implicit racial bias, provider discrimination and racism, culturally unsuitable or medically inept screening services, and baseless race-based beliefs in biological differences (Almeida et al., 2013; Khanlou et al., 2017; Nestel, 2012).

Study Purpose/Aim

The purpose of this *exploratory qualitative design utilizing an interpretive approach* was to examine the perinatal experiences of immigrant women in Southern Alberta, including,

1. Understanding the possible factors that may support or deter the perinatal healthcare *access* of immigrant (refugee and migrant) women.
2. Understanding the factors that may support or deter the perinatal healthcare *utilization* of immigrant (refugee and migrant) women.

Research Question

The goal of this study was to better understand the perinatal experiences of immigrant women in Southern Alberta and add to the growing body of literature that aims to shed light on this topic. The following research question guided the study: What are the healthcare experiences of migrant and refugee women, and how do they support or deter their access to *and utilization of perinatal health services in Southern Alberta?*

Significance of the Research

Defining the perinatal period requires an extended timeline when examining immigrant and refugee populations. While standard clinical frameworks, such as those used by the World Health Organization, restrict this tracking window to 22 weeks of gestation through seven days postpartum for statistical purposes (WHO, 1992), this study follows a timeframe from conception to one year after childbirth. Shorter tracking intervals hide the reality of migration-related stress, language barriers, and structural isolation, which routinely persist long past delivery. Current perinatal health equity literature relies on this 12-month postpartum timeline to catch the ‘unresolving anxiety trajectories’, deep isolation, and fragmented care that standard, brief tracking windows routinely overlook (Gao et al., 2018; Hajira et al., 2026).

This broader lens is essential in Canada, where maternal risks are highly unequal. The "healthy immigrant effect" offers some protection to certain groups, yet refugee claimants and women from Sub-Saharan Africa and the Caribbean face disproportionately higher rates of severe maternal health problems (Urquia et al., 2007; Urquia et al., 2015). Ultimately, these structural disparities drive up rates of adverse perinatal outcomes, proving that institutional access barriers translate directly into preventable clinical harm for newcomer families.

Early and continuous prenatal care serves as a safeguard against clinical risks. However, standard health services often fail to provide this support equitably. Women who receive early and consistent prenatal care typically experience improved health outcomes. Immigrant and refugee women are a potentially vulnerable demographic that may experience disparities in accessing essential prenatal care due to obstacles related to cultural, linguistic, and financial factors, ultimately heightening the likelihood of adverse pregnancy outcomes (Debessai, 2016; Almeida et al., 2013). Research shows that women originating from migrant and refugee backgrounds who currently reside in most high-income countries face a higher likelihood of experiencing adverse perinatal outcomes compared to women who are native to the host country (Almeida et al., 2013; Gibson-Helm et al., 2015; Heslehurst et al., 2018; WHO, 2017).

This study provides a better understanding of the perinatal experiences of immigrant women in Southern Alberta. As well, the study provides information that may help to assess the various factors that support or deter access and utilization of necessary services. Additionally, providing an opportunity for the study population to voice their experiences may provide valuable information that may help to influence the development of policies, programs, standards, and interventions that may improve the level of care and healthcare utilization among this population.

Chapter 2: Literature Review

Canada's population is significantly influenced by immigration, establishing itself as a prominent high-income nation that attracts immigrants from varied ethnocultural backgrounds and social situations. In 2021, the proportion of landed immigrants or permanent residents in the Canadian population was 23.0%, totaling more than 8.3 million individuals. This represents the largest proportion of immigrants since Confederation, exceeding the previous record of 22.3% set in 1921, and is the highest among G7 countries (Statistics Canada, 2022c). The 2011 Canadian National Household Survey estimates that more than 3.5 million immigrant women and girls in Canada accounted for over 21% of the country's female population, marking the highest percentage of immigrants among Canada's female population in a century (Hudon, 2015).

Migrant women account for a growing proportion of births in Canada, underscoring the necessity to address and enhance their health and care as needed (Gagnon et al., 2013). The 2021 population census reveals that, in general, the immigrant demographic is somewhat younger than the population born in Canada. Among the recent immigrants who arrived between 2016 and 2021, there was a higher number of women than men, indicating that a greater proportion of women of childbearing age were within the immigrant community. Additionally, foreign-born mothers now deliver over 42% of all newborns in Canada, a demographic shift that underscores the need for equitable national maternity services (Provencher, 2025). This chapter will provide information on the Canadian health care system, perinatal/maternal health, and newcomer utilization of health services.

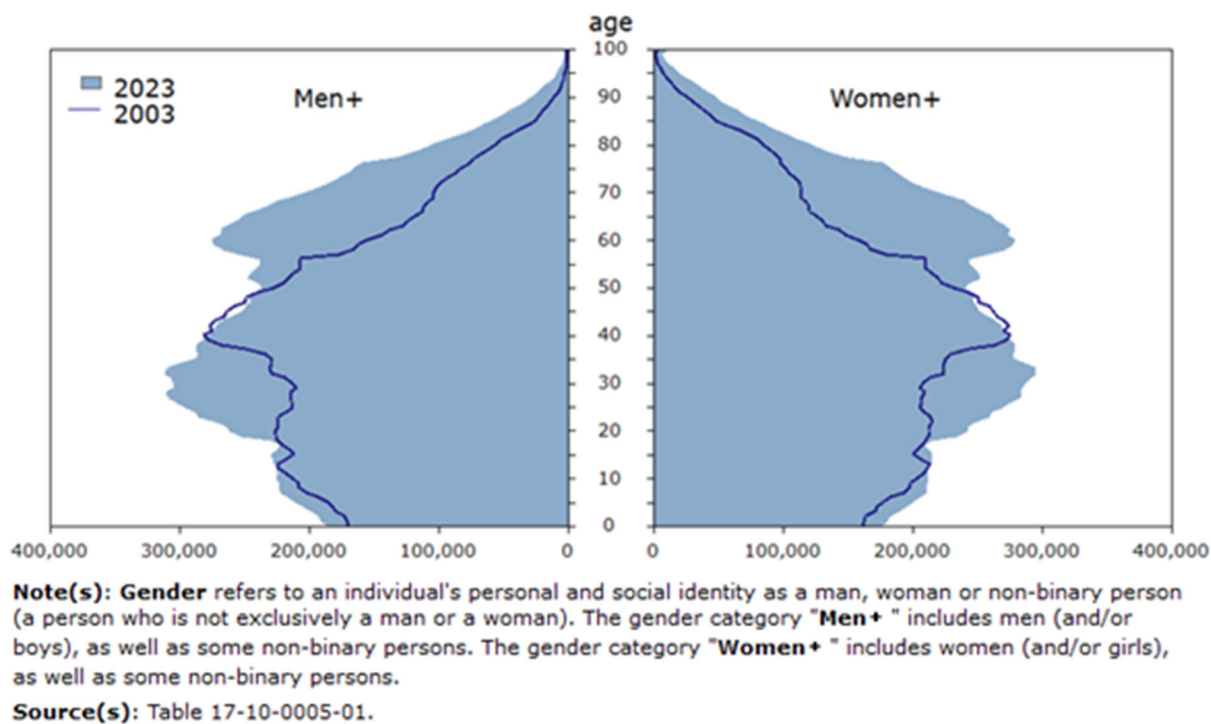


Figure 1: Age and Gender Pyramid, as of July 1, 2003, and 2023, Canada

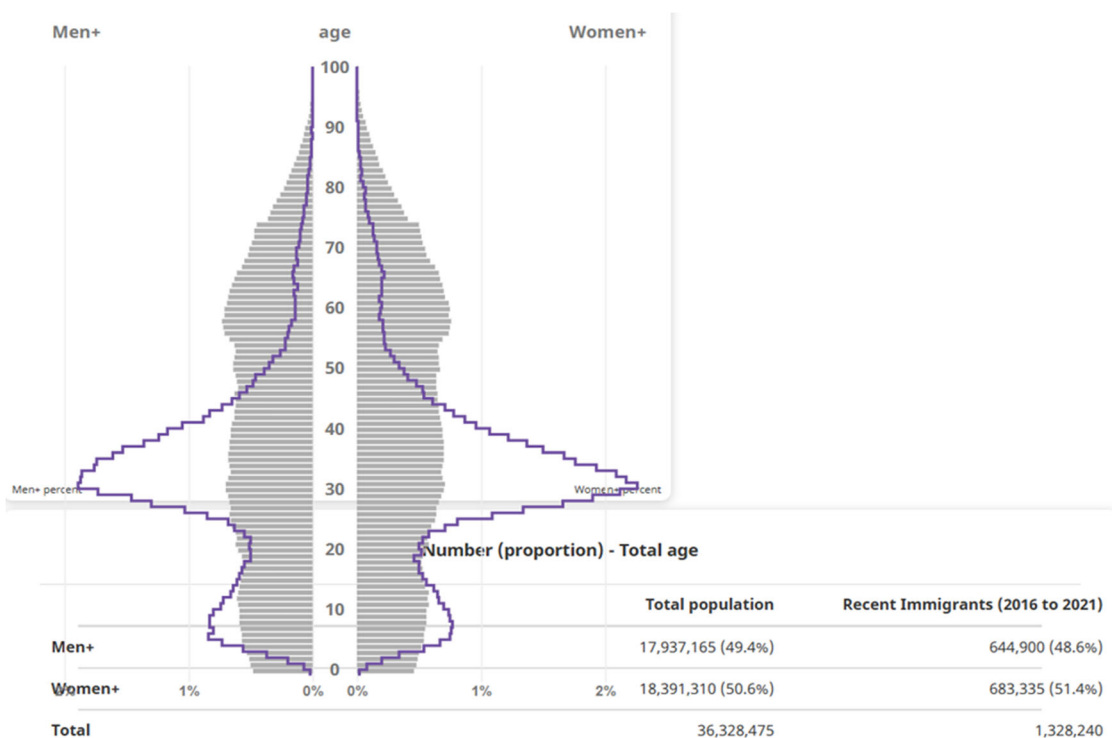


Figure 2: Total Population vs. Recent Immigrants in Canada 2021

Canadian Healthcare System - Overview

Canada operates a publicly funded healthcare system called Medicare, in which each province and territory has its own unique healthcare insurance plan, as opposed to a centralized national plan (Government of Canada, 2023a). This system ensures that all Canadian citizens and permanent residents have sufficient access to essential hospital and physician services without incurring personal costs (Government of Canada, 2023a). Canada's healthcare funding is sourced from general revenue generated through federal, provincial, and territorial taxation, including personal and corporate taxes, sales taxes, payroll levies, and other forms of revenue (Government of Canada, 2023a). Access to health services is regarded as a fundamental right in Canada, which ensures all citizens and permanent residents have the right to these services.

Health care service delivery for Canadian residents is shared among the federal, provincial, and territorial governments, including the management and organization of the system (Government of Canada, 2023a). The Federal Government of Canada is responsible for fulfilling four main roles in maintaining the functionality of the Canadian Healthcare System (Government of Canada, 2023a). These responsibilities include: (a) establishing and implementing national standards for the health system in accordance with the Canada Health Act; (b) aiding in the provision of health services to specific populations such as First Nations individuals residing on reserves, Inuit communities, members of the Canadian Armed Forces, qualifying veterans, inmates in federal prisons, and certain groups of refugee claimants; (c) offering financial support through cash and tax transfers to provincial and territorial health services via the Canada Health Transfer; and (d) overseeing health protection measures and

regulations concerning pharmaceuticals, food and medical equipment, consumer safety, as well as disease surveillance and prevention efforts. It also provides support for health promotion and health research.

Most of Canada's health care services are administered and delivered by the provinces and territories. Provincial and territorial governments possess primary authority for the delivery of health services within the Canadian constitutional framework. These responsibilities include administering public health insurance plans, funding hospital operations, and managing physicians and allied health professionals. Regional ministries are also responsible for local public health promotion and for negotiating fee schedules with medical associations. Although service delivery is decentralized, the federal government retains national influence through the Canada Health Transfer. To receive full federal cash contributions, provincial and territorial insurance systems must comply with the criteria of public administration, comprehensiveness, universality, portability, and accessibility established by the Canada Health Act (Department of Finance Canada, 2026; Health Canada, 2025).

The Canada Health Act is a federal health insurance regulation that “defines the national principles that govern the Canadian health insurance system” (Health Canada, 2023, p. 1). The following five principles are noted to reflect the underlying Canadian values of equity and solidarity: (1) *public administration* (all provincial and territorial plans must be administered on a nonprofit basis by a public authority accountable to the provincial or territorial government); (2) *comprehensiveness* (provincial and territorial plans must insure all medically necessary services provided by hospitals, medical practitioners and dentists working within a hospital setting); (3) *universality* (provincial and territorial plans must grant eligible residents uniform health insurance coverage); (4) *portability* (provincial and territorial plans must cover all eligible

residents when they relocate to another province/territory within Canada and when they travel outside of Canada); and (5) *accessibility* (provincial and territorial plans must provide all eligible residents equitable access to medically necessary hospital and physician services without additional barriers) (Health Canada 2023, p. 1; Government of Canada, 2023a).

Maternal and Perinatal Health

Maternal health refers to the health of women during pregnancy, childbirth, and the postnatal period (WHO, n.d.b). Perinatal Health is the health of women and babies before, during, and after birth (Alaska Department of Health, n.d.). Three critical periods during a woman's maternal and perinatal health care journey are the prenatal period, which is during pregnancy; the postpartum period, which is up to twelve weeks following delivery; and the late postpartum period, which is up to one year after giving birth (Allen, 2023). The intrapartum period is the duration encompassing childbirth, starting from the beginning of labor until the expulsion of the placenta (National Institutes of Health, n.d.). Safeguarding maternal and infant health during the vulnerable perinatal period requires consistent, ongoing tracking (Grand-Guillaume-Perrenoud et al., 2022). This can be guaranteed by ensuring adequate antenatal care.

Antenatal care, an “evidence-based intervention” aimed at reducing the risk of adverse health outcomes for pregnant women and their newborns, is an “umbrella term” used to describe comprehensive health supervision of medical procedures and care provided from preconception through the postnatal period (Ray, 2021, pp. 107- 108). Healthcare providers play a crucial role in the provision of essential primary healthcare services for pregnant individuals, as well as in the prevention, detection, and treatment of maternal and neonatal complications that may arise during this period (Kuhnt & Vollmer, 2017). Where effective antenatal care exists, birthweight and gestational age, which are essential indicators of both short-term and long-term health

outcomes, can be accurately assessed (Hanson & Gluckman, 2014). Conversely, antenatal care that is inadequate has been linked to adverse outcomes especially for ethnic minorities and women from socially disadvantaged backgrounds (Raatikainen et al., 2007). Notable studies have confirmed that substandard care and/or lower socioeconomic status are associated with poorer pregnancy outcomes, including low birth weight and premature birth (van den Akker & van Roosmalen, 2016; Ramraj et al., 2020; Eslier et al., 2020; Reppen et al., 2023).

The health of women and babies during pregnancy is called the prenatal period. Studies have demonstrated that women who receive regular and early prenatal care will have better pregnancy outcomes (Debessai et al., 2016; Rosa et al., 2014). However, adverse outcomes such as premature birth, intrauterine growth retardation, low weight at birth, and maternal and child mortality due to infections in the perinatal and postnatal period may occur due to a lack of prenatal care (Rosa et al., 2014). This is a notable concern due to there being a consistent and substantial body of evidence which indicates that adverse pregnancy outcomes not only represent the leading cause of fetal and maternal morbidity, but those diagnosed with adverse pregnancy outcomes present a “2- to 4- fold increased risk of future cardiovascular disease” (Barry et al., 2022, p. 475; Parikh, 2021).

Adverse Pregnancy Outcomes (APO) are viewed as an indicator of future maternal cardiovascular health. APOs display key traits that suggest a common underlying cause, including insufficient placentation, inflammation, and maternal vascular dysfunction. It is believed that APOs result from comparable underlying metabolic or vascular issues and stem from faulty placentation (Lane-Cordova et al., 2019). Crump et al. (2024) reported that a National Cohort study in Sweden involving over 2 million women revealed that women who experienced major adverse outcomes during pregnancy, such as preterm delivery, small for

gestational age, preeclampsia, other hypertensive disorders, and gestational diabetes, faced heightened mortality risks that persisted for over 40 years. Parikh (2021) further notes that Black and Asian women have a larger proportion of APOs, with more severe clinical symptoms and worse outcomes than White women.

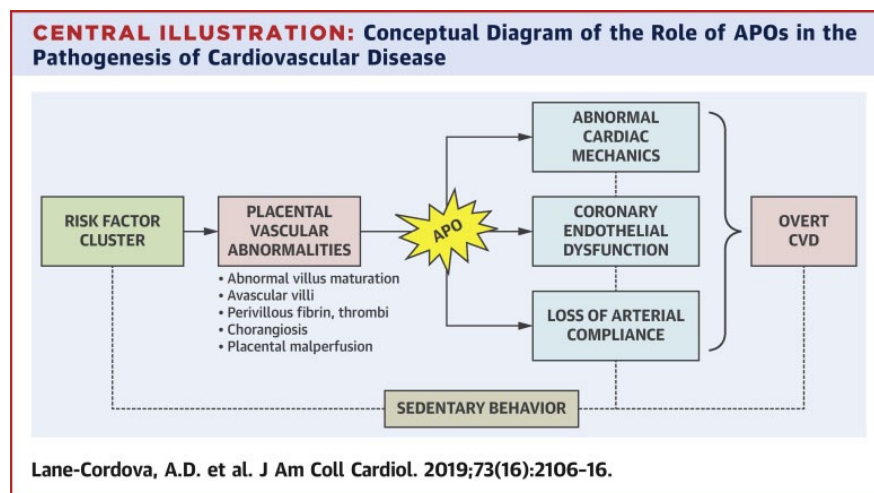


Figure 3: Conceptual Diagram of the Role of APOs in the Pathogenesis of Cardiovascular Disease

These early health deficits do not simply resolve after infancy; instead, they leave a lasting footprint on the child, their family, and the wider medical system. For instance, individuals born prematurely or underweight face a steep trajectory, with significantly higher baseline risks for childhood high blood pressure, learning and developmental challenges, adult cardiovascular disease, and all-cause mortality (Markopoulou et al., 2019; Almond et al., 2018; Risnes et al., 2011). This pattern is a growing concern within Canada's shifting demographics. National data reveals a stark disparity, showing that infants born to immigrant mothers have a notably higher rate of low birth weight (7.9%) than those born to Canadian-born mothers (6.4%) (Statistics Canada, 2023a).

Prenatal care is underutilized by immigrant women, despite research indicating that non-Western women are at an increased risk for adverse perinatal outcomes (Boerleider et al., 2013). Within the Canadian context, the experiences and circumstances that influence refugee newcomers to leave their country of origin may cause those of childbearing age to have poorer pregnancies and birth outcomes, especially when compared to other migrant groups (Heslehurst et al., 2018; Keygnaert et al., 2016). Additionally, existing literature confirms that newcomer migrant women of all socioeconomic backgrounds, along with their children, are more likely to experience adverse maternal health outcomes during the perinatal period. These outcomes include neonatal morbidity and mortality, pregnancy complications, and maternal morbidity when compared to individuals in the native population (Almeida et al., 2013; Heslehurst et al., 2018). Protecting maternal and infant well-being depends heavily on steady, uninterrupted surveillance throughout this fragile developmental window. Overlooking the complex, overlapping healthcare needs of these pregnant immigrant women does more than compromise the immediate postpartum period, risking health problems that have intergenerational effects.

Migrant and Refugee Women Health Status

Newcomers to Canada represent a deeply heterogeneous population, leading to substantial variation in baseline health profiles upon arrival. Many individuals have escaped environments destabilized by armed conflict, economic collapse, or environmental disasters, and these distinct pre-migration traumas exert a profound impact on long-term health outcomes (WHO, 2022). Beyond the initial displacement, the migration journey itself often results in a severe deprivation of necessities such as clean water, adequate nutrition, and safe sanitation. For pregnant women and other vulnerable subgroups, these structural deficiencies directly heighten the risk of obstetric complications, unintended pregnancies, and exposure to gender-based

violence, while simultaneously increasing susceptibility to acute injuries and chronic non-communicable diseases (WHO, 2022).

This paradox is heavily documented through the framework of the "Healthy Immigrant Effect." Epidemiological observations consistently demonstrate that while foreign-born individuals arrive with a distinct health advantage over native-born Canadians, this baseline wellness systematically erodes over time with extended residency in the host country (Gushulak et al., 2011; Vang et al., 2017; Elshahat et al., 2022). In contrast, other studies highlight health disparities and the gradual decline in health among immigrants to Canada (Fuller-Thompson et al., 2011). Unfortunately, this effect tends to diminish with time. Several factors have been suggested to explain this decline, including a mistrust of Western medicine and a preference for traditional healthcare approaches (Higginbottom, 2015), as well as the selection of healthier individuals for immigration to Canada (Ng et al., 2021).

Canada's selective immigration framework directly drives this health stratification. Because economic applicants face rigorous vetting regarding their immediate capacity to join the workforce, they arrive with a far more robust baseline health profile than other newcomers (Ng et al., 2021). The selection process operates on entirely different criteria for other streams; family-class entry depends on domestic sponsorship ties, whereas refugees are accepted based on a pressing humanitarian need for physical protection (Ng et al., 2021). These distinct legal classifications alongside the chaotic conditions that often prompt migration ultimately dictate the specific medical realities of newcomer women. Global data show that a significant portion of displaced women are of childbearing age, forcing them to navigate the immense physiological strains of pregnancy and delivery during transit or early resettlement (International Organization for Migration, 2017). While the perinatal phase compromises well-being for any migrating

woman, these systemic disruptions layer severe danger onto refugees, radically increasing the incidence of entirely preventable maternal and newborn complications (Higginbottom et al., 2015; Malebranche et al., 2017).

Migrant women experience unmet health needs during pregnancy and are at a higher risk for adverse outcomes compared to women in the receiving country. Nonetheless, the presence of robust integration policies has been shown to reduce these risks (Gagnon et al., 2013). Research conducted in two major Canadian cities, which serve as primary destinations for migrants, focused on migrant women during the post-natal period. The study revealed that migrant women faced an increased susceptibility to health issues and were at higher risk of having their healthcare needs unmet compared to Canadian-born women (Gagnon et al., 2013).

Barriers & Facilitators to Accessing Maternal Healthcare

According to Hart (1971), the inverse care law asserts that access to quality medical care is often limited in populations with greater need for it, particularly in areas where market forces strongly influence the provision of healthcare services. On the other hand, this inequality is less pronounced in settings where medical care is less influenced by market forces. This law highlights the perverse relationship between the need for healthcare and those who utilize it. Higginbottom et al. (2015) report that difficulty in navigating the healthcare system during the prenatal, intrapartum, and postnatal period often exists for immigrant women. Studies have revealed that non-Western women face a heightened risk of adverse perinatal outcomes. Despite this, there is a lack of adequate utilization of prenatal care services among this demographic, with previous research indicating a concerning trend among migrant women, as they repeatedly did not follow up on post-birth care referrals (Boerleider et al., 2013; Gagnon et al., 2010). This may be a result of a variety of barriers, including the inability to engage with practitioners during

post-natal visits, as well as cultural conflicts, potential racism, and unfair judgement from the healthcare system.

Newly arrived populations navigate an incredibly uneven landscape of healthcare determinants, where a migrant woman's region of origin heavily dictates her specific barriers and facilitators to care. To analyze these interconnected barriers, Grand-Guillaume-Perrenoud et al. (2022) utilized a theory-guided systematic review of perinatal maternal health access among socially marginalized groups. This framework centers on clinical reciprocity, directly mapping supply-side systemic traits like approachability and affordability against a patient's actual capacity to seek, reach, and engage with care. Although it was not designed specifically for migrating cohorts, this analytical model applies directly to the resettlement experience. This intersection becomes clear when looking at the severe financial hardship newcomer populations face in host nations. In Canada, this economic gap is stark; national data reveals significantly higher poverty rates among immigrants than native-born citizens, creating a systemic strain that disproportionately burdens refugees and recently arrived families (Statistics Canada, 2022a).

A study on barriers and facilitators at the patient and clinician level found that both clinicians and migrant women participants identified barriers to care, which included limited decision-making autonomy, lack of trust in the healthcare system, and financial constraints limiting healthcare access (Filler et al., 2020). Lack of trust in the health care system was also seen in a qualitative study conducted with Somali women in Canada, which showed that this population struggled with trusting healthcare providers who did not have experience in dealing with childbirth among women who had undergone genital mutilation (Small et al., 2008). Another qualitative study carried out in Norway revealed that immigrant women expressed skepticism towards the universal healthcare system, citing a lack of individual choice that

conflicted with their expectations of quality care (Mehrra et al., 2022). These studies demonstrate that barriers to health care use are nuanced, and perceptions and expectations of care can impede its utilization.

Other factors that could impact the utilization of maternal healthcare services by multiparous immigrant women include childcare responsibilities and prior childbirth experience. Multiparous women did not perceive prenatal classes as essential due to their prior childbirth experiences. Furthermore, some individuals cited the unavailability of childcare as a barrier to attending prenatal classes (Boerleider et al., 2013). Furthermore, factors such as low health literacy, discrimination, and inadequate communication have been identified as obstacles that can contribute to a negative patient-provider relationship, ultimately affecting the childbirth experience (Small et al., 2014; Henderson et al., 2018; Fair et al., 2020). Among the refugee newcomer populations, similar findings were recorded. For example, Kentoffio et al. (2016) noted that barriers to accessing optimal maternity care include low language literacy, lower socioeconomic status, and social disadvantage. These barriers frequently lead to a decrease in the number of prenatal and postnatal appointments attended by individuals within this demographic group.

In examining the use of prenatal care by non-Western women in industrialized Western countries, Boerleider et al. (2013) were able to illustrate the findings of their review regionally. Among sub-Saharan African, North African, Asian, and Turkish women, individual barriers such as lack of knowledge of the Western healthcare system acted as barriers. Health beliefs among Somali and Asian populations, dependency on husbands among Asian and North African women, accessibility barriers among Asian and North African populations, as well as expertise and personal treatment considerations among Somali women, were identified as inhibiting

factors in healthcare utilization. It is important to highlight that every woman included in the study identified their inadequacy in language skills, communication difficulties, and lack of familiarity with the Western healthcare system as hindrances to accessing healthcare services, irrespective of their geographic location. Conversely, the predominant facilitator of healthcare access was found to be providing suitable and essential information and care in the women's native language.

Internalized Oppression

Oppression operates on several levels, ranging from the individual to societal. In their work, '*To dismantle structural racism in science, scientists need to learn how it works*', Weinreb and Sun (2023) emphasize that oppression is not solely a result of individual biases or practices, but rather it involves a complex system of *internalized, interpersonal, and structural factors*. Internalized racism involves introjection, where an individual unconsciously accepts and adopts negative beliefs about themselves and their group (American Psychological Association [APA], n.d.). Interpersonal racism occurs during interactions between individuals and involves the thoughts and behaviours of one group, often the dominant group, toward members of another group, the oppressed group (Weinreb & Sun, 2023). This may present itself in the form of unconscious bias, microaggressions, and harassment. Structural racism operates as a power system with multiple interrelated components perpetuating disparities in institutions and various social structures among disadvantaged and marginalized groups (Race Forward, n.d.).

Fig. 1: Mechanisms of oppression.

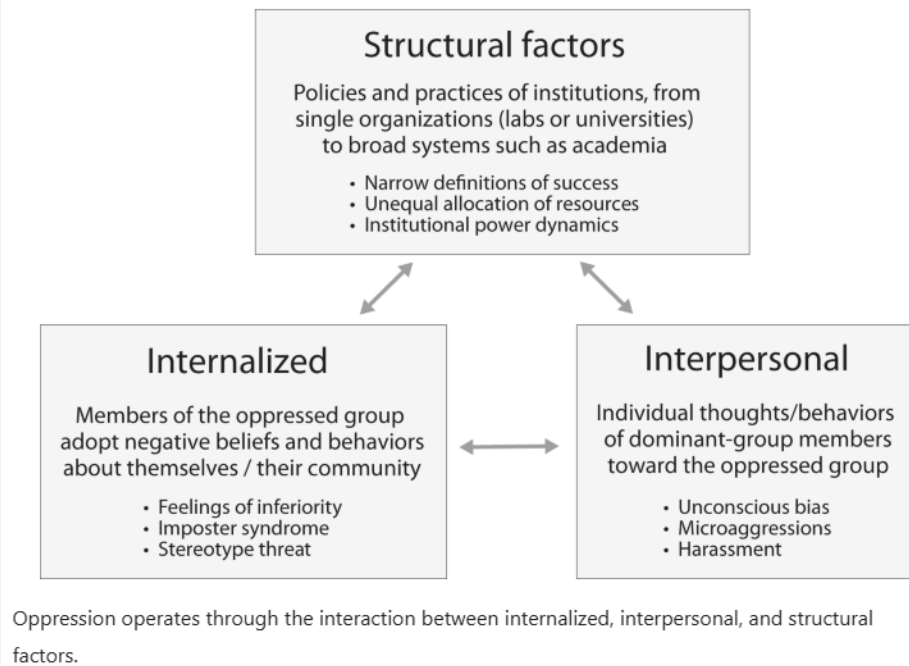


Figure 4: Mechanisms of Oppression

While not mentioned by Weinreb and Sun (2023), institutional racism is embedded within institutions and systems of power, such as healthcare, and should be considered as part of the complex system of racism that factors into oppression. Institutional racism refers to implicit or explicit policies, rules, and practices within organizations and institutions which reinforce and support an unfair advantage of one group and the unfair or harmful treatment of another (Schulich EDID – Western University, 2025; Cambridge University Press, n.d.).



Figure 5: Levels on which Racism Exists

David (2014, p. 3), in his work '*Internalized Oppression: The Psychology of Marginalized Groups*', states:

Oppression occurs when one group has more access to power and privilege than another group, and when that power and privilege is used to maintain the status quo (i.e., domination of one group over another). Thus, oppression is both a state and a process, with the state of oppression being an unequal group access to power and privilege, and the process of oppression being the ways in which inequality between groups is maintained.

According to Altman et al. (2019), patient-provider interactions can be viewed as a structural element of the healthcare system which subsequently affects how patients perceive care.

Disrespect, abuse, and discrimination in the health system have influenced how women of color access and experience care during pregnancy, birth, and postpartum, contributing to negative

outcomes for both mother and baby (Attanasio & Kozhimannil, 2015; McLemore et al., 2018; Ruiz et al., 2014; Salm Ward et al., 2013).

Internalized oppression carries a heavy emotional burden. It directly shapes a person's self-image, triggering deep feelings of inferiority and self-doubt that can ultimately break down self-esteem into total helplessness. When individuals absorb a highly stigmatized identity, it directly worsens their physical and mental health outcomes over time (Molina & James, 2016). This happens because the trauma of facing discrimination often forces people to turn those negative experiences inward, leading to deep self-blame and self-devaluation (Carter, 2007). Crucially, this internal struggle does not stay locked in a patient's mind; it actively stops them from trying to use healthcare services. This reality was clearly captured in a qualitative study by Bayram and Sakarya (2023), who tracked how centuries of oppression shape the medical experiences of the Kurdish population in Turkey. They found that a major consequence of internalized oppression was a profound reluctance to seek medical help in the first place. This mindset directly bleeds into the doctor-patient relationship, causing patients to enter the clinic with an unspoken, defensive expectation that healthcare providers will simply devalue them (Bayram & Sakarya, 2023).

Theoretical Perspectives

Various theoretical frameworks can be applied to enhance the comprehension of maternal immigrant healthcare access and utilization. This research was informed by Kimberlé Crenshaw's Intersectionality framework.

Intersectionality Theory

Evaluating health equity effectively requires moving past isolated analytical labels like sex or gender; instead, the framework of intersectionality demands a much deeper level of

critical reflection (Hankivsky et al., 2014). It requires the researcher to consider the complex relationships between various dimensions of social inequality. When these forces collide at both macro and micro levels, they drive a highly unpredictable spectrum of disparities across individual and community health (Hankivsky, 2017). Ultimately, while health is experienced on a deeply personal, physical level, individual well-being cannot be separated from systemic gaps. These personal experiences remain tethered directly to the shifting power structures that operate within the wider society (Hankivsky et al., 2017).

The intersectionality theoretical framework was used to guide the design of this research. Intersectionality, rooted in Black feminist activism and academic disciplines such as women's studies, highlights how power and privilege are structured differently within and between diverse groups of people, thus combining to create different levels of discrimination and privilege (Crenshaw, 1989). Kimberlé Crenshaw first coined the term 'intersectionality' in 1989 in her essay "*Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*" to elucidate the oppression and violence against African American women (Crenshaw, 1989). She expanded her framework in her seminal paper "*Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*" in 1991 to include identity politics, structural violence, and political marginalization, which revealed the diverse ways oppression and marginalization operate (Crenshaw, 1991). In an interview conducted at the Columbia Law School (2017), Professor Crenshaw asserts that "Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects" (para. 5).

In examining women's experiences and access to and utilization of healthcare services in Southern Alberta, intersectionality must be considered. This theoretical framework will help to

identify markers and intersecting statuses such as identity, gender, race, ethnicity, marital status, socioeconomic status, immigration status, experiences, among others, that may compound healthcare inequality and influence its access and use by the population of study. Incorporating intersectional theory as an analytical tool in this study will assist in evaluating and highlighting the lived and possibly complexed experiences of the population of study, examining individual constructs and identities and denoting factors that hinder or facilitate their healthcare use and access.

Summary

Considering that an increasing number of births in destination countries are being attributed to international migrant women, it is essential to closely examine their health and the health of their infants, as these are significant concerns relating to migration. Analyzing these matters from the viewpoint of migrant women can offer valuable insights that stakeholders can utilize to enhance maternal-child health care that is sensitive to the needs of migrants (Gagnon, 2013).

The insights gained from migrant women's viewpoints were analyzed using the theoretical framework of Intersectionality (Crenshaw, 1989, 1991). It allowed for the focus to be placed on collecting relevant information specific to the population of interest and examining how overlapping social factors such as gender and race shape immigrant women's healthcare access and utilization. As such, this framework assisted in generating questions and probes for the interview, as well as aiding in the analysis of the data collected.

Chapter 3: Methodology

Study Design

This study used an *exploratory qualitative design utilizing an interpretive approach* to explore the nuance of immigrant women's perinatal experiences. This method was chosen to move beyond rigid statistical metrics and focus directly on the experiences and perspectives of the participants. As Williams (2024) notes, exploratory qualitative frameworks offer critical depth when investigating complex social phenomena by uncovering the unique contexts and personal meanings individuals assign to their experiences. When applied to health research, this interpretive approach is particularly valuable because it respects frontline clinical realities, which ensures that the resulting data translates into practical, context-driven clinical insights (Hunt, 2009).

Semi-structured interviews served as the primary data collection method for understanding participant experiences. This format is better suited for drawing out rich narratives. As DeJonckheere and Vaughn (2019) note, semi-structured formats allow researchers to extract deep insights from informants with first-hand experience and distinct beliefs. The method is inherently flexible; it allows for the discovery of raw, exploratory data while simultaneously leaving room for data validation via member checking.

Positionality/Reflexivity

My positionality as a researcher is important to this research as it will provide insight into experiences that may influence the research that I am conducting. I hold multiple identities that highlight who I am. I am a woman, mixed race, Caribbean, person of colour, a mother, a student, and a self-proclaimed feminist. These intersecting identities encompass just a fraction of who I

am as a person. These identities also frame and influence my outlook and viewpoint on many issues.

I have personally grappled with challenges related to healthcare utilization and access. When I was pregnant as an immigrant in Southern Alberta, I utilized the healthcare system. I remember being frustrated, annoyed, and questioning many aspects of the care I received. Being a Caribbean woman, I am accustomed to bodily and health autonomy. If I lived in the Caribbean when I was pregnant, I would have had the choice of whichever provider I deemed best to accompany me along my pregnancy journey. Individuals have the choice to go directly to an OBGYN at the start of pregnancy, access any tests deemed necessary, and work with a healthcare provider who thoroughly explains all results and issues to the patient.

When I was pregnant and accessing healthcare services in Lethbridge, Alberta, this was not the case. I often argued and battled with health providers to get relevant information regarding my pregnancy, reasons for tests or the refusal of tests, and the dismissive attitudes of health providers. On occasion, I was deemed “difficult” because I refused to just be a passive participant in my pregnancy, but instead required and, on occasion, demanded that I be involved in the care and all aspects of my pregnancy and delivery. I remember clearly once, during a prenatal visit, asking about the results of a test I found concerning. I was told by my health provider that I should not concern myself with the results and that the doctor should be the one concerned. The OBGYN clinic I was referred to while pregnant had a rotation of four doctors, and you would see whichever doctor was available at the time of your appointment. I had to wait until my next visit, and in being “difficult,” the findings were explained to me.

In my experience, my perinatal care (prenatal, antenatal, and postnatal) was less than ideal. My birth plan was not followed, which, to me, resulted in complications after delivery and

many other issues relating to the care of my baby from nursing staff. I frequently reflect on whether my persistence after delivery and during postnatal visits, insisting that my baby be evaluated due to my concerns, ultimately saved my baby's life. Health providers repeatedly advised me to breastfeed more, despite my conviction that something was wrong with my baby. After multiple visits, I eventually saw a doctor, himself an immigrant, who consulted a pediatrician at Chinook Hospital. Following this consultation, my child was admitted to the hospital for nearly two weeks, during which multiple tests were conducted, and a combination of antibiotics was administered. This experience greatly influenced my perception of maternal care and affected my desire to have more children.

While I continue to be 'difficult' according to some health providers, I have heard multiple stories, both positive and negative, from immigrant women and women of colour regarding their pregnancy and birth experiences in Southern Alberta. This highlights the fact that the experiences of immigrant women who have accessed and utilized maternity services are varied and nuanced.

Theoretical Approach

The intersectionality theoretical framework coined by Kimberlé Crenshaw (1989) was used to guide the design of this research. This framework was used to inform the approach to data collection, coding of participants' transcripts, and as an analytical lens to explain and understand findings. This framework is instrumental for analyzing data and explaining the diverse experiences of the study participants, such as their immigrant identity, gender, culture, education, health, and maternity experiences, and how they coincide to influence healthcare utilization.

Legal scholar Kimberlé Crenshaw (1989) asserts that Intersectionality is a critical framework that examines how race, gender, and other identity factors interconnect and shape an individual's lived experience and create challenges unique to that individual. Intersectionality rejects the prioritization of any single social category, treating overlapping identities and interlocking systems of power as inseparable dynamics (Bowleg, 2012). The versatility of the framework has enabled other scholars such as Rosenthal and Lobel (2011) to examine and explain how Black American women are more prone to unique sources of stress throughout their lives due to their multiple identities and how these influence racial disparities in birth outcomes.

Social inequalities are interconnected and cannot be examined in isolation. Green et al. (2017) argue that racism, sexism, and classism often overlap and interact, rather than operating independently. When researchers study health disparities by focusing on just one factor, they overlook important connections. The combined effects of these overlapping identities create new and unique forms of privilege and oppression. These structural forces influence not only public health outcomes but also individuals' daily experiences, the obstacles they encounter, and the opportunities accessible to them.

In *The Problem with the Phrase Women and Minorities: Intersectionality - an Important Theoretical Framework for Public Health*, Bowleg (2012) speaks about how the terms *women* and *minorities* are deeply interwoven into public health discussions, policy, and research. The author further asserts that public health's commitment to social justice naturally fits with intersectionality's focus on marginalized groups (Bowleg, 2012). This study adopted an intersectional lens to trace how structural inequalities and individual social positions interact to ultimately determine healthcare access and drive health outcomes.

Research Setting

This study was conducted with the help of immigrant women living in Southern Alberta. Alberta is in Western Canada and is the country's fourth largest and most populous province, with a population of over 5.0 million (Government of Alberta, 2025). The proportion of immigrants residing within Alberta steadily increased from 18.1% in 2011 to 23.2% in 2021 (Statistics Canada, 2022b). Alberta's share of national immigration was 11.8% of total arrivals to Canada, which was 0.6% higher than the same period in 2022. International migration is a big driver in Alberta's population growth, contributing over 35,000 net new residents in the first quarter of 2023 (Government of Alberta, 2023). According to Statistics Canada, the top countries of birth of recent immigrants to Canada between 2016 and 2021 were India, the Philippines, China, Syria, and Nigeria. In 2021, the top places of birth among recent immigrants to Alberta were the Philippines, India, and Nigeria (Statistics Canada, 2022c). Southern Alberta comprises three major cities, Brooks, Lethbridge, and Medicine Hat, as well as several towns and villages, and is located east of the Rockies and outside of the Cypress Hills (Wikipedia, 2026).

Data were collected from participants in a natural environment using face-to-face interviews conducted in a conversational manner to foster open communication and elicit detailed, comprehensive responses. This natural environment included the participant's home or other location where the participant felt comfortable and safe. Depending on the participant's location, the interview was conducted using Microsoft Teams. Where this medium was employed, all research protocols were followed, as in an in-person interview.

Participant Recruitment

This study used purposive and snowball sampling techniques to recruit seven participants from the immigrant community in Southern Alberta. Initially, the aim was to recruit

10-12 participants, but due to recruitment challenges, the sample size was reevaluated. Creswell and Poth (2018) and Creswell and Plano Clark (2011) note that in using purposeful sampling, a group of people is intentionally identified and selected for sampling that can best inform the researcher about the research problem due to their experience with the phenomenon of interest. As such, I used this technique to recruit participants with lived experience of the research problem being investigated. Additional participants were identified with the assistance of currently enrolled research participants through a process called snowball sampling. Snowball sampling is a convenience sample often used when it is difficult to access participants who may be able to inform the study, and existing participants assist in recruiting others within their community who meet the research criteria (Naderifar et al., 2017). It requires the selection of a group of people that can best provide information to the researcher about the research problem (Creswell & Poth, 2018, p.148). As such, the researcher asked immigrant women participants to recommend other immigrant women who fit the criteria of this study. It should be noted that snowball sampling has the potential for sampling bias because participants refer others who are experiencing the phenomenon being studied. To help mitigate this, I attempted to recruit from various parts of Southern Alberta.

The eligibility criteria of this study included women who: (1) were immigrants, (2) identified as a woman, (3) were at least 18 years of age, (4) had a child in Alberta within the last five years, (5) utilized the Alberta Health Care system, (6) lived in Southern Alberta for at least six months (7) and spoke and understood the English language. Participants who met these criteria and had experience with the health care system related to perinatal care, offered valuable insights into the phenomenon of interest.

It should be noted that the recruitment of non-dominant ethnic and racial groups into research is complicated by a myriad of barriers, including fear, stigma, discrimination, mistrust of researchers, language barriers, perceived power differential, and a lack of awareness of the problem (Knobf et. al., 2007; Olgilvie et. al., 2008). As such, participant recruitment was facilitated by building rapport and engaging stakeholders that serve refugee newcomer communities and various cultural and immigrant associations in Southern Alberta. Recruitment materials were distributed through these partner agencies and their social media channels, including Facebook and Instagram. Efforts were made to promote ethnic diversity during data collection and recruitment.

Upon receiving approval from the University of Alberta Research Ethics Board to conduct this study, a formal letter (Appendix A) was sent to various stakeholders to establish rapport, explain the research purpose, and seek assistance with participant recruitment. To address any queries that arose, I was available for an in-person meeting or Microsoft Teams session to clarify any ambiguities and ensure comprehensiveness. Recruitment posters (Appendix B) were posted on stakeholder organizations' notice boards, social media platforms, and related websites. Posters were also displayed on public information boards, such as public library, community, and University and College notice boards.

Individuals who agreed to take part in the study received information about its purpose, the reasons for collecting the data, risks, benefits, ethical considerations, privacy and confidentiality, and the potential uses of the information gathered. This allowed participants to make an informed decision about the nature of the study, thus enabling free, informed, and ongoing consent from potential participants. The consent form in Appendix C outlines details about the study's purpose, the tasks participants were asked to complete, eligibility criteria,

potential risks and benefits, compensation or reimbursement, privacy protection and confidentiality, reporting of results, the process for withdrawing from the study, conflicts of interest, as well as contact information for any questions. Participants were allowed to ask any questions related to the form to ensure clarity. The participant's comprehension of the consent form was determined verbally, with the participant acknowledging that they had fully understood what was read. The researcher asked the participants to sign a consent form prior to the commencement of the interview. In instances where interviews were conducted using Microsoft Teams, participants had the option to either digitally sign the consent form or sign a hard copy of the document. The researcher received an email containing a photograph of the signed form prior to the commencement of the interview. Where preferred, verbal consent was used after reading the REB-approved Informed Consent Form to the participant.

Data Collection and Procedure

Barret and Twycross (2018, p. 63) state that “qualitative research requires data which are holistic, rich, and nuanced, allowing themes and findings to emerge through careful analysis.” Gill et al. (2008) and Ryan et al. (2007) affirm that a range of strategies can be employed when collecting qualitative data, such as interviews (semi-structured, unstructured, individual, group), participant observation, non-numerical questionnaires featuring open-ended questions, and textual or visual analysis, including books or videos. Interviews and focus groups are commonly employed in healthcare research, as they have been shown to yield comprehensive, detailed data pertinent to the phenomenon under investigation (Gill et al., 2008; Barret & Twycross, 2018).

In this study, semi-structured interviews were used to collect data from the study population. This method of data collection was used to gather information from key informants and proved successful in obtaining qualitative, open-ended data. It facilitated the exploration of

participants' sentiments, perspectives, and convictions on a given subject and was particularly useful for delving into personal and sensitive topics (Dejonkheere & Vaughn, 2019). This approach was proved to be ideal for gathering investigative data because it enabled participants the freedom to elaborate on information that was significant to them, potentially offering deeper insights into the phenomenon under study.

Individual, face-to-face, in-depth interviews are the most common form of semi-structured interview used in qualitative research (Dejonkheere & Vaughn, 2019). This form of interview was most appropriate for this study, as it allowed me to deeply explore social and personal matters of the interviewee, as opposed to a group interview, which may prevent me from delving deeply into the individual's personal information due to the public nature of the process (DiCicco-Bloom & Crabtree, 2006). A semi-structured interview guide (Appendix D) was created to ensure alignment with the study's purpose and objectives (Ryan et al., 2009). Barrett & Twycross (2018) recommend that a "small group" of experts on the research topic review the research guide before the study begins to ensure all key issues are covered. In this case, the researcher's supervisory committee reviewed the interview guide to confirm that all major topics of the study had been addressed.

Interviews with participants were conducted one-on-one, lasting approximately 60 to 90 minutes, at a mutually agreed-upon location, date, and time. With the participant's consent, the interviews were audio-recorded using a digital recorder. This ensured accurate transcription, minimized bias, and created a permanent record of what was said and not said (Pontin, 2000). Consent for audio recording was obtained from all participants. Brief notes were taken during the interview, followed by comprehensive notes that included observations I took immediately after

the interview of participants' body language (Knott et al., 2022). When in-person interviews were not possible, I offered participants the option to join the interviews via Microsoft Teams.

The interview started with broad, easy-to-answer opening questions related to the research topic, allowing the participant to ease into the conversation before moving on to more challenging or sensitive questions. This approach helped build rapport, "break the ice," and create a comfortable environment for the participant (DiCicco-Bloom & Crabtree, 2006; Gill et al., 2008; Knott et al., 2022). Participants were encouraged to speak freely about their perceptions and experiences, and I listened attentively to what was being said so that participants could recount their experiences as fully as possible without unnecessary interruptions (Gill et al., 2008). After the opening questions, the interview proceeded to more direct questions related to the research, accompanied by verbal and nonverbal probes designed to "elicit concrete details and examples from the participant" (Knott et al., 2022, p. 2). At the conclusion of the interview, participants were thanked for their time and invited to share anything else they would like to add. This provided an opportunity for participants to elaborate on information they considered important, which can often reveal new, unanticipated insights (Gill et al., 2008). After each interview, participants received a \$20 gift card as a token of appreciation for their participation.

Data Management Plan

Data in qualitative research include, but are not limited to, field notes, transcriptions, audiotapes, and videotapes. The data collected from participants in this research were primarily from interviews, audio recordings, and field notes. It was organized into digital files, and a file-naming system was created, as suggested by Cresswell & Poth (2018, p. 185). This ensured that the data were kept safe and organized and could be easily retrieved when needed with accuracy. NVivo was used for data management and analysis.

It is essential to uphold and safeguard the privacy of every participant involved in research endeavors. Lin (2009) emphasizes the significance of maintaining confidentiality, safeguarding human subjects, and properly managing data storage, sharing, and ownership in the context of qualitative data management. I safeguarded participant identities by using pseudonyms to anonymize their names. To ensure the security of each participant's audio recordings, they were transferred to an encrypted folder on a password-protected computer in the researcher's office. The research data were accessed exclusively by me, my supervisor, and my supervisory committee to verify the accuracy of the data and transcription. Physical copies of transcripts and field notes were securely stored in a locked file cabinet, and a password-protected external hard drive was used to safeguard participants' data and mitigate the risk of data loss.

Data Analysis

Data gathered for this study were subjected to inductive analysis, in which codes and categories were not predefined but were identified and labeled as I reviewed the data (Bingham, 2023). I followed Braun & Clarke's (2022) six-phase process, which helped me to analyze, identify, and attend to the key features of thematic analysis. The six phases suggested do not follow a linear progression but instead necessitate that the researcher transition back and forth between phases as necessary (Braun & Clarke, 2020). Reflexive thematic analysis, according to Creswell and Poth (2018), is an adaptable and ongoing process, taking place concurrently from the beginning of data collection to the publication of findings. Braun and Clarke (2022, p. 12) maintain that effective reflexive thematic analysis requires viewing "subjectivity as something valuable, rather than problematic," thus placing the researchers' subjectivity as an essential part of the analysis. These six phases (Braun & Clarke, 2022) served as guiding principles rather than strict rules for conducting the analysis.

I transcribed each audio recording verbatim to ensure a rigorous thematic analysis. The transcripts were imported into NVivo software (Version 12) for inductive qualitative coding. I adhered to the guidelines established by Braun and Clarke (2022), systematically working through the six phases using an iterative approach. In phase 1, I familiarized myself with the dataset by reviewing the transcripts multiple times, removing identifying information, and cross-checking the transcripts with the audio recordings for accuracy. In phase 2, I analyzed participants' responses in detail, noting recurring phrases and quotations to identify initial codes. After grouping the initial codes, I evaluated each group for relevance and confirmability with the research topic. Once the codes' relevance and agreement with participants' experiences were established, I further analyzed the coded data to determine how they could be combined based on shared meanings and distinctions. No pre-set framework was imposed; codes were derived directly from participants' statements. In phase 3, I generated themes by identifying shared patterned meanings throughout the dataset. Codes that shared a core idea and could provide a meaningful answer to the research question were compiled, and potential themes that addressed the research question were identified. In phase 4, I developed and reviewed themes, confirming that each theme was coherent with the coded extracts and the full dataset, and pointed out the most significant relationships between themes. In phase 5, I refined, defined, and named each theme, providing clear descriptions and scope, using participants' language where possible. In phase 6, I completed the write-up by integrating data extracts with verbatim quotes to construct a coherent account that supported the study's findings and addressed the research question.

These phases guided the development of themes and sub-themes. I continually reviewed and refined the themes to preserve alignment with participants' contributions and to uphold coherence and distinctiveness. The process was cyclical, as I repeatedly moved between phases.

As Saldaña (2013, p.8) notes, coding is a “cyclical act,” frequently requiring multiple cycles to “further manage, filter, highlight and focus the salient features of the qualitative data for generating categories and themes.” Figure 6 shows Braun & Clarke’s phases of reflexive thematic analysis.

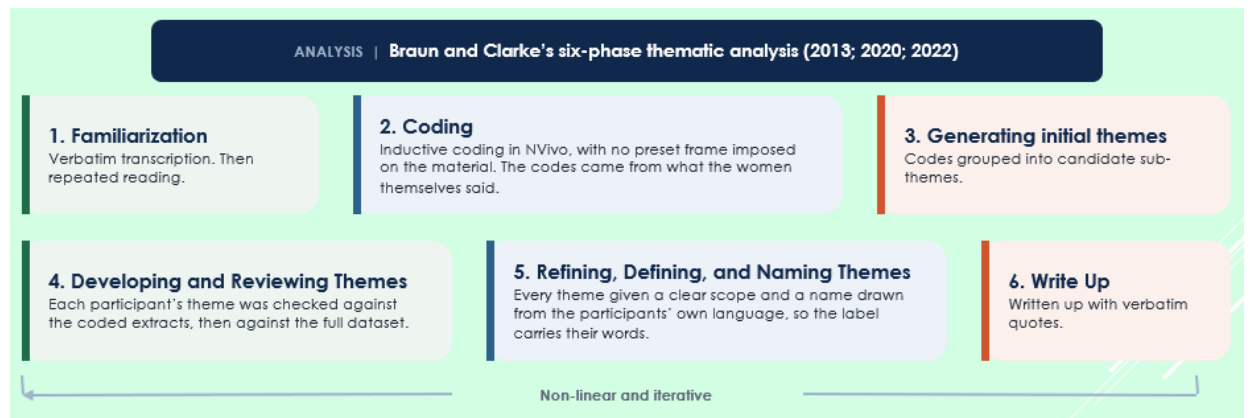


Figure 6: Phases of Reflexive Thematic Analysis (Braun & Clarke, 2013, 2020, 2022)

Scientific Rigour & Trustworthiness

Rigour refers to the process of establishing the plausibility, credibility, and integrity of qualitative research (Ryan et al., 2007). To ensure the trustworthiness of this study, I applied Lincoln & Guba's (1985) four criteria for qualitative rigor. This involved addressing credibility, transferability, dependability, and confirmability throughout the research process.

Credibility

Credibility refers to the consistency between participants' views and the researcher's presentation of those views (Ryan et al., 2007). Credibility was demonstrated through theoretical and methodological triangulation and member checking. Tsindos (2023) defined theoretical triangulation as the implementation of multiple theories to inform the research methodology. To achieve this objective, I utilized an intersectionality framework. To enhance methodological

triangulation, I conducted semi-structured interviews with participants, took notes during the interviews to identify recurring themes, and re-listened to audio recordings to compare them with the transcribed information. I employed multiple methods for data collection and analysis, which included interviews and field notes. Tsingos (2023, p. 248) describes this as “bringing together the various methods used to collect data [which] can provide a more nuanced explanation of results.”

Member checking of preliminary findings was conducted, allowing participants to confirm whether the information accurately reflected their views and experiences. Stahl and King (2020) highlight that member checking can take place through face-to-face interviews as well as "institutional checking on research" with supervisors and direct supervisors. This process enables input from individuals not directly engaged in the research, including supervisors, who can provide valuable perspectives on the research methodologies and results.

Transferability

Transferability relates to the applicability of the study’s findings to similar settings. Transferability was achieved by providing a thick description of the phenomenon, which Lincoln and Guba (1985) assert is a way of achieving external validity. Holloway (1997, p. 154) states that a “thick description builds up a clear picture of the individuals and groups in the context of their culture and the setting in which they live.” I achieved this by providing a thorough depiction of the participants' experiences, the environment, and any pertinent cultural subtleties, thereby evidencing the potential applicability of the study's conclusions across various contexts.

Dependability

Dependability refers to the auditability of the research process. According to Ryan et al. (2007), it allows the reader to assess the reliability of the study and the researcher, based on the information provided. The authors further assert that “a study may be deemed auditable when another researcher can clearly follow the trail used by the investigator and potentially arrive at the same or comparable conclusions (p. 743). I ensured this was achieved by creating an audit trail for this research. I documented the study's procedures from the beginning (participant selection), tracked any developments (including recording and reporting any changes), and presented the final findings.

Confirmability

Confirmability demonstrates the neutrality of the researcher in the research process. It requires the researcher to show how interpretations and conclusions have been reached (Koch 2006; Ryan et al., 2007). Koch (2006) believes that “the entire study should function as an inquiry audit,” and that all decisions made in the research and their possible influences should be transparent throughout the study. Simply put, confirmability “is getting as close to objective reality as qualitative research can get” (Stahl & King, 2020, p. 28). In this study, confirmability was achieved by maintaining an audit trail, triangulation, and reflexivity.

The findings of this study were supported by direct quotations from participants (Bradshaw et al., 2017). To ensure confirmability, the review of field notes, audio recordings, transcriptions, various theoretical perspectives related to the research, and feedback from the supervisor/committee helped to identify any potential bias or selective perception. Through reflexivity, I consistently reflected on how my identity as a researcher and other contextual factors influenced both the information collected and the study's findings. As a novice researcher, questions I continually asked myself included, “What do I know? How do I know

what I know? What has shaped my perspective? With what voice do I share my perspective? What do I do with what I have found?” (Patton, 2015, p.72). This ensured that reflexivity was incorporated throughout the research, from start to finish.

Ethical Considerations

Ryan et al., (2009) assert that informed consent, anonymity, confidentiality, and the protection of participants’ rights are foundational aspects of conducting an interview. This consent form can be found in Appendix C of this study. Furthermore, an ethical attitude that incorporates respect, sensitivity, and tact towards participants throughout the research process should be evident from the outset, even before recruitment commences (Dejonckheere & Vaughn, 2019). To ensure an ethical attitude was maintained throughout the research process and that the foundational aspects of conducting an interview were followed, I obtained ethical approval from the University of Alberta Research Ethics Board.

The Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2 (2022) promotes the ethical conduct of research involving humans and serves as a guide for Canadian researchers (Government of Canada, 2023b). I, the researcher, adhered to the ethics guidelines outlined by the Tri-Council Policy which are based on three core principles: a) Respect for persons, b) Concern for Welfare, and c) Justice, which are “complementary and interdependent” (Canadian Institutes of Health Research [CIHR], Natural Sciences and Engineering Research Council of Canada [NSERC], & Social Sciences and Humanities Research Council of Canada [SSHRC], 2022, p. 6).

Respect for Persons

Respect for individuals acknowledges the inherent worth of human beings and encompasses the ethical treatment of both directly involved research participants and those

indirectly involved. This principle encompasses the ethical obligations regarding respect for autonomy and the protection of individuals with reduced autonomy (CIHR et al., 2022, p. 6). I ensured *respect for persons* by providing a full explanation of the nature of the research and the format of the interview, and by obtaining written consent before the interview (Ryan et al., 2009). This was demonstrated by providing a Letter of Information and Informed Consent Form for the potential participant to sign. To ensure that autonomy was maintained, the potential participant was given sufficient time to decide, without interference, whether they wanted to be part of the study. Ongoing informed consent was maintained, and participants were reminded that they could withdraw their consent at any time during the interview. To ensure anonymity and confidentiality, the participants' names and personal details not important to the study were not collected. Knott et al. (2022, p.5) state that “anonymizing is a safer option for minimizing harm to participants as it is hard to foresee all the consequences of de-anonymizing.

Concern for Welfare

Concern for Welfare “means that researchers should aim to protect and promote the welfare of participants, in view of any foreseeable risks associated with the research” (CIHR et al., 2022, p. 8). Qualitative interviews can trigger unprocessed grief and intense emotions, and as such, the potential harm to participants was considered, and measures were put in place to prevent this. Prior to the interview, power dynamics, emotional state, and interactional dynamics between the researcher and participant were considered and accounted for (Knott et al., 2022, p. 5). I prepared a list of organizations that could provide support and advice to the participant. If the interviewee had become distressed, I was prepared to remind them of the consent process and ask if they wanted to continue or needed to take a break for an agreed amount of time between the researcher and participant. None of the participants in this study became distressed during the

interview. To ensure that the participant is protected from any foreseeable risks, I anonymized all participant-identifying information, ensured the interview was safely stored by password-protecting and encrypting the files, and properly analyzed the data.

Justice

Justice is “the obligation to treat people fairly and equitably” and “the recruitment process is an important component of the fair and equitable conduct of research” (CIHR et al., 2022, p. 9). To ensure *justice* was maintained throughout this study, potential participants were eligible based on the inclusion criteria set out in this study, which were justified by the research question. A key threat to justice “is the imbalance of power that may exist in the relationship between researcher and participant” (CIHR et al., 2022, p. 9). To mitigate this, I ensured that participants were not exploited for my gain and that participants were allowed to view and edit transcripts before the final analysis was conducted.

Conclusion

This chapter detailed the design for conducting this research. It included the study design, the researcher’s positionality, the theoretical approach guiding the study, research setting, participant recruitment, data collection methods, and analysis. This allowed me to thoroughly investigate and understand the experiences of immigrant women and how these experiences supported or deterred healthcare access and/or utilization. The necessary ethical considerations and processes that ensured rigour, trustworthiness, credibility, and transferability were discussed. In Chapter 4, I present and discuss the study’s findings.

Chapter 4: Study Findings

The experiences of migrant and refugee women in this study were wide-ranging yet comprehensively addressed the scope of the study. In this chapter, I discuss the findings of the research question: *What are the healthcare experiences of migrant and refugee women and how does it support or deter their access and utilization of perinatal health services in Southern Alberta?* In this chapter, I summarize the research findings, focusing on participant demographics and the central themes derived from the qualitative data. To ensure participant confidentiality, a general description of each study participant was provided to provide context for the findings.

The findings of this study are based on individual, semi-structured qualitative interviews with seven immigrant women in Southern Alberta, including one participant from a refugee background. While I initially aimed for 10 to 12 interviews, I experienced recruitment challenges. However, the depth and richness of the seven participants' narratives provided strong information power and sufficient insight to address the research question (Braun & Clarke, 2019; Malterud et al., 2016). Information power refers to the concept that the adequacy of a qualitative sample depends on the richness and relevance of the data collected rather than the actual number of participants (Malterud et al., 2016). This approach was endorsed by Braun and Clarke (2019) as a flexible, interpretive alternative to rigid data saturation checklists. In this thesis, detailed, first-hand accounts of the participants' experiences navigating the perinatal healthcare system as immigrants yielded sufficient depth and substance for a meaningful reflexive thematic analysis. My supervisory committee also deemed this sample size appropriate for a Master of Health Sciences thesis project.

Demographic Information of Participants

The participants' demographic information was obtained at the start of the interview. It allowed participants to share aspects of themselves before more detailed questions were asked. This information was valuable because it helped me understand who was sharing it and how various social and cultural interpretations of the self may influence diverse perspectives on individual perinatal experiences.

All seven participants of this study were Southern Alberta residents, over 18 years of age, and were currently or previously pregnant. Six participants were married, and one was single. The sample consisted of two participants from Kenya, two from Nigeria, one from South Korea, one from the Philippines, and one from South Sudan, who grew up in Kenya. Although participants reported varying levels of comfort in English, they could hold everyday conversations and communicate their needs. They also felt comfortable reading and writing in English. Five of the participants held degrees, one held a nursing diploma, and another held a high school diploma. Within this sample, only one participant identified as being from a refugee background. All participants were assigned pseudonyms. Table 1 shows the demographic details of the participants.

Table 1

Demographic Summary

Participant	Country of birth	Ethnicity self-described	Language (English self-rating)	Level of Education	Marital status	Children	Pregnancy births in Southern Alberta
Moh	Kenya	Kenyan	Good	Degree	Married	2	Both
Nancy	Philippines	Filipino	Comfortable	Degree	Married	2	One birth

Abigail	Nigeria	Nigerian	Excellent	Degree	Married	3	All births
Deng	South Sudan (raised in Kenya)	Dinka	ESL communicat ive	High school (Canada)	Married	5	One birth; pregnant at interview (second birth)
Jennifer	Nigeria	Nigerian	Good	Two Degrees	Married	2	One birth
Mary	South Korea	Korean	Intermediate	Degree	Married	None 1st pregnancy	Pregnant. No prior births
Kareena	Kenya	Kenyan	Very fluent	Diploma (LPN)	Single	1	One birth in Southern Alberta

Description of Themes

Semi-structured qualitative interviews were used to elicit participants' perspectives on their experiences. During the interviews, participants were asked a broad range of questions designed to illuminate factors within their individual experiences, highlighting both intersections and differences in healthcare access and utilization across the study populations.

The six phases of reflexive thematic analysis, as presented by Braun and Clarke (2022), were used to analyze these data. The themes listed below were produced after following the six phases.

Table 2

Themes and Subthemes

Themes	The Village: Navigating Support Networks	The Velvet Rope System	Hitting A Wall: The Living Toll
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Subtheme	The village as a compass: Family and community as a way through care	Navigating in the dark	Like a game of perinatal pinball
	Seeking Safe Harbour in Uncharted Waters	“I Wish These Things Were Clearly Written Somewhere”: Navigating the unwritten rules of the system	The anxiety of being caught in a time trap
	Unpressured options	Extending the hand of support	Carrying the weight in silence

Theme 1: The Village: Navigating Support Networks

The theme “The Village: Navigating Support Networks” addresses social networks and support, encompassing three subthemes: The village as a compass: family and community as a way through care, a safe harbour in an unknown system, and an unpressured space. This theme focuses on the networks and relationships individuals form, which influence how they access and use perinatal healthcare services. This theme captured numerous participants' accounts of the key role that various social supports played in their ability to access and use available health services and resources.

The Village as a Compass: Family and Community as a Way Through Care

Family support. Within the family system, spousal involvement appeared to help mitigate stress when navigating the system or accessing care. Participants such as Jennifer, Moh, and Deng spoke positively of their husbands. They expressed appreciation for their husbands’ presence, emotional support, assistance with transportation, and efforts to prevent exhaustion caused by late-night feedings. Jennifer mentioned “*having a supportive husband. Like I remember both pregnancies. He didn't miss any antenatal. Even to the point where he knew he*

couldn't go in, he would just drive me there, remain in the car while going.” Jennifer also emphasized the importance of her husband’s support. She shared one instance when his support was not available and the impact it had on her health.

It's just that one, one, one time [...] I think I went through emotional, um, drainage like once when I didn't sleep at night, and usually I slept. I sleep, I take care of them at night. And then my husband would take them in the morning. But then I think that he wasn't around. So, I feel so emotionally exhausted.

Moh’s account emphasized the importance of family support in managing stressful situations, accessing healthcare, and navigating the healthcare system. She described her spouse’s support following an episode of premature bleeding, during which she was advised to seek care in Calgary. Additionally, she credited her brother-in-law for providing childcare, which enabled her husband to support her at the hospital during this emotionally stressful period. Moh explained

On my 25th week, it was like a large amount of blood I lost. So my husband took me in and at that time they were like, yeah, we have to send you to Calgary. It was ‘nerve-wracking’ ‘cause I have a three-year old at home. Who was going to take care? Who is going with me?... my husband had to stay behind and then he just went and then he came the following morning. Good thing his brother was here, so he stayed with the child and that helped. I was like quite emotional even calling my parents home and telling them. Like I did not tell them myself. So my husband had to do that.

Deng, another participant, observed that challenges may arise when only one parent provides support. She emphasized the significant assistance her husband offered, particularly regarding transportation and attending appointments. Deng explained,

Is just that African women... they're great when they have kids, yeah, but it's not easy when you have kid here with no other parent helping you...but good thing my husband is supportive. If he goes to work like now, he goes to work in the evening, he can come and take us out. [...] My husband is the one who always drive me, and I've never took the bus. I just go with my husband because if I know my appointment, we go in the morning. They let me choose which time is good for me. So, I told them before my husband go to work, we go there every morning.

Community support. When asked what supported their access to maternal care, some participants credited their community and personal connections. Jennifer, Mary and Abigail indicated that, in the absence of this support, establishing a connection with a family physician and accessing prenatal care or other essential resources would have been challenging and likely delayed. Jennifer stated,

So moving to Lethbridge (...) we didn't know a lot of people, but we knew like one person who kinda helped us settle in. This person kind of introduced us to other people that are part of our community, the Nigerian community, with whom we fellowship every week. And then he introduced us to a doctor because I think even at that point it was hard getting a doctor... but we didn't experience that because he had a relationship with the doctor, and then that helped us. Get in. We didn't have to go through any. We just did the meet and greet and became a patient, yes. So I think I would say community helped...I think it's if we didn't have the community, it would have been harder to even like having a

doctor (...) wouldn't have been a priority at the point because we would have tried to like want to find our feet around to settle down and so we wouldn't have (...) plus the pregnancy came as a surprise, so kind of caught me off guard.

Mary, another participant who was pregnant and expecting her first child, shared a similar experience. She emphasized the importance of community support as essential in providing information about resource availability. Mary explained

there are many organizations that help people who are pregnant, which I didn't know. So I just got to know those places by friends, maybe, or a coworker, or from the church. So, unless you have that connection or community, you would never know what the things that are available in Lethbridge are.

Like other participants in this study, Nancy relied on friends for assistance in navigating the healthcare system. She also expressed appreciation to her employer for guidance in locating a family doctor. This suggests that Nancy's access to a healthcare provider was primarily facilitated through informal networks rather than formal information or traditional healthcare pathways. Nancy shared,

"Trying to ask... some thoughts of my friends that is been pregnant as well...and they were here in Canada too. Good thing our employer before is like, oh, you have to look for a family doctor because you cannot just go, and no walk-ins or whatever. So at least there's at least there's someone who was guiding just like that."

Family and community support were also credited in helping to deal with emotional exhaustion and prevent postpartum depression. This demonstrated that community and family networks functioned as a form of navigation system, which provided support, reassurance, and

helped to reduce possible negative health outcomes such as postpartum depression. Abigail narrated,

I had like a good community that rally around me. They provide, in fact, they provided diapers, they provided some people who want to even come and stay. I have somebody who was coming from the day I came home for the twins... for 6 weeks... Just to come and see me and bathe the girls at night and things like that. [...] if there's anything I'm grateful for, I didn't experience this postpartum, you know? I didn't experience that, to be sincere. I had a good community, and then for him [referring to younger son], my mother-in-law was around.

Seeking Safe Harbour in Uncharted Waters

The role of healthcare providers was deemed necessary and beneficial to healthcare access and well-being. Participants consistently described patient-provider interactions as central to their sense of support within the healthcare system. Feelings of support were shaped not just by clinical care but by the quality of interactions with healthcare providers, including rapport, openness, attentiveness, and care. When providers took time to listen, communicate clearly, and respond with patience and empathy, participants described a heightened sense of safety, trust, and emotional reassurance. Kareena exemplified this in her narration,

I was treated well. I would go to the gynecologist. They would always ask, you know, the small things that matter. They will always ask, Do you need water? Are you OK? Anyone has seen you? Anyone has attended to you? (...) I don't know if it's I should call it hospitality. I would see like they were so nice to me. I would, I would say it was a good quality.

Several participants emphasized the importance of providers being approachable and responsive. One participant described her family physician and healthcare team as “*open enough*,” noting that they actively checked in with her understanding and needs, provided contact information, and encouraged communication. This openness extended beyond traditional clinical encounters; she recalled being offered home visits and personalized guidance during pregnancy. For this participant, who was both an international student and a new immigrant, such gestures were interpreted as meaningful expressions of care and inclusion. The willingness of providers to meet her where she was, both literally and figuratively, ensured she felt supported during a period marked by vulnerability and transition. For example, Moh said,

My family doctor was open enough. It was asking me if I've done this. Do you know about this? (...) In healthcare unit, they gave me their contact information like if you have any questions, just give us a call and we'll get someone come over. And they were really so supportive knowing that I was international student. Yeah. So, they were like willing to even come meet me in my house and talk about how to deal with that in pregnancy. I was a student plus just immigrated. So yeah. They were really willing to help out.”

Health providers also supported patients by being physically present and communicating clearly during times of pain and uncertainty. Jennifer described how nurses remained present during labour, offering physical and emotional support while ensuring she was informed by explaining each increase in Oxytocin dosage. The same participant highlighted the anaesthesiologist's patience in her care, allowing her time for autonomy and to change her mind if needed. This unpressured form of support was perceived as a caring gesture or a form of reassurance, which contributed to the participant's sense of control. Jennifer stated,

When I got to the hospital, I was already four centimeters dilated. And so to speed this up, I had to take oxytocin, and I remember the two nurses that were there were so helpful, like they sat down with me, and each time before they increased the dosage, they would let me know. ... And through this time they had asked if I wanted epidural, which I said no, but the anesthesiologist told me he was just gonna be in the lobby. So, if I changed my mind, he was gonna come in and administer it. [...] so walking in and having the anesthesiologist wait for two hours in the lobby, waiting for me to make up my mind, like at least even not up to, even if it's not up to two hours, but at least an hour, I'm waiting for me to make up my mind. He was very patient.

Another participant encapsulated her overall experience with healthcare providers in one word: “comfort.” Interactions with nurses were described as “polite” and marked by “good attitudes” and “good moods.” As an aspiring healthcare worker, the participant was reassured by this experience that she would be entering a “good field” of care. The ongoing caring interactions and respectful attitude provided reassurance, a feeling of safety, and comfort throughout pregnancy and the birth experience. Kareena expressed,

I'll say throughout the pregnancy, it was OK. It was good. I would rate it. It was nice. All the nurses were polite (...) I really was like, I mean, this is good field if this is how I'm going to be. [...] Their attitude all through, I'll say it was OK. I don't know which word I should use, which is good, but they were all in good attitudes and good moods...They gave me that like comfort that you. You're going to be OK. You're in the safe hands.

Throughout this study, findings indicated a link between perceived support and providers' capacity to create relational safety. The interactions of healthcare providers with participants during pregnancy and the birthing process played a significant role in these women

feeling emotionally supported. It also improved feelings of belonging and helped establish trust. When healthcare providers displayed empathy and encouraged open communication, this facilitated help-seeking, bolstered decision-making, and influenced the overall perception of healthcare access and ease of use. This is demonstrated in the accounts of Moh, Kareena, and Jennifer,

(Moh) It [healthcare provider interactions] made me feel like I was welcomed and like I have someone I'm not alone in the middle of... well, like a country that I know nothing about, right? Yeah. So, it made me feel (...)like I'm home. Someone is willing to help. They're asking, do you got, do you got rent? Rent. Like who pays your rent? Stuff like that. Financial. Yeah. They were asking such kind of things. We can get you a social worker that could help you guys with that.

(Kareena) My primary doctor she gave me access like she told me whenever I need to come, I should book an appointment. And I was also directed. I was also directed to a gyna, gynecologist and also I got a therapist. Free of charge.

(Jennifer) Like I said, were two of them [nurses]. They were so helpful, they were so encouraging and it's and then when it was time for me to push doctor came in and like I feel like my baby even came out before the doctor got into there cause it was that fast... [I] had to move to postpartum care. Everything went well... I really was in pain that I couldn't really do much. And so even after nursing her, like the nurses didn't mind me pressing the call band, they will, help me take her and put her back in the crib, in the bassinet.

Unpressured Options

A notable mention related to the patient-provider relationship and interactions was autonomy. Many of the participants highlighted the importance of health providers respecting their autonomy and allowing them to make decisions without coercion or undue influence. This fostered self-determination, allowing individuals to choose care that aligned with what they deemed best. In some instances, this allowed participants to make alternative childcare arrangements if they had other children. Jennifer stated,

They didn't make any decision[s] for me, but they helped me , they guided me to make the decisions that was the best. And I remember the example I shared like my gynecologist listening to my medical records and how long it took me to push my baby out. She told me what my choices were and I made an informed decision as to what I wanted at the end of the day. I was grateful I did that because I was at peace knowing that my son, even if he wasn't with me, I was able to keep him with a family friend and that he was safe and he was well taken care of. And then my husband was able to be with me.

Abigail detailed how she opted for a second c-section as opposed to a 'regular' delivery. Even when asked whether she was sure of her decision, Abigail felt that basing it on past deliveries was best for her and her situation. This decision was also supported by her husband, which allowed for spousal support of Abigail's agency and shared decision-making. The healthcare provider respected Abigail's decision to have a second c-section.

They asked me if I want to try. I said no, I don't want to try anything. There is nobody that was awarded for pain before. I'm sorry to say that, but no, I told them no. And they were laughing at me. I said no, just because I had C-section the first time. So I just let's just go and have the second C-section. My husband was like, " Are you sure you don't want to try?" I said no. I don't wanna go through that. I will go through pain and which

is ...the C-section pain. They didn't oppose anything. They just asked me, is that my final decision? I say yes. And then they asked my husband, " What does he want?" He said no, she's the one going through it, and she's the one that knows how she's feeling. So whatever she decides, I'm good with that, and then we agree on the C-section.

In summary, various forms of support from family, community, and healthcare providers helped shape immigrant women's ability to navigate healthcare experiences. Positive interactions and support helped to mitigate stress, anxiety, and loneliness. The ability to have autonomy over decisions regarding individual care was also important to the participants.

Theme 2: Velvet Rope System

This theme relates to information access and gatekeeping, which acted as a systemic barrier to resource navigation and information visibility for participants. A significant determinant of participants' access to perinatal resources was their awareness of these resources and the information readily available to them. The provision of, and access to, information from different health resources was identified as essential to enabling participants to learn about the resources they could use. Without the necessary and relevant information, participants experienced increased barriers to accessing and using health services. Many participants emphasized that health providers did not guide them to available resources; instead, they had to 'figure out' the system and what was available. The three sub-themes that were generated after analysis of 'The Velvet Rope System ' were "Navigating in the Dark;" "'I Wish These Things Were Clearly Written Somewhere:' Navigating the Unwritten Rules of the System;" and "Extending the Hand of Support."

Navigating in the Dark

For those unfamiliar with the healthcare system, there appeared to be limited visible information regarding the availability of perinatal programs and related pregnancy supports. Some participants reported being further along in their pregnancy before they accessed the available services, which only became apparent during conversations with others. However, when participants were made aware of perinatal services in subsequent pregnancies, they were able to access services at an earlier stage of pregnancy. Moh explained that she was unaware of the available perinatal resources; however, she was supplied with information and introduced to the health unit through a friend.

We were just chatting. Then I'm like, by the way, I'm pregnant. (...) She's had a child also. So she told me...do you know about this? I'm like nope, I don't know. So she's like, hey, you call them? We went together actually after class to old train station...So the first one, a friend of mine referred me to health unit here in Lethbridge train station. So I went there, I got registered to that prenatal classes. For my second one (...), I had already gone through on my first, so I just called the health unit to register for the classes.

Similarly, Abigail recounted that she was initially unaware of the available resources, “*I didn't know about it from the beginning,*” and only learned of what was available from someone else. This highlights the invisibility of resources to immigrant women if a targeted approach is not taken to share this information with them. Acknowledging that she was not initially aware of the resources available, Abigail suggested that providing information about these resources would be helpful. Abigail said,

I didn't know about it... some of the knowledge I knew about immigrants is because of the interpretation... but maybe a little bit of education. Yeah, if they can maybe have a

little community that can educate them on this is what we have available or this is the assets we have.

Participants reported positive experiences when information was provided by their healthcare providers. This demonstrated that providing information about where services can be accessed increased both the access to, and utilization of, available services. Kareena from Kenya stated,

(...) as the pregnancy progressed, I was referred (...) through the community. With community immunization, the community hospital, I was directed to the therapist and that's where I would get all. Sometimes I would get support like for food support, I would get gift cards and everything.

Throughout these accounts, most immigrant women were made aware of perinatal services and other pregnancy supports through various social connections. So, while the services were available, they were not always visible to those who may need to access them. This acted as a significant barrier to access because immigrant women without social connections may not be provided with timely information to access these services. Kareena noted that some immigrants may not know certain services exist and would not learn of them without some form of connection. She stated,

Some of the people like I've heard of don't know if these are kind of services exist, and (...) the only hospital they will know is the Chinook hospital. What if we have that kind of knowledge there? I don't think most of it is there. Like, unless you have a connection, like someone who knows someone or you find a nurse who is generous enough to give you the

information, it's not on the triage, neither the registration. If they see a woman who is pregnant, of course, they need to be known.

Mary, an immigrant from South Korea, described needing to ask for information rather than having it provided by her healthcare provider. Mary detailed that she needed healthcare providers to supply more information first, rather than her having to ask questions, request information, or conduct independent research to verify whether the doctor is doing what is needed.

Sometimes I feel like I have to ask, like instead of they're coming to me, that [Mary], this is your like 30 weeks you have to do this, check this, check this, check. They don't say unless I have, like, do I need to do blood work this time? Like what? What else do I need to do? (...) I don't know. I want more information from them first instead of me. I have to search everything before I go, and then I double-check whether they're doing it for me or not. (...) I want more like explanation.

“I wish these things were clearly written somewhere:” *Navigating the Unwritten Rules of the System*

Participants who migrated from countries where information is more readily available may find the lack of information within the Canadian healthcare system distressing. When there is limited information provision and guidance surrounding the steps to access relevant care or information at each stage of pregnancy, this may lead to feelings of anxiety, lack of care, or may force individuals to turn to Google for information, which may not always be accurate, thus resulting in misinformation and increased mental strain.

One participant articulated that having a clear maternal care pathway or timeline that identifies what to expect during her pregnancy would be helpful. Mary reported being unsure of various care options, especially since it was her first time being pregnant and about to give birth in Canada. She emphasized the importance of having things clearly written and readily available for pregnant women upon confirmation of pregnancy.

This is my first time in Canada giving birth and being pregnant. I don't know what to expect, but nobody is giving me any like schedule of like what are the things that I have to do unless I Google. Like I wish I could get more information from doctor or I wish I have some like a website that I can maybe access that. OK, you're 12 weeks pregnant, so you can expect this, this, maybe this blood work, urine test, this, and you have to do this, or at 25 weeks you have to do this, this, this. You have to see doctor for this, this. I wish, like, all these things are like clearly written somewhere, or maybe when I visit, like, family doctor first time when I knew that I was pregnant, maybe they have a pamphlet or something, like a paper sheet that is written...

Mary mentioned that she was unaware that she had a choice between a midwife and an obstetrician. She suggested that if this information were readily available, then information seeking on platforms such as Instagram or Google would not be necessary.

Where, what website I can go and get some information about...this pregnancy like nothing. I received those things, or I did was just Googling or like Instagram or just I have to figure out like what to expect? Yeah, even like midwife or OB, like I wasn't sure. Like what's the process? Like what are the options for me to pick? Like, yeah, what to do? Like zero idea. Nobody was telling me.

Deng, who also gave birth in Manitoba, contrasted her experiences with information dissemination and resource availability there with those of her current city in Southern Alberta. Deng noted that in the three years she has lived in Lethbridge, she has not been made aware of any programs, either prior, during, or after pregnancy, that provide support similar to what was available in Manitoba. She reported that although such support may have been available, no doctors, nurses, or health providers have informed her of their existence.

I don't see something like that...in some cases like if you need like some program to go to like in Manitoba, they were having like places for people who are pregnant to go there. So they have a public nurse to teach them how they like people who have never give birth and when they don't know what to do when they're giving birth or what happened when you are pregnant. So when you are there in that group of health public nurse, they teach a lot so that you can understand what is going on, how you can breastfeed your baby, how you can what kind of sickness when the baby is born, do your baby having what kind of rashes you can understand what is that. But here I don't know because I have never seen it in Lethbridge. Yeah, maybe it may be somewhere but I haven't heard it from the doctors to send me there or nurses to tell me that there is a place that you can go during pregnancy or during giving birth...But I'm not really sure here if they're here 'cause I have been here now for almost three years, but I have never [heard] of it.

Extending the Hand of Support

Throughout the study, participants suggested providing information or making it more easily accessible to improve perinatal healthcare access and utilization. Participants, such as Nancy, recommended giving health information before individuals arrive in Canada or having immigration officers provide it to immigrants at the airport. She noted that it is “*hard to start in*

a country that you don't know anyone," and she thinks this may help prevent the "feeling that I shouldn't be coming here." To increase outreach and disseminate information, one participant also suggested increasing service visibility at locations frequented by newcomers, such as grocery stores and bus stops. Moh from Kenya stated,

Maybe put in posters in the bus stop (...), you go to college or university have some posters around, sometimes in grocery store, right? That's it. That's there. There's someone in there offering those services. Here's some pamphlets about newcomers, that's what you get. Like what you can learn in this community or about healthcare.

To bridge the gap in awareness between available services and newcomers' knowledge of these services, some participants suggested partnering with immigrant-serving agencies, creating a directory or provider list of where these services can be found, and liaising with family doctors, since they can serve as a valuable gateway to provide resource information. Mary from South Korea said

When we see family doctor first time after pregnancy test, I think that's the great time to like educate immigrant people or give them some resources to access. I think that'll be really helpful(...) like as an immigrant, (...) I just imagine someone maybe very new, one with less than one year and already pregnant. They wouldn't know where to go... So like how can we provide all this information like right away? That's my question.

Kareena also shared similar sentiments to Mary's, in that she believed a booklet with information on available resources would be helpful. She noted that newcomers may not readily locate this information on their phone if financial constraints are an issue. Kareena, from Kenya,

Some of them haven't paid the phone, so we can't say the information is readily available on the phone. What if they get a headache or a stomach-ache and they go to the hospital and they get handed that kind of booklet? Now (...) they know where the resources are, right? They can get, oh, there's this one, there's that whenever I need this. So it's very handy that small book. It's very handy when you have it or that kind of information, or they say, OK, if you need a gynae, we have this kind of list. We don't get that unless you go online. What if we don't have that kind of money to pay for the phones? Some people haven't paid for the phone, and you find that they ... they just use Wi-Fi. [...] Then it means that they can't call direct. They can't go on any links.

Theme 3: Hitting A Wall: The Living Toll

The experiences of immigrant women accessing and utilizing health care in Southern Alberta revealed structural and systemic barriers that hindered care. Several participants likened their experiences to repeatedly hitting a wall. Ultimately, these barriers undermined the participants' overall well-being, perpetuated health inequity, and posed a potential risk to their perinatal health outcomes. The three sub-themes that were generated after analysis of "Hitting A Wall: The Living Toll" were "Like a game of Perinatal Pinball;" "The Anxiety of being Caught in a Time Trap;" and "Carrying the Weight in Silence," which are discussed below.

Like a Game of Perinatal Pinball

The subtheme "Like a Game of Perinatal Pinball" reflects the experiences of five of the seven participants, who reported feelings of helplessness and a lack of control. Similar to a ball moving unpredictably, these women were redirected from one clinic to another without a clear trajectory, disrupting the continuity of their care. Such fragmentation increases health risks and exacerbates emotional distress among immigrant women. Participants reported frustration with

managing multiple providers, frequently requiring repeated explanations of their medical histories. Additionally, maintaining accurate health information across various professionals was described as highly burdensome. Collectively, these accounts illustrate how fragmented care can directly delay timely access to medical services.

One participant, Abigail, a mother of three from Nigeria, pointed out that a shortage of doctors made it harder for her to access healthcare, stating,

there's a shortage of doctors, so they had to, I think it has to be like a weekly visitation from Calgary. A doctor need to come from Calgary to come and see, um, a pregnant woman here... So they come weekly from Calgary because there were shortage of doctors here.

With her first and second pregnancy, Abigail reported she felt as if the doctor was not listening to her or paying attention, and the appointment felt rushed, possibly due to other patients waiting. Abigail said,

...because there were shortage and even when the doctor came to see you, it won't be like trying to do they try to listen. But then they have a lot of people waiting and then they need to just poop, poop, poop like not up to 20 minutes or 15 minutes. You are they are already out of the room. So I feel like it was just a rush, rush, rush, rush and not paying much attention.

Mary also reported feeling rushed during her visits with her healthcare provider. This helps to highlight how fragmented care negatively affects already marginalized mothers who must navigate a disconnected and complex health system. Mary shares,

I still could feel that they're busy like they gotta go right away. Yeah, sometime like, I just have to... I have one more thing to ask you and I have to just kind of like, catch, like, get their attention, you know, before they leave. Yeah.

The participant also noted that she was subject to a revolving door of different physicians each week and identified the possibility that the physician often did not have time to properly review the patient's chart before the appointment. She also spoke of filling in the doctor on previous appointments. This increased distress and frustration and impacted patient-provider trust-building among immigrant women, which ultimately impacted care. Abigail went on to say,

You might see the same doctor today, another doctor next week and then another doctor... So it's not like I saw an accurate like the same person always... maybe the doctor didn't even get a chance to read your chart like he just glanced through. And then when the doctor came, you have to start telling him, oh, last week this is what happened or last month that that was what happened... He's not like the one that already knew what you went through, so he he has an idea what's going on.

A similar sentiment was shared by Deng. She reported seeing a different doctor at each visit but regarded this as beneficial since the absence of a family doctor would result in a lack of care. It illustrates how navigating a complex healthcare system without a family doctor force marginalized individuals to accept inconsistent care. Deng explains,

So that like gynecologist and that one who deliver the babies in the delivery room, but they come and check women who are pregnant. So today if I go, I get different person and then the next time I get different person. But it's helpful because if you don't have anyone to take care of you, then it's not good.

The fragmentation in care and lack of continuity left the participant feeling scared and questioning whether she would even know the physician who would deliver her baby. Abigail described being unable to build a connection with the delivering physician due to the short time between the meeting and delivery. Although the physician acknowledged this disconnect and asked the participant to trust her, the participant chose to rely on her faith for safety. Abigail said,

It got to a stage where I was thinking...who is going to see me during delivery? Because if you know somebody and you communicate with the person, maybe you will be able to like put one or two together and said...OK, I think I'm comfortable with this one, but you got to a stage where? OK, who is the person? So I had to meet her [doctor] before the day and she was like, OK, I know you haven't seen me, but I want you to know that and you need to trust me. In my mind I was like, I trusted my God, God, will control you and God, will take charge. So like, yeah, like things like that. So it was a bit scary.

Deng shared a similar sentiment regarding family doctor shortages and the revolving door of physicians. However, she acknowledged that, although this system was not favourable to her care, it was helpful because she did not have a family doctor. Deng said,

When I came here, it was very hard for me to get a family doctor OK, because I came when I was almost due and it was not easy to get a family doctor. All the family doctors were full... So that that place, they have many doctors who can take care of you. Not one person... they come and check women who are pregnant. So today if I go, I get different person and then the next time I get different person. But it's helpful because if you don't have anyone to take care of you, then it's not good.

A lack of continuity of care also transpired when doctors moved away from the city or the clinic, disrupting patient care. In cases where patients had already formed a bond with their family doctor, they wished that the doctor could have remained until they had given birth, even though they were ultimately assigned another physician by their clinic. Mary said,

During my pregnancy, my family doctor moved to hospital, so she's no longer my family doctor...She just like gave me the last visit before she moved to the hospital. She just said, yeah, I wish you the best with the pregnancy. And she gave me a hug, you know? So, like, it was very nice. And just special...So luckily they [the clinic] put me like different doctor right away who were available at the clinic. But it's not really my family doctor, just like temporary. So like, I wish I could have my same doctor like my entire pregnancy.

Kareena's doctor moved to Calgary, and she discussed her difficulty in connecting with another healthcare provider. Each time she attempted to book an appointment to see a doctor or visited the hospital, she had to remind staff that her doctor had moved to Calgary. This acted as a barrier to care and healthcare access. Kareena discussed how her utilization of health services was hampered by this reality.

the fact that whenever you call to book an appointment or maybe to go to the hospital, they always say you need to see your doctor, even when you explain you don't have a doctor. I feel like that prevented me from getting a lot of care...I'm not sure if it's before or after birth, but I think I ended up having to see another doctor in my clinic. Because every time I would just be calling and they'll be like, oh, your doctor, I'm like, my doctor is in Calgary. I can't follow them, yeah.

The Anxiety of Being Caught in a Time Trap

Throughout the interviews, long wait times were identified as a significant barrier to care, especially when participants sought access to family physicians, emergency departments, and diagnostic test results. These long delays not only postponed necessary care but also contributed to substantial anxiety and psychological distress, as participants experienced uncertainty and concern about potential deterioration of their health conditions. For several women, this emotional burden was intensified by comparisons between the Canadian healthcare system, which was deemed slow, and the more immediate access they would have received back in their home country.

Nancy, who has one child and is from the Philippines, described how she waited for many hours at the ED when she was pregnant. She found this situation challenging and noted that when she was finally seen by the physician, her symptoms had already subsided.

It's just like I feel I get nauseous and then I throw up...I'm pregnant that time. So I went to emergency and I waited for a long period of time and I feel better already when I'm waiting before the doctor can see me. When they came of course...they have to ask you how are you feeling now? Of course I'm already OK after waiting for four or five hours. I try to manage myself, already been waiting. So yeah, that's just the challenging one here.

Some participants found the long wait times unreasonable, while others questioned whether the ED could even be called an emergency department when those prolonged wait times were taken into consideration. Nancy emphasized that “*health service should be just like accessible to everyone*” and considered it unreasonable to wait five hours to see a doctor. She further added that, “*if it's emergency, it should be treated like emergency because nobody will go into the emergency if it doesn't feel good, right?*” This point of view was shared by Kareena, who affirmed that, “*I don't like going to emergency cause it's not emergency anymore.*”

If health providers were unavailable, then the emergency department would be used to access care. The inconvenience of waiting at the ED to be seen was contrasted with the convenience of having an appointment with the family doctor. In Deng's account, she described going to the emergency as "not easy." Deng said,

Going to emergency is not easy. You have to be on the line for long. So it's not like going to your doctor. You don't have a appointment right away. They just give you time and maybe if you go at 8:00, you can come at home at one or three. So you have to wait there on the line for so long.

Jennifer spotlighted that if there were no doctors to provide care to immigrant women, then the only choice for this population was to visit the ED. The long wait times were seen as discouraging and thought to be systemic, given the available resources. Jennifer stated,

If there's no doctor to provide the care to the woman, then are they gonna keep going to the ER, and the ER, you're there for hours, and that's so discouraging. That is so discouraging and so It's more I feel like it's more systemic based on the available resources...

Delays in diagnostic care and results were a source of discomfort, anxiety, and intensified worry for immigrant women. When participants came from countries where timely access to care and test results was readily available, the Canadian system, which lacks immediate action, was frustrating and challenging. In her account of events, Mary, who is from South Korea and experiencing her first pregnancy, describes how the long wait time between when she saw her doctor, got a diagnostic appointment, and was expected to get follow-up results made accessing and utilizing maternal health care services difficult.

[In the] Last few weeks I've been having so much like lower back hip pain. So I went to see my family doctor and then he referred me to ultrasound...now ultrasound place like they booked me July 28th which I went to see my doctor June 30th. So, it takes one month for me to check my hips with ultrasound. I think I will be healed by then, you know.

As a first-time mother without family support, Mary shared that the long wait times for diagnostic results can be very emotionally stressful, especially for first-time mothers. She discussed the difficulties of not knowing whether something might be wrong with her baby. She also compared the healthcare system in her new country with that of her homeland.

I feel like in Korea we have like specialist instead of family doctor. So if I have a problem with my pregnancy, I will just go right away to someone OB, you know.

And they can check up everything for me, even like ultrasound in the clinic. I can do ultrasound right away. I can do blood work right away. So I don't need to wait for my next appointment to come for ultrasound and this and that. Just one day when I visit there, I will be checking everything to make sure. But here like I go to see doctor, family doctor first and they wait for ultrasound and they wait for the result and this and that just taking so long. So like whenever I need like for example I'm worried about something, maybe I have a symptom I wanna know right what's going on. It makes me nervous. But like, I cannot access right away. I cannot get the answer right away. And yeah, that's quite tricky.

Carrying the Weight in Silence

This subtheme described how neglect, cultural stereotypes, and accent bias undermined participants' clinical safety. A significant concern was "pain assumptions," harmful biases in which practitioners minimized or dismissed women's physical suffering. This dismissal led to

severe, unaddressed postpartum complications, including physical trauma from wound reopening. Fearing negative perceptions and systemic linguisticism, some participants actively avoided seeking further help. Ultimately, navigating this intersection of discrimination and clinical neglect eroded their sense of safety and directly affected the quality of care.

Clinical neglect profoundly compromised the participants' physical and emotional safety. Throughout the interviews, women shared alarming accounts of postpartum complications paired with incredibly slow medical responses to these potentially dangerous events. These systemic delays left the participants feeling abandoned by the healthcare system during highly vulnerable moments and facing a terrifying gap in urgent care.

This systemic abandonment was vividly illustrated by Kareena, a participant from Kenya who is also a Licensed Practical Nurse. She recounted a severe postpartum crisis in which her caesarean section wound reopened, yet healthcare providers instructed her to wait until Monday for medical attention. This delay left her deeply distressed, trapped between self-blame and systemic frustration. She stated:

I did a C-section, and let's say I had five days because I was stapled. I gave birth on Friday and I was stapled. So my staples were taken out on the other Friday...then after the staples were taken out...my wound started opening up one side. I went to the hospital the night ...the doctors stitched me... and they asked me if I could come the next day to ultrasound and I was called the next day on a Saturday...when I woke up, they always say bladder empty. You empty your bladder, and then you get a full glass of water. And then I woke up to find that my wound had opened up again. It was on a weekend. Now that is where my problem started. I don't know if I should blame the system or I should blame myself on that.

The situation was further complicated when Kareena was sent home without being re-stitched and was again instructed to wait until Monday because her gynaecologist was unavailable. Prior to this event, the participant held a positive view of the healthcare system. The participant characterized the experience as “that killed me”.

I went to the hospital, they did ultrasound in my state, but I was let go home without any stitches, just because my gyna or whoever, like whoever helped me give birth, wasn't there and I was told to come back on Monday. So tell me, so there I had no problem with the healthcare system until then I was told to go home and that will be on a Saturday, Sunday and then I have to come back on Monday... But that point that they tell you that we can't do anything until Monday because your doctor is not around. That killed me.

Following this experience, Kareena expressed regret for not recalling the healthcare provider's name, believing that this information would have enabled her to pursue legal action. She also reported confusion about the delay in her care until Monday and questioned whether, in the event of her doctor's death, she would be required to wait for his return before receiving care. Kareena,

Yeah, I wish in the days that after I would say I would always be careful with the names and everything. I would really remember who it was, but it's too late. And actually, if I wanted, I would have sued the hospital because I didn't understand how would someone tell me that I need to wait until Monday. I really didn't understand. What if my doctor or whoever was supposed to be, what if he or she was dead? Should I wait for him to come from the dead? I really thought a lot after. It really killed me... It was it was a little draining... I would say I really questioned the healthcare system.

When participants reported postpartum complications and suggested that healthcare practitioners may have made errors, their concerns were dismissed. In the case of Deng, responsibility was assigned to a so-called 'lazy uterus.' This participant was already a mother of four at the time of her son's birth. She reported that a procedural step was missed in Lethbridge, which was performed in another province. She believes this error resulted in blood clots and hemorrhaging. Deng thought she would die that day,

...when the baby was delivered, the doctor remove the placenta and everything, but what they didn't did to me, I don't know whether they forgot or something else. They didn't squeeze my umbilical cord so that the blood can come out. So and the doctor left, he left me with the nurses and then they take me to the ward. I start blood clot because of the blood was still in the stomach, they didn't press it. When I used to give birth in Manitoba, they used to press my umbilical cord three times so that the blood can come out. But this here they didn't. So when I went to the ward, the blood start clotting, clotting and then that's when the nurse called and then all the nurses came and that doctor came and then again that's when they come and remove the blood from my stomach. It was really horrible. I thought I will die that day, but God was there... then after that they said you will not go home quickly because you lose the blood and your hemoglobin is down.

Deng questioned whether the breakdown in care was a result of negligence from the nurses or the doctor. When she asserted that her womb was not lazy since she was able to deliver the baby, she reported that the providers did not want to accept blame, so she decided to 'keep quiet.' Deng 'keeping quiet' underlined the existence of a power imbalance and she adopted silence as a means of coping after pursuing accountability.

I don't know if it is the fault of the nurse or is it the fault of the doctor 'cause they supposed to press my yeah belly so that the blood can come out...they didn't [apologize] they keep telling me that maybe the uterus is lazy. I said how come the uterus is lazy and then why the baby come out? Then why is it uterus is lazy when it is blood to come out? But you guys didn't press my stomach so that the blood can flow. So but 'cause they didn't want to accept, we just keep quiet.

While obvious neglect was present among participants, there were also covert forms of neglect that participants noticed and questioned. Abigail described her postpartum care, in which she initially received attention and assistance. Over time, she noted the absence of follow-up, which was subsequently attributed to her failure to depart at the designated discharge time. This lack of follow-up can result in complications post-birth and affect help-seeking in a time of need. Abigail stated,

After I stayed there, they were supposed to come and see me. In fact, they didn't even want to come and attend to me anymore because they felt like...it was already time for me to go...She [health provider] came and check on me. How are you? I hope everything is fine. I said yes. And then she didn't come to me anymore. I was like, asking my husband, "What's going on?" And then I get to notice, I get to hear from somebody like, OK, they gave you two days, so you were supposed to be off. But I said, is there duty to check on me since I'm still in the hospital, right?

The "Strong Black Woman" stereotype heavily influenced the experiences of some participants. In this study population, deep-rooted racial tropes and implicit biases directly compromised healthcare access and utilization. Several participants reported that their physical suffering was dismissed or minimized due to the persistent and harmful belief that Black women

have a higher pain tolerance than other demographic groups. This racialized perception frequently compelled participants to conceal symptoms or downplay complaints to avoid clinical dismissal, a defensive coping strategy that increases the risk of adverse health outcomes. When asked about considerations for clinicians caring for immigrant or refugee women, Kimberley described a hostile encounter with a provider who explicitly used her race to assume her pain was nonexistent. Reflecting on this dismissive attitude, Abigail, a Nigerian participant, stated:

I think sometimes they tend to assume that we women are strong. We, the African women, are more stronger. But they shouldn't assume that. A pain is a pain, right? Every woman is going [to] go through pain, even though we come from a place where we manage pain in different ways.

Abigail's recollection of events highlights the importance of equitable care for everyone, without assuming that one group has a higher pain tolerance than another. She noted the importance of healthcare providers acknowledging that pain is experienced in different ways and that the dismissal of someone's pain symptoms may lead to stonewalling or disengagement by the patient. Abigail shared,

No, a pain is a pain. So they shouldn't just shut them down when they are complaining of pain, you know. I had a nurse that told me that, oh, you women, you black women have more ability to hold pain more than us here. Which she's not supposed to say that as a nurse, right?

Cultural considerations are also important in equitable care. It may help healthcare providers understand how pain is managed across different groups. Moh, a Kenyan participant who is also a nurse, shared a similar sentiment about pain and offered a cultural understanding of

why pain may not be shown. A contrast was made between the Canadian healthcare system which looks for signs of visible pain instead of considering cultural factors which emphasises showing strength, “if you cry, you’re not tough”. Moh stated,

one thing was about the pain as I get for my culture where like high tolerance when it comes to pain and we don't show in like facial. I'm a nurse myself and I know what we look into when we are asking our patients, what's your pain rate? Usually we do face like, yeah, they showing any signs that they're like in a lot of pain. So in that case, it's like here they tend to do more like actions. Yeah, I might say I'm in pain, but I'm not actually showing in my face, but in me I'm like in a lot of pain.

So I've had a friend, she went in, I was already a nurse, so I went in with her. So she was not showing any signs of pain or like she was in labour but not really showing. So she got sent home and she went home. The water broke and she was afraid to go back because she was told come back in few days if you feel [anything]. So she went home. And while at home she is in a lot of pain. Like I can tell her pacing around, she's not showing like she's like tough with pain. So I had to force her actually to come in. And at that time when she came in, she like her. It was like her blood pressure and baby's blood pressure was all over the place. So they had to go in emergency c-section at that time. But if they had actually listened to her when she came in with pain without having to show it, they would have actually done without even having to send her back home and risk that.

Accent bias has emerged as a significant structural barrier that directly undermines healthcare access and utilization. Pregnant and postpartum women who encounter linguistic discrimination frequently report perceived racism, which often leads to delays or complete avoidance of medical services. Given that transparent communication is essential for patient

safety, such linguistic barriers severely intensify clinical misunderstandings, reinforce perceptions of judgment, and hinder critical follow-up care. The systemic nature of this exclusion is illustrated by the experiences of Deng, a participant from Sudan and Kenya. She reported immediate judgment during clinical encounters, including situations in which healthcare providers abruptly ended phone calls. As a result of feeling dismissed and invalidated, Deng reported feeling disappointed and less motivated to seek follow-up care. She said,

I went to school here and I know how they treat immigrant...they don't really tell you directly that they have racism, but there is. And so some people, they judge you with your language or your accent when you are talking, like when you are talking on the phone with them. It's different when you are together with them, when you are talking on the phone, they just judge you according to your accent. Someone may cut the phone or say, "I didn't hear you," and you are trying to express yourself, talking, and someone can say, "I didn't hear what you are saying." So that one can make you disappointed and not to do what you wanted to have before.

Deng further spoke about having to repeat herself numerous times, which eventually led the nurse or healthcare provider to ask to speak to someone else. She questioned what immigrants should do if no one else is around to assist with communication. Deng said,

"[the nurse] say I didn't hear what you are saying and if you keep repeating, he said, I don't know what you are saying, maybe someone else can talk to me. But if you don't have anyone to talk to, to give it to so that he can talk, who will? Nobody."

This interaction would most likely result in evident frustration because of healthcare provider biases. This can harm immigrant women by discouraging them from seeking help. It

increases vulnerability for barrier-to-care populations, prevents appointment booking due to fear of stigmatization, and creates a dependence in which immigrant women do not book appointments or access health services unless there is someone there to assist them with communication.

Summary

The healthcare experiences of migrant and refugee women in Southern Alberta were examined, with particular attention to how these experiences influence access to and utilization of perinatal health services. Chapter 4 outlined the data collection procedures and presented findings from a thematic analysis of transcripts from seven immigrant and refugee women representing diverse backgrounds, including Kenya, Nigeria, South Korea, the Philippines, and South Sudan. The analysis identified a tension between supportive networks, systemic barriers, and structural barriers. This tension is reflected in three primary themes and their associated subthemes: The Village: Navigating Support Networks; The Velvet Rope System; and Hitting A Wall: The Living Toll.

The interviews exposed deep vulnerabilities rooted in systemic healthcare failures, ranging from dismissive provider attitudes to delayed responses during critical medical crises. Racial stereotypes heavily warped the quality of care. For several women, these deep-seated biases led practitioners to outright dismiss their physical suffering. Accent-related barriers compounded this isolation, effectively preventing patients from accessing essential services. These negative experiences ultimately discouraged patients from engaging with the healthcare system, leading to frustration and eroding trust in medical institutions. While positive personal relationships and robust social supports helped mitigate some obstacles, they were insufficient to

address the persistent structural disparities, fractured systems, and ongoing information gaps that continue to limit healthcare access.

Chapter 5: Discussion of Findings

In this chapter, I discuss and situate the findings of my study in the context of prior research on the topic, the intersectionality theoretical framework, and my research question: *What are the healthcare experiences of migrant and refugee women, and how do these experiences support or deter their access to and utilization of perinatal health services in Southern Alberta?* The intersectionality framework demonstrates that social categories like gender, race, and socio-economic status do not exist independently, but rather interact dynamically to shape distinct experiences of inequality (Crenshaw, 1989). As a result, these systemic disadvantages remain deeply tied to specific historical periods and cultural contexts (Bambra, 2022; Gkiouleka et al., 2018). This study's findings show that using this theoretical lens helps explain how factors such as race or ethnicity, language or accent, newcomer status, family support, reproductive stage, and healthcare systems collectively influence care experiences. The findings also point to a clear tension in perinatal care. While individual relationships with professionals are often deeply supportive, patients are still forced to navigate heavy structural power imbalances within the system.

Overview of the Inquiry

The intent of this exploratory qualitative design utilizing an interpretive approach was to examine the perinatal healthcare experiences of migrant and refugee women. It should be noted that of the seven immigrant women who participated in this study, only one was from a refugee background. In using an intersectional lens, this study explored the specific barriers and facilitators that shaped how participants accessed perinatal healthcare. Semi-structured interviews were conducted with seven immigrant women, one of whom was from a refugee background. The participants originated from five different countries. They shared how their

migration experiences directly impacted their healthcare utilization. I audio-recorded and transcribed all interviews verbatim, then shared them with participants to confirm that the transcripts accurately reflected the discussions. These data were coded, and the generated themes adhered to Braun and Clarke's (2022) approach to thematic analysis. Table 1 presents the themes and subthemes generated from the analysis of the interview transcripts. The three main themes were The Village: Navigating Support Networks; The Velvet Rope System; and Hitting A Wall: The Living Toll, each with subsequent sub-themes. The ensuing sections will discuss how these findings align with current research, using an intersectional framework to deepen understanding of the themes.

This chapter presents a thorough analysis of themes reflecting participants' experiences across the relational, informational, and systemic aspects of care. Ultimately, the findings show that while supportive relationships facilitate initial access to healthcare, they cannot fully fix deep systemic obstacles like fragmented systems, inaccessible information, or exclusion from services. Additionally, the chapter further discusses the implications for practice, acknowledges the study's limitations, identifies directions for future research, and concludes by summarizing the study's contributions to understanding perinatal healthcare for migrant and refugee women in Southern Alberta.

The Village: Navigating Support Networks

The theme, "The Village: Navigating Support Networks," illustrates how social networks directly influence a patient's care trajectory. This theme encompasses three subthemes: "The Village as a Compass: Family and Community as a Way Through Care;" "Seeking Safe Harbour in Uncharted Waters;" and "Unpressured Options." These informal support systems shape how individuals find and use perinatal health services. The theme itself emerged from participants'

consistent descriptions of communal support serving as a bridge to formal resources. Ultimately, these accounts demonstrate that perinatal access is not an isolated clinical experience. Instead, it relies heavily on a woman's unique intersectional position within her family, community, and healthcare environment.

The Village as a Compass: Family and Community as a Way Through Care

Women from immigrant and refugee backgrounds in this study reported that family and community support, establishing relationships with healthcare providers, and maintaining autonomy and choice in care facilitated their access to perinatal healthcare. Family members, spouses, friends, church groups, and individuals from the same ethnic background played significant roles in helping women identify healthcare providers, understand available services, manage childcare responsibilities, and cope with emotional stress during pregnancy and the postpartum period. The support from family and community was especially essential for maternal well-being and healthcare access during periods of settlement and transition, especially when women may have limited knowledge of the formal healthcare system.

This aligns with existing research showing that migrant and refugee women often depend on informal social networks to bridge institutional gaps in maternity care, especially when they are unfamiliar with local services or newly arrived in a country or area (Khanlou et al., 2017; Rogers et al., 2021; Higginbottom et al., 2014). Studies of migrant maternal care have similarly identified social isolation, information asymmetry, and unfamiliarity with healthcare systems as important barriers, while community-based support and continuity relationships can improve women's confidence and care experiences (Ewesesan et al., 2022; Khanlou et al., 2017; Higginbottom et al., 2015). Rather than viewing these supports as secondary, the findings in this study suggest they were often central to whether care became accessible in practice.

An intersectional evaluation of the findings reveals that support is not evenly distributed. Participants with greater connected networks received more support and were able to learn about available services, manage pregnancy challenges, and access providers and local programs. In contrast, first-time mothers, those newer to Canada, or those with fewer local supports appeared more exposed to confusion, isolation, and delayed access to information. In this way, support served not just as a personal resource but also as a key factor shaping who had access to opportunities based on their social identities. The results indicate that social capital, migration history, reproductive stage, and family circumstance worked together to shape whether the healthcare system appeared navigable or exclusionary.

Seeking Safe Harbour in Uncharted Waters

Patient-provider relationships were significant determinants of participants' perinatal experience and facilitated access to and use of perinatal healthcare. Participants described feeling supported not only when clinical care was available, but when healthcare providers were attentive, communicated clearly, demonstrated patience, and were respectful of their autonomy. These findings suggest that support through relational care can be significant to migrant and refugee women, especially if relational support offered by family and community is not available. A strong patient-provider relationship can mitigate risk factors such as social isolation, uncertainty about what to expect, and the need to navigate an unfamiliar and complex system.

A previous study by Gagnon et al. (2013) found that migrant women were at an increased susceptibility to health issues and were at a higher risk of having unmet healthcare needs. Study participants identified high-quality care as involving attentive listening, clear explanations, and emotional reassurance. These positive clinical encounters appeared to cultivate feelings of relational safety. These findings align with evidence from Baltzan et al. (2025), who reported

that across all phases of maternity care, migrant women spoke favourably of healthcare providers who were respectful and made them feel reassured and encouraged. Providing respectful care encourages and strengthens quality maternal care. Existing literature indicates that respectful and inclusive care is a key element of quality maternal care, as they foster an environment where patients feel safe and supported, thereby increasing the likelihood that they will ask questions and disclose concerns (Homer & Bohren, 2021). In this sense, respectful care acts as a structural facilitator of healthcare access.

Unpressured Options

Participants in this study emphasized the importance of autonomy and of not feeling pressured into making decisions. This is especially important for the study population, who may have originated from backgrounds where autonomy was not guaranteed. A study by Filler, Jameel, and Gagliardi (2020) on barriers and facilitators at the patient and clinician levels found that both clinicians and migrant women participants identified limited autonomy for women in decision-making as a barrier to care. When healthcare providers' respect for patient autonomy is demonstrated, patients reported feeling secure, prepared, and in control, especially when making decisions about delivery options or managing family responsibilities. These findings suggest that although vulnerabilities exist within this study population, healthcare providers should strive to cultivate environments that actively affirm patient autonomy and resist paternalistic assumptions about individuals or groups. A Canadian study looking at the disparities in autonomy during pregnancy found that facilitators of autonomy included building trust during perinatal visits and giving women time to decide. Comparatively, barriers to autonomy included limited knowledge about reproductive rights, limited birth preparation, or limited decisional capacity (Stoll et al., 2025).

The Velvet Rope System

This theme centers on information gatekeeping as a systemic barrier that actively blocks access to essential reproductive resources. The “velvet rope” metaphor highlights a significant contradiction. While the healthcare system appears open and well-resourced on the surface, it remains largely unattainable for many. Marginalized groups frequently lack the institutional knowledge or confidence required to navigate these complex networks. This is especially true for immigrant and refugee women with limited social networks. As a result, they are effectively “roped out” of adequate perinatal care. In practice, these barriers delay critical interventions and cause patients to miss opportunities for support. Instead, some are forced to rely on the emergency departments or unverified online sources. Analysis of the overarching theme, “Velvet Rope System,” revealed three distinct subthemes: “Navigating in the Dark;” “‘I Wish These Things Were Clearly Written Somewhere:’ Navigating the Unwritten Rules of the System;” and “Extending the Hand of Support.”

Navigating in the Dark

Participants’ ability to access perinatal resources was largely determined by their knowledge and how easily they could locate information. Insufficient information significantly limited their capacity to utilize available health services. Many participants indicated that healthcare providers did not direct them to relevant resources, leaving individuals to navigate the healthcare system independently and identify available options. A prior study confirms that the lack of integrated social services to support immigrant women's diverse needs hinders their navigation of and access to social support, and that health providers miss opportunities to provide information and linkages to other services (Finlayson et al., 2023).

Throughout the study, participants reported uncertainty about which services were available, the appropriate timing for seeking care, available options during pregnancy, pertinent questions to ask, and the available strategies for navigating an unfamiliar health system. Most participants learned about perinatal programs and support services through informal advice from conversations, social networks, or independent online research. These findings indicate that, although healthcare resources may formally exist, they often remain inaccessible due to a lack of visibility, unclear communication, or perceived complexity, particularly for immigrant and refugee women unfamiliar with provider roles and referral pathways. Therefore, access to information itself constitutes a critical determinant of healthcare access.

Gatekeeping of health information, whether intentional or unintentional, presents substantial barriers for immigrant women, particularly during vulnerable periods such as pregnancy. Immigrant women frequently receive inadequate guidance regarding prenatal care options because informational materials are often available exclusively in the dominant language, which restricts their understanding and ability to make informed decisions (Moreno-Santillan et al., 2025; Sudhinaraset et al., 2023). These findings indicate that healthcare access is influenced not only by the availability of services but also by the accessibility of information. This positions information as a critical determinant of access. This perspective posits that informational inequity constitutes a form of structural inequity. When healthcare systems require individuals to navigate services independently without ensuring equitable knowledge among all users, access to care becomes unevenly distributed.

“I Wish These Things Were Clearly Written Somewhere:” Navigating the Unwritten Rules of the System

Participants' desire for clear writing, structured timelines, and practical explanations of what to expect throughout pregnancy also underscored the importance of health literacy and anticipatory guidance. Some participants in this study wanted timely, relevant, and accessible information that would help them navigate each stage of the perinatal journey. This is significant because the burden of "figuring things out" was often placed on the women themselves, even when they were managing pregnancy in a new country with varying degrees of social support. These findings therefore support the view that effective maternal care for migrant and refugee women requires not only clinical responsiveness but also active guidance and explanation. Existing research on refugee and migrant perinatal health recommends using plain-language, socio-culturally appropriate health information and awareness initiatives, along with improved communication about antenatal and postpartum services (WHO, 2018). Viewing this theme through an intersectional lens reveals that information gaps do not affect everyone equally. Women who are new to Canada, have little local support, are experiencing their first pregnancy, or face financial and communication challenges are especially affected.

Extending the Hand of Support

Participants' suggestions for posters, booklets, provider lists, and early information-sharing at the point of pregnancy confirmation reveal a profound misalignment between institutional design and newcomers' realities. Health care systems often operate on the assumptions of universal literacy, uniform interpretation of information, individual confidence in self-advocacy, and reliable access to digital or informal networks. However, the findings indicate that these assumptions exclude some women more than others. Health literacy during pregnancy is shaped by a range of factors, including cultural background, educational attainment, and socioeconomic status. Existing research supports these results, indicating that pregnant women

are often required to navigate diverse sources of health information despite barriers faced by vulnerable populations (Meldgaard et al., 2022; Vicente-Díaz & Alvariñas-Villaverde, 2025; Riza et al., 2021; Hyman et al., 2022). This dynamic reproduces inequity, as women who know less at the start of their perinatal journey must work harder to understand the health system, secure care, and access much-needed resources (Azugbene & Buman, 2026; Kim et al., 2025; Plaisimond et al., 2025). A comprehensive understanding of health literacy levels among pregnant women allows health providers to design targeted outreach strategies. This approach empowers women to identify their own information gaps and successfully navigate healthcare services (Chandraker et al., 2025). These themes and subthemes illuminate the intersection between newcomer status, social support networks, health literacy, resource accessibility, and how these factors interact to influence perinatal healthcare use and access.

Hitting A Wall: The Living Toll

The lived experiences of immigrant women accessing healthcare in Southern Alberta demonstrated deep structural and systemic barriers that actively impede their care. Most participants in this study reported being directly affected by these institutional hurdles. Analysis of the third theme, "Hitting a Wall: The Living Toll," identified three distinct subthemes: "Like a Game of Perinatal Pinball;" "The Anxiety of Being Caught in a Time Trap;" and "Carrying the Weight in Silence."

Like A Game of Perinatal Pinball

This subtheme highlights how systemic healthcare barriers significantly increase vulnerability during pregnancy and postpartum recovery. For many participants, fragmented care was a primary source of anxiety. Instead of experiencing a smooth path, these women felt like pinballs tossed erratically through a broken machine. Compelled to bounce between multiple

providers and repeatedly recount their medical histories, patients felt overlooked and deeply uncertain. Extended wait times for emergency or diagnostic care only compounded this systemic bouncing. These gaps explicitly mirror broader evidence; continuity of care is vital for socially vulnerable women because consistent access builds trust, improves communication, and secures better birth outcomes (Lognos et al., 2024; Cellissen et al., 2026). For migrant and refugee women, these institutional shortcomings do not happen in a vacuum. Instead, they are aggravated by heavy logistical hurdles, from navigating unfamiliar referral systems to juggling childcare and limited transport. Ultimately, a standard health system issue takes on a much more hazardous dimension when it collides with the intersection of pregnancy, migration, and social inequities.

The Anxiety of Being Caught in a Time Trap

Ultimately, these findings reveal a harsh reality: race, accent, and gender-based expectations intersect to significantly distort patient care trajectories. This unequal treatment is not limited to migratory status. Rather than receiving objective medical care, immigrant and refugee women often encounter systemic barriers arising from entrenched cultural biases. Participants reported a consistent pattern of clinical neglect, with practitioners minimizing physical suffering and openly judging their accents. In practice, these discriminatory racial assumptions directly undermine a patient's safety. Navigating this intersection of bias does more than just cause emotional distress; it actively shuts down access to essential perinatal healthcare services. Participant accounts of postpartum complications and delayed responses show that when the system fails to react quickly or respectfully, it leaves women in danger. This aligns with other studies, which highlight the ill effects of delayed response to postpartum complications (Lee et al., 2026; Sacks et al., 2024; Zhu, 2023). This makes these experiences profoundly

troubling due to the heightened psychological and emotional vulnerability sometimes experienced during pregnancy. Such encounters may leave women feeling unsafe and excluded.

Carrying the Weight in Silence

Clinical neglect and patient safety gaps became clear through vivid participant accounts of ambiguous protocols, delayed care, and ignored postpartum complications. When institutional communication breaks down, it causes a direct psychological toll. These systemic failures forced participants into deep distress, sparking a pervasive fear that broke their trust in healthcare and made them highly reluctant to seek future medical care. On the other hand, positive interventions created a completely different experience. When providers responded promptly to crises and monitored situations closely while delivering respectful care, participants felt instantly protected and prioritized.

Mary's narrative highlights the heavy psychological toll of this protective barrier collapsing. She faced extended wait times for a critical ultrasound, an issue heavily compounded by an agonizing absence of feedback following an abnormal test result. This institutional silence caused severe, unrelenting anxiety. Because she could not secure answers from her physician until a routine appointment three weeks later, Mary felt completely abandoned, later concluding that the delay happened because her doctor simply failed to review her charts. Deng's experience also exposed severe safety vulnerabilities caused by incomplete postpartum care. For Deng, this clinical omission had a terrifying psychological effect, escalating directly into an active fear of dying.

By contrast, Moh's account illustrated how early safety interventions can actively change these negative experiences. During a life-threatening episode of placenta previa and bleeding,

quick risk recognition and immediate medical transfer to a higher level of care mitigated the emergency. The healthcare team's immediate response and clear communication created a direct sense of security, allowing Moh to feel completely safe despite the clinical crisis. These observations fit into a broader trend in perinatal safety. According to the United Nations Population Fund (2024), proactive provider responses and transparent tracking are essential to protect vulnerable patients from trauma and harm. In turn, these clinical tracking protocols directly support the collaborative, woman-centered frameworks advocated by Cellissen et al. (2024).

Existing literature shows that interactions with healthcare providers largely determine whether childbearing women build trust or experience deep distress (Leinweber & Stramrood, 2024). When medical staff listen attentively and show genuine empathy, this validation directly reduces patient fear and helps women feel both safe and empowered. On the other hand, when staff systematically ignore patient concerns, it triggers intense anxiety and erodes confidence (Barkensjö et al., 2016). While positive clinical interactions can create relational safety, care across the system remains highly inconsistent. This stark variation proves that a woman's social position does not just shape her experience; rather, deep-seated social inequities directly threaten her physical and emotional safety within the wider healthcare system (Basile-Ibrahim et al., 2024).

Among Black African participants, experiences of pain dismissal, neglect, and assumptions of exceptional strength demonstrated the intersection of racialized and gendered stereotypes within healthcare settings. The identification of the "Strong Black Woman" stereotype highlights how racialized beliefs regarding pain tolerance can shape healthcare providers' interpretations of patient distress. In *Anti-Black Medical Gaslighting in Healthcare:*

Experiences of Black Women in Canada, the authors documented how systemic racism in healthcare often results in clinicians dismissing Black women's symptoms. This erasure stems from an unfounded and persistent belief that these women have a higher pain tolerance and inherent resilience (Boakye et al., 2025).

Black African participants in this study encountered intersecting forms of oppression. As described by Crenshaw, they experienced not only racism or sexism, but specific forms of obstetric vulnerability that resulted from the unique ways their coexisting identities as women, migrants, and racialized individuals intersected (Crenshaw, 1991). An example from this study is Abigail, who reported being informed that Black women possess greater pain tolerance, which exemplifies a stereotype extensively critiqued in Black feminist theory (Saluja & Bryant, 2021; Brantley, 2023), as it perpetuates disbelief, undertreatment, and preventable harm. Stereotypes that inaccurately attribute higher pain tolerance to Black individuals distort the assessment of their discomfort (Drwecki, et al., 2018). As a result, healthcare providers may misjudge and undertreat Black patients' pain due to providers underestimating its severity (Tait & Chibnall, 2014; Taylor, 2020).

Accent bias demonstrates that language differences extend far beyond basic communication challenges to serve as systemic markers of social categorization. When healthcare providers profile patients based on their voices, this discrimination directly compromises care, which leaves patients feeling judged, ignored, or perceived as less deserving of medical care (Fuertes et al., 2012; Milroy, 2001). Deng's experience of accent-based dismissal proves that these breakdowns are never simple, technical misunderstandings. Linguistic exclusion operates as a direct site of clinical judgment and institutional power, revealing exactly how intersectionality manifests in practice. For these women, race, accent, and cultural

background did not exist independently; instead, they converged within clinical environments. When a patient's migration status collided with racialization and language barriers, her vulnerability escalated. This intersection created subtle yet deep forms of institutional exclusion that carried severe emotional consequences.

The Convergence of Inequality in Perinatal Care

Evaluating these findings through an intersectional framework confirms that perinatal health disparities are not isolated vulnerabilities. Instead, they are the direct result of structural power imbalances built into the healthcare system itself (Crenshaw, 1991). Informal support networks operate as a parallel infrastructure, stepping in to bridge critical institutional gaps (Khanlou et al., 2017; Rogers et al., 2021; Ewesesan et al., 2022). However, this community reliance exposes a deeper systemic failure: institutions routinely gatekeep basic information, turning healthcare knowledge into a barrier rather than an entry point to care (Sanchez et al., 2023). For immigrant and refugee women with "thin" social networks, this gatekeeping forces them to navigate an unfamiliar, fragmented system entirely on their own (Higginbottom et al., 2014).

This structural isolation gets even worse when combined with racial stereotypes, like the 'Strong Black Woman' myth, and accent discrimination (Fuertes et al., 2012; Milroy, 2001). When clinical staff assume a Black woman has a higher pain tolerance or dismiss a patient based on what they sound like, it is more than just individual prejudice. These actions activate deep structural biases that directly jeopardize patient safety. By forcing the rationing of care, they also trigger severe emotional distress (Hoffman et al., 2016; Gluszek & Dovidio, 2010; Hardeman et al., 2020; Drożdżowicz & Peled, 2024).

Remarkably, the unexpected findings from this study challenge the assumption that socioeconomic status protects against discrimination. Privilege did not shield these women. Even those with higher education, stable finances, and fluent English still faced systemic administrative neglect, dismissed pain, and ongoing barriers to care (Adegoke, 2025; Finlayson et al., 2023). This clinical exclusion rarely looked like open hostility. Instead, it showed up in routine administrative mistakes, missed referrals, and a total breakdown of tracking protocols when women moved between provinces (Guliani, 2015; Zhang, 2025). These results show that individual status cannot fully protect a patient inside a broken system. Ultimately, a woman's perinatal experience depends entirely on how care is organized and delivered, proving that health literacy is a structural outcome rather than a fixed personal trait (Meldgaard et al., 2022; Riza et al., 2021; Hyman et al., 2022; Bambra, 2022; Gkiouleka et al., 2018).

Strengths of the Study

Firstly, the study used a qualitative design to obtain detailed accounts of individual experiences that would not have been possible with a quantitative design. This qualitative approach also allowed for semi-structured interviews, which enabled participants to discuss their experiences with the health system, pregnancy, childbirth, and postpartum care directly. The qualitative design offered a clearer understanding of the systemic complications involved in traversing the perinatal healthcare system in Southern Alberta.

Secondly, the use of the intersectionality framework enhanced the study by facilitating a deeper understanding of participants' experiences. Using the intersectionality framework shows that these experiences are determined by multiple, overlapping factors, including race or ethnicity, accent, language, and family support. It also revealed that immigrant and refugee women may experience healthcare differently, even within the same geographic setting.

Thirdly, the participants' accounts were both rich and insightful, further strengthening the study. Although this sample size was small, the final group of seven participants was evaluated as having strong information power (Malterud et al., 2016). Because the women shared highly specific, first-hand experiences, the findings identified barriers to access and utilization, as well as enabling factors that supported healthcare engagement.

Limitations of Study

This qualitative study is one of the few to explore the perinatal experiences of immigrant and refugee women in Southern Alberta. The study provides important insight into the possible intersecting factors that may support or deter immigrant and refugee women's access to and use of perinatal healthcare. The objective of this study was not to extrapolate the findings and experiences to all immigrant and refugee women, but to gain an in-depth understanding of the specific population's lived experiences. However, several limitations of this study should be acknowledged.

A primary limitation of this study was the difficulty encountered during the recruitment phase. While I originally aimed for ten to twelve participants, seven months of continuous recruitment efforts only yielded seven. This hurdle was not due to a lack of interest, since high responsiveness was seen after flyer distribution and detailed project information was provided. During informal conversations, some individuals openly shared their personal experiences and even suggested peers who might fit the criteria. However, when it came to formal enrollment, the majority shared that they were nervous and uncertain regarding formal participation. Two additional individuals contacted me via phone and email to inquire about participating after the recruitment window had closed and data analysis had commenced. Due to this, I was unable to include them in the study.

Secondly, because the study primarily recruited women in Lethbridge, the findings reflect a more localized geographic context. While efforts were made to recruit participants from diverse sociocultural backgrounds, data collection was constrained by a low response rate, which limited the representation of multicultural groups within the immigrant and refugee population. Some participants who had previously delivered in other provinces provided comparisons between Southern Alberta and their previous province of delivery. While this added depth to the study, it limits the transferability of the findings to other settings. Healthcare access in Southern Alberta is shaped by specific contextual factors, such as provider shortages and specialized referral systems, which may differ greatly from other provinces.

Thirdly, this study had a small sample size of seven participants. Although this sample size is appropriate for an in-depth qualitative study (Creswell, 2013; Malterud, et al., 2013), a larger sample might have revealed additional themes and highlighted more intersectional differences (Vasileiou et al., 2018). Particularly, data from these seven participants provided sufficient information power to build a deep, interpretative analysis, which provided a rich understanding of how these specific immigrant women accessed perinatal healthcare. However, because the sample is small, these findings may not fully represent the wider experiences of immigrant women from different geographical or cultural backgrounds navigating the healthcare system.

Fourthly, a considerable limitation arises from the composition of the sample. Only one participant in this study entered Canada as a Government-Assisted Refugee. Since this individual possesses a refugee background, her unique entry class and resettlement history differentiated her from the other immigrant participants. Given that her viewpoint is the only one representing this background, the study's findings predominantly reflected the perspectives of immigrants without

this specific forced-migration history. While this single account provides valuable insight into her individual experience, it does not allow transferability to other immigrants from refugee backgrounds and their healthcare use and access. Therefore, this perspective should be understood as an isolated viewpoint rather than a pattern of shared meaning.

Fifthly, most participants were married, had attained some post-secondary education, and reported being able to communicate in English, as evidenced by their participation in an English-language interview. Therefore, the study may fail to accurately depict the experiences of migrant and refugee women who are socially isolated, parenting without partner support, have lower levels of formal education, or need language assistance for communication. These intersecting factors could greatly affect healthcare utilization and access, particularly among segments of this population with low health literacy, or who may be experiencing greater systemic inequities. Therefore, these findings reflect a localized set of meanings rather than the full diversity of experiences across the wider newcomer perinatal cohort.

Self-selection bias presents a final limitation here. Although I applied inclusion and exclusion criteria to lower this risk, some bias likely remains. Participants who chose to share their experiences may have been driven by either strong positive or negative interactions with health providers or the health system. By contrast, those who are more private, overwhelmed, or experiencing financial distress may have been harder to reach. Ultimately, those with higher educational attainment are more likely to volunteer for participation in studies. The unique insights of those with lower educational attainment or social status may be underrepresented, thus overrepresenting women with the time, confidence, and educational advantage to participate.

Reflexivity

This section presents my reflexivity as a researcher. It describes how my reflexivity informed my research approach and was incorporated into data coding, analysis, and interpretation of findings. As a Caribbean immigrant woman of mixed ancestry, I acknowledge that complete detachment from the research process is both impossible and counterproductive. My background inevitably shaped how I interacted with the data. My personal history and beliefs have influenced both data collection and interpretation. I am visibly a woman of colour and, within North American contexts, am identified solely as a Black woman. My upbringing in a matrifocal society has shaped my worldviews, beliefs, and expectations. Furthermore, I have personally experienced pregnancy and have accessed the perinatal healthcare system in Southern Alberta.

The perinatal healthcare system in Southern Alberta contrasts markedly with that of the Caribbean. Much of my understanding of the Caribbean healthcare system stems from childhood memories, especially during my mother's pregnancy. This personal foundation is reinforced by the lived experiences of friends and family who navigate the system both as patients and healthcare professionals. These dual vantage points provide a sharp contrast to my time in Canada, allowing for a more critical comparative analysis of both systems. In the Caribbean, family physicians do not function as gatekeepers, and individuals may consult specialists directly. During pregnancy, women generally see a gynaecologist from the beginning of care through to delivery. Wait times are typically shorter, and specialized testing and results are frequently available within the same day or week.

I experienced considerable disappointment and frustration with the perinatal health system and the care I received in Southern Alberta. My negative experiences began at my initial prenatal visit, when a physician insisted I was not pregnant despite my report of three positive

pregnancy tests. Subsequently, the clinic receptionist contacted me to apologize, explaining that my urine sample had been mixed up with that of a senior patient, thereby confirming my initial claim. A follow-up appointment was scheduled a few days later. This incident was not isolated.

Throughout my perinatal experience in Southern Alberta, I encountered racial bias, difficulties navigating the perinatal system in Lethbridge, limited awareness of available resources, fragmented care, and the dismissal of my pain, symptoms, and observations. These challenges were particularly pronounced given my prior knowledge of the healthcare system in my birth country, where I had greater agency over my care. I recall instances in which providers dismissed my symptoms, requiring me to advocate persistently for a referral to a gynaecologist, repeatedly explain my concerns to different providers, and ultimately be discharged after a traumatic birth and hemorrhaging without pain medication. In contrast, my neighbour, who was white and gave birth a month earlier with the same maternity doctors, received pain medication and a follow-up appointment with the delivering physician.

I share these experiences to demonstrate that my interactions with the perinatal healthcare system still carry weight, even after more than a decade. My interest in this topic stems from years of reflecting on whether the system has genuinely evolved. It also grew out of raw conversations with other immigrant and refugee women regarding their own encounters and critiques. Ultimately, these discussions forced me to confront wider concerns regarding reproductive justice, bodily autonomy, and healthcare accountability. Far from a detached academic exercise, this study served as a dual process: a personal journey toward healing and a scholarly effort to map how immigrant and refugee women navigate maternal care in Southern Alberta.

Throughout this study, I consistently practiced reflexivity. Although my interpretations were grounded in participants' narratives, the processes of coding, theme development, and analysis required subjective judgment about what was most meaningful, which may have been influenced by my prior experiences. To ensure the final findings genuinely reflected the participants' perspectives rather than my own biases, I integrated member-checking into the research design, allowing participants to directly validate the accuracy of my interpretations.

To isolate personal preconceptions from the data, I maintained a reflexive memo log immediately following each interview and coding session (Appendix G). Documenting these immediate emotional reactions and analytical queries provided a transparent framework to confront potential biases before they could skew the coding process. This continuous self-auditing was paired with exhaustive transcript immersion. By reviewing the data multiple times, comparing notes across different days, and cross-checking emerging discrepancies, the analysis remained strictly anchored to the text. In practice, this moving back and forth between raw transcripts and emerging themes kept my personal biases in check. By anchoring every claim directly in the data, I ensured the final discussion stayed completely true to the participants' experiences.

Recommendations for Future Research

Although this study has certain limitations, its findings contribute to a deeper understanding of the perinatal experiences of migrant and refugee women in Southern Alberta. These insights advance the ongoing discourse on the challenges this population faces and potential improvements in care. Future research should build on these findings. Areas for further research have been identified, and recommendations are outlined below.

Accent bias and communication challenges were highlighted in this study. Future research should focus on women who require interpretation services. The participants in this study completed the interview in English. Their views and experiences may differ from those of participants who face a language barrier. Conducting research using trained interpreters who can adequately convey participants' experiences would add an even greater depth to this body of research on how communication barriers, health literacy, and partial or full language exclusion shape access, use, and decision-making when accessing healthcare services during the perinatal period.

Some of the study's participants suggested that health system navigation and information dissemination needed greater improvement. It was stated that access to care depended heavily on insider knowledge and informal networks rather than on transparent institutional communication. Future research could examine the most appropriate outreach strategy for the target population. It could also study effective information tools, digital or non-digital forms of information delivery, and what community and system navigation supports would best serve the population. Research in this area may help reduce information inequities in health system navigation and dissemination.

While this research centred on patient experiences, insights can be gained from future research that examines the perspectives of healthcare providers and decision-makers. Some barriers mentioned in this study, such as fragmented care, limited continuity, and delayed referrals, can be analyzed more thoroughly to deepen understanding of how these barriers are formed and maintained. This research could go a step further and examine structural racism and the racialization of pain among this population. Health providers may not be aware of the harm that occurs because of racialization and other racialized stereotypes, such as the “Strong Black

Woman.” Further research could inform education and training for health providers, as well as maternity care practices rooted in anti-racism.

Finally, future research should recruit a larger, more varied sample that includes multiple geographic settings within Alberta and across Canada. Although the current political climate has reduced the number of immigrants entering Canada, a significant number of newcomers remain of childbearing age. Expanding the participant pool would provide richer and more nuanced accounts of perinatal experiences across cultural, socioeconomic, and family backgrounds. Future research can clarify how specific immigration categories, including private sponsorship, temporary residency, or asylum status, shape healthcare utilization. Including participants from throughout Alberta and Canada would allow researchers to compare rural and urban areas across the country. This approach would identify which barriers are unique to certain locations and which are more widespread. It would also identify which maternal care models best serve rural communities versus larger cities.

Significance of the Study and Implications for Practice

This study’s intent was to explore the perinatal experiences of immigrant women in Southern Alberta and to understand the factors that support or deter their access to and utilization of perinatal healthcare. It employed the intersectionality framework and, as such, contributed to the body of work using this framework. The findings from this study have important implications for healthcare practice. It demonstrates that access to care is shaped by multiple factors, including availability of resources, relationships with providers, information dissemination, and the communication of available resources to the targeted population. Stakeholders such as policymakers, health professionals, immigrant-serving agencies, community organizations, and health decision-makers would be provided with invaluable

information to enable a more inclusive and responsive model of perinatal care, thereby enhancing service delivery, access, and utilization of perinatal health services.

Many participants in my study described their experiences with disjointed care pathways, alternating among health providers, and, in some instances, having to retell their health issues to providers. This may be frustrating and undermines trust in the healthcare system and health providers. Implications for practice should then focus on bolstering continuity of care, especially for populations who may not understand the complexity of the healthcare system. It is understandable that ongoing provider shortages and various structural limitations may not be a quick fix and may take some time to address. However, creating a straightforward coordinated referral process and careful review of patient charts ensures more consistent care. When seamless handover between providers and clear communication between patients and providers occur, it helps ensure that this population understands their care and is involved in it. Streamlining care would help to support the perinatal care experience for this population.

Another implication for practice that was evident in the findings of this study is culturally safe and trauma-informed care. Participants described instances of poor communication, dismissed concerns, perceived racism, and delayed care. This led to emotional distress, uncertainty, and mistrust of providers and the health system. In contrast, participants described feeling supported and acknowledged when health providers were respectful, attentive, patient, clear, and responsive to their concerns. Women from refugee backgrounds may have previously experienced displacement, neglect, and exclusion. These experiences can strongly influence how they interact with health systems and providers. When implementing culturally safe and trauma-informed care, perinatal health providers can validate patient concerns, listen attentively, explain procedures clearly, emphasize safety, and address discrimination and power imbalances.

Providers also need to examine how assumptions about race, culture, accents, and pain tolerance may influence how they provide care. These assumptions can put immigrant and refugee women at a disadvantage.

The final implication for practice is having equitable, barrier-free information sharing and access. Throughout this study, many participants reported learning about available services, programs, and provider options through informal networks, such as friends and family. Even though they had already contacted a health provider, they were still not informed about available health resources and information. Although the information and services may be available to everyone, it appears that this information is not reaching all audiences, especially those who may be more marginalized. For implementation, providers should assume that patients are unaware of the available support and programs. At all stages of the perinatal journey, health workers should provide information on pregnancy, birth, postpartum care, provider choices, available programs, and anything else deemed necessary based on the individual patient's needs. Shifting from a biomedical approach to a more relational approach would allow health providers to become privy to a patient's needs and spot where information is missing. While perinatal health information may be equally available, its actual distribution remains inequitable.

Knowledge Mobilization

A printed copy of this thesis is available at the University of Lethbridge through the library catalogue and the digital thesis through OPUS, which is the University of Lethbridge Research Repository. This will contribute to the existing body of research on this topic and ensure widespread availability to all. The results of this study were shared with organizations that assist immigrant and refugee women in accessing and navigating health services. Sharing it with community organizations, religious organizations, and other culturally serving organizations

would benefit from the information. They would be able to distribute it, discuss it with one another, and, hopefully, establish a perinatal health plan to navigate the healthcare system. Results will also be disseminated to participants in this study who requested to receive them. Finally, when the opportunity presents itself, I will share the findings of this study with stakeholders such as immigrant-serving organizations, policy working groups, university classes, and other related workshops. I will also explore opportunities to present at conferences focused on immigrant women's access to and use of perinatal healthcare and will seek to publish my research in qualitative journals such as the Canadian Journal of Multidisciplinary Qualitative Research. This approach allows me to broaden the accessibility and depth of the study's findings for a wider range of stakeholder groups. Disseminating this information will ensure valuable insights are gained that may inform perinatal services and programs benefiting the study population.

Conclusion

In answering the research question, relational care actively expanded healthcare access. When providers listened genuinely and offered clear explanations, they completely transformed the clinical experience. Respect for autonomy stood out as another critical factor. This occurred when patients made decisions with adequate information and true freedom of choice. To navigate this, participants relied heavily on personal networks, often calling them "The Village," to help manage the everyday tasks needed to access healthcare. Family, neighbors, and their immigrant community stepped in to provide this hands-on, practical support. This deep reliance on communal networks underscores why relational continuity is so essential to a patient's overall care. Having healthcare providers who were already familiar with patients' histories directly eliminated the frustrating requirement for women to repeatedly recount their medical experiences

across separate clinic visits. On the other hand, clinics severely hindered utilization by failing to proactively provide critical information. This administrative gatekeeping rendered available services completely invisible to patients, despite their physical presence. A fractured system created distinct structural barriers. It indirectly forced pregnant and postpartum women to constantly retell their histories while enduring delayed diagnostics, undermining patient trust and directly compromising health outcomes for socially vulnerable groups. This lack of safety grew worse when providers relied on racialized assumptions regarding the pain tolerance and physical endurance of Black women. Accent bias further closed doors, as staff devalued a participant's input based on their linguistic identity. In the end, informal support networks step in to mask these systemic flaws. While community reliance keeps patients safe, it inadvertently hides deep structural failures within formal healthcare delivery.

References

- Adegoke, K., Adegoke, A., Dawodu, D., & Kayode, T. (2025). Systemic racism in Canadian healthcare: A policy and equity analysis. *Journal of Primary Care & Community Health, 16*, Article 21501319251386672. <https://doi.org/10.1177/21501319251386672>
- Alaska Department of Health. Division of Public Health. (n.d.). *What is perinatal health?* <https://health.alaska.gov/dph/wcfh/Pages/perinatal/default.aspx>
- Allen, C., Van, C. M., & Mossburg, S. E. (2023, March 29). *Maternal safety and perinatal mental health*. PSNet. Agency for Healthcare Research and Quality. <https://psnet.ahrq.gov/perspective/maternal-safety-and-perinatal-mental-health>
- Almeida, L. M., Caldas, J., Ayres-de-Campos, D., Salcedo-Barrientos, D., & Dias, S. (2013). Maternal healthcare in migrants: A systematic review. *Maternal & Child Health Journal, 17*(8), 1346–1354. <https://doi.org/10.1007/s10995-012-1149-x>
- Almond, D., Currie, J., & Duque, V. (2018). Childhood circumstances and adult outcomes: Act II. *Journal of Economic Literature, 56*(4), 1360–1446.
- Altman, M. R., Oseguera, T., McLemore, M. R., Kantrowitz-Gordon, I., Franck, L. S., & Lyndon, A. (2019). Information and power: Women of color's experiences interacting with health care providers in pregnancy and birth. *Social Science & Medicine, 238*, Article 112491. <https://doi.org/10.1016/j.socscimed.2019.112491>
- American Psychological Association. (n.d.). Introjection. In *APA dictionary of psychology*. <https://dictionary.apa.org/introjection>
- Attanasio, L., & Kozhimannil, K. B. (2015). Patient-reported communication quality and perceived discrimination in maternity care. *Medical Care, 53*(10), 863–871. <https://doi.org/10.1097/MLR.0000000000000411>
- Azugbene, E. A., & Buman, M. P. (2026). Reframing maternal health literacy as a structural determinant: A health systems equity agenda. *SSM - Health Systems, 7*, Article 100266. <https://doi.org/10.1016/j.ssmhs.2026.100266>
- Bambra, C. (2022). Placing intersectional inequalities in health. *Health & Place, 75*, Article 102761. <https://doi.org/10.1016/j.healthplace.2022.102761>
- Baltzan, I., Merry, L., Fraser, W., Semenik, S., Pelaez, S., Edington, A., Baig, A., & Gagnon, A. (2025). Migrant-friendly maternity care in Montreal, Canada: A cross-sectional study on migrant women's care perspectives. *PLoS One, 20*(8), Article e0330830. <https://doi.org/10.1371/journal.pone.0330830>
- Barkensjö, M., Greenbrook, J. T. V., Rosenlundh, J., Ascher, H., & Elden, H. (2018). The need for trust and safety inducing encounters: A qualitative exploration of women's experiences of seeking perinatal care when living as undocumented migrants in Sweden.

- BMC Pregnancy and Childbirth*, 18, Article 217. <https://doi.org/10.1186/s12884-018-1851-9>
- Barrett, D., & Twycross, A. (2018). Data collection in qualitative research. *Evidence-Based Nursing*, 21(3), 63–64. <https://doi.org/10.1136/eb-2018-102939>
- Barry, V. G., Johnson, T. N., Herrick, C., Lindley, K., & Carter, E. B. (2022). Adverse pregnancy outcomes and postpartum care as a pathway to future health. *Clinical Obstetrics and Gynecology*, 65(3), 632–647. <https://doi.org/10.1097/GRF.0000000000000724>
- Basile-Ibrahim, B., Combellick, J., Mead, T. L., Sorensen, A., Batten, J., & Schafer, R. (2024). The social context of pregnancy, respectful maternity care, biomarkers of weathering, and postpartum mental health inequities: A scoping review. *International Journal of Environmental Research and Public Health*, 21(4), Article 480. <https://doi.org/10.3390/ijerph21040480>
- Bayram, P., & Sakarya, S. (2023). Oppression and internalized oppression as an emerging theme in accessing healthcare: Findings from a qualitative study assessing first-language related barriers among the Kurds in Turkey. *International Journal for Equity in Health*, 22(1), Article 5.
- Behboudi-Gandevani, S., Bidhendi-Yarandi, R., Panahi, M. H., Mardani, A., Prinds, C., & Vaismoradi, M. (2022). Perinatal and neonatal outcomes in immigrants from conflict-zone countries: A systematic review and meta-analysis of observational studies. *Frontiers in Public Health*, 10, Article 766943. <https://doi.org/10.3389/fpubh.2022.766943>
- Bingham, A. J. (2023). From data management to actionable findings: A five-phase process of qualitative data analysis. *International Journal of Qualitative Methods*, 22, 1–11. <https://doi.org/10.1177/16094069231183620>
- Boakye, P. N., Prendergast, N., Bailey, A., Sharon, M., Bandari, B., Odutayo, A., & Anane Brown, E. (2025). Anti-black medical gaslighting in healthcare: Experiences of Black women in Canada. *Canadian Journal of Nursing Research*, 57(1), 59–68.
- Boerleider, A. W., Wieggers, T. A., Manniën, J., Francke, A. L., & Devillé, W. L. J. M. (2013). Factors affecting the use of prenatal care by non-western women in industrialized western countries: A systematic review. *BMC Pregnancy and Childbirth*, 13, Article 81. <https://doi.org/10.1186/1471-2393-13-81>
- Bowleg, L. (2012). The problem with the phrase *women and minorities*: Intersectionality—an important theoretical framework for public health. *American Journal of Public Health*, 102(7), 1267–1273. <https://doi.org/10.2105/AJPH.2012.300750>

- Boyle, J., Willey, S. M., & Abbasova, G. (2018, March 1). Supporting better outcomes for migrant and refugee women. *O&G Magazine*, 20(1).
<https://www.ogmagazine.org.au/20/1-20/better-outcomes-migrant-refugee-women/>
- Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, 4, 1–8.
<https://doi.org/10.1177/2333393617742282>
- Brantley, M. (2023). Black feminist theory in maternal health research: A review of concepts and future directions. *Sociology Compass*, 17(5), Article e13083.
<https://doi.org/10.1111/soc4.13083>
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage Publications, Thousand Oaks (2013).
- Braun, V., & Clarke, V. (2019). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, 13(2), 201–216.
<https://doi.org/10.1080/2159676X.2019.1704846>
- Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, 18(3), 328–352.
<https://doi.org/10.1080/14780887.2020.1769238>
- Braun, V., & Clarke, V. (2022). *Thematic Analysis: A practical guide*. SAGE Publications.
- Business Council of Alberta. (2023, August 2). *A snapshot of Canadian immigration (Part 1): Who is immigrating to Canada and Alberta?* <https://businesscouncilab.com/insights-category/immigration-snapshot-who-is-immigrating-to-canada-and-alberta/>
- Cambridge University Press. (n.d.). Institutional racism. In *Cambridge advanced learner's dictionary & thesaurus*.
<https://dictionary.cambridge.org/us/dictionary/english/institutional-racism>
- Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada. (2022). *Tri-Council policy statement: Ethical conduct for research involving humans* (TCPS 2 2022). Secretariat on Responsible Conduct of Research.
<https://ethics.gc.ca/eng/documents/tcps2-2022-en.pdf>
- Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist*, 35(1), 13–105.
- Cellissen, E., Hendrix, M. J. C., Budé, L., Shareef, N., Vogels-Broeke, M., & Nieuwenhuijze, M. J. (2024). Integrated maternity care: A concept analysis. *PLOS ONE*, 19(7), e0306979.

- Cellissen, E., Hendrix, M. J. C., Budé, L., Shareef, N., Vogels-Broeke, M., & Nieuwenhuijze, M. J. (2026). Women's experience of continuity during antenatal care: A cross-sectional study in the Netherlands. *Birth*, 53(1), 145–154. <https://doi.org/10.1111/birt.70008>
- Chandrakar, A., Ramasamy, S., Galhotra, A., & Shenoy, M. S. (2025). Maternal health literacy (MHL) for improved maternal and child outcomes: A scoping review. *Indian Journal of Community Medicine*, 50(5), 733–738. https://doi.org/10.4103/ijcm.ijcm_390_24
- Coleman, H., Pemu, A., Rankin, J., Heslehurst, N., & Brown, H. (2018). Perinatal health outcomes and care among asylum seekers and refugees: A systematic review of systematic reviews. *BMC Medicine*, 16, Article 179.
- Columbia Law School. (2017, June 8). *Kimberlé Crenshaw on intersectionality, more than two decades later* [Interview]. <https://www.law.columbia.edu/news/archive/kimberle-crenshaw-intersectionality-more-two-decades-later>
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989(1), Article 8. <https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8>
- Crenshaw, K. (1991). Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241–1299. <https://doi.org/10.2307/1229039>
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). SAGE Publications.
- Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). Sage.
- Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE Publications.
- Crump, C., Sundquist, J., & Sundquist, K. (2024). Adverse pregnancy outcomes and long-term mortality in women. *JAMA Internal Medicine*, 184(6), 631–640.
- Debessai, Y., Costanian, C., Roy, M., El-Sayed, M., & Tamim, H. (2016). Inadequate prenatal care use among Canadian mothers: Findings from the Maternity Experiences Survey. *Journal of Perinatology*, 36(6), 420–426. <https://doi.org/10.1038/jp.2015.218>
- Department of Finance Canada. (2026, May 13). *Canada Health Transfer*. Government of Canada. <https://www.canada.ca/en/departement-finance/programs/federal-transfers/canada-health-transfer.htm>
- DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health*, 7(2), Article e000057.

- DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, 40(4), 314–321. <https://doi.org/10.1111/j.1365-2929.2006.02418>.
- Drożdżowicz, A., & Peled, Y. (2024). The complexities of linguistic discrimination. *Philosophical Psychology*, 37(6), 1459–1479.
- Drwecki, B. B. (2018). Race and pain: A dual injustice. In *Social and interpersonal dynamics in pain* (pp. 455–480). Springer International Publishing.
- Eslier, M., Deneux-Tharaux, C., Sauvegrain, P., Schmitz, T., Luton, D., Mandelbrot, L., Estellat, C., & Azria, E. (2020). Association between migrant women's legal status and prenatal care utilization in the PreCARE cohort. *International Journal of Environmental Research and Public Health*, 17(19), Article 7174. <https://doi.org/10.3390/ijerph17197174>
- Elshahat, S., Moffat, T., & Newbold, K. B. (2022). Understanding the healthy immigrant effect in the context of mental health challenges: A systematic critical review. *Journal of Immigrant and Minority Health*, 24(6), 1564–1579. <https://doi.org/10.1007/s10903-021-01313-5>
- Ewesesan, R., Chartier, M. J., Nickel, N. C., Wall-Wieler, E., & Urquia, M. L. (2022). Psychosocial and behavioral health indicators among immigrant and non-immigrant recent mothers. *BMC Pregnancy and Childbirth*, 22, Article 612. <https://doi.org/10.1186/s12884-022-04937-z>
- Fair, F., Raben, L., Watson, H., Vivilaki, V., van den Muijsenbergh, M., & Soltani, H. (2020). Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. *PLOS ONE*, 15(2), Article e0228378. [doi.org](https://doi.org/10.1371/journal.pone.0228378)
- Fellmeth, G., Fazel, M., & Plugge, E. (2017). Migration and perinatal mental health in women from low- and middle-income countries: A systematic review and meta-analysis. *BJOG: An International Journal of Obstetrics & Gynaecology*, 124(5), 742–752. <https://doi.org/10.1111/1471-0528.14184>
- Filler, T., Jameel, B., & Gagliardi, A. R. (2020). Barriers and facilitators of patient centered care for immigrant and refugee women: A scoping review. *BMC Public Health*, 20, Article 1013. <https://doi.org/10.1186/s12889-020-09159-6>
- Finlayson, K., Sacks, E., Brizuela, V., Torlesse, H., Lawrie, T. A., & Downe, S. (2023). Factors that influence the uptake of postnatal care from the perspective of fathers, partners and other family members: A qualitative evidence synthesis. *BMJ Global Health*, 8(Suppl 2), Article e011086.
- Fuertes, J. N., Gottdiener, W. H., Martin, H., Gilbert, T. C., & Giles, H. (2012). A meta-analysis of the effects of speakers' accents on interpersonal evaluations. *European Journal of Social Psychology*, 42(2), 120–133. <https://doi.org/10.1002/ejsp.862>

- Fuller-Thomson, E., Noack, A. M., & George, U. (2011). Health decline among recent immigrants to Canada: Findings from a nationally-representative longitudinal survey. *Canadian Journal of Public Health*, 102(4), 273–280. <https://doi.org/10.1007/BF03404048>
- Gagnon, A. J., Carnevale, F. A., Saucier, J. F., Clausen, C., Jeannotte, J., & Oxman-Martinez, J. (2010). Do referrals work? Responses of childbearing newcomers to referrals for care. *Journal of Immigrant and Minority Health*, 12(4), 559–568. <https://doi.org/10.1007/s10903-009-9242-y>
- Gagnon, A. J., Carnevale, F., Mehta, P., Rousseau, H., & Stewart, D. E. (2013). Developing population interventions with migrant women for maternal-child health: A focused ethnography. *BMC Public Health*, 13, Article 471. <https://doi.org/10.1186/1471-2458-13-471>
- Gao, W., Paterson, J., & Schmied, V. (2018). Unique trajectories of anxiety among Chinese-Canadian immigrant and Canadian-born women over the first postpartum year. *Journal of Affective Disorders*, 234, 184–190.
- Gibson-Helm, M., Teede, H. J., Cheng, I.-H., Block, A., Knight, M., East, C. E., Wallace, E. M., & Boyle, J. A. (2015). Maternal health and pregnancy outcomes comparing migrant women born in humanitarian and nonhumanitarian source countries: A retrospective, observational study. *Birth*, 42(2), 116–124. <https://doi.org/10.1111/birt.12159>
- Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal*, 204(6), 291–295. <https://doi.org/10.1038/bdj.2008.192>
- Gkiouleka, A., Huijts, T., Beckfield, J., & Bambra, C. (2018). Understanding the micro and macro politics of health: Inequalities, intersectionality & institutions - A research agenda. *Social Science & Medicine*, 200, 92–98. <https://doi.org/10.1016/j.socscimed.2018.01.025>
- Global Affairs Canada. (2017). *Canada's feminist international assistance policy*. <https://www.international.gc.ca/world-monde/assets/pdfs/iap2-eng.pdf>
- Global Affairs Canada. (2024, January 22). *Canada and the United Nations High Commissioner for Refugees*. Government of Canada. https://www.international.gc.ca/world-monde/international_relations-relations_internationales/multilateral-multilateraux/unhcr-hcr.aspx?lang=eng
- Global Migration Data Analysis Centre. (2023). *International migrant stocks*. Migration Data Portal. migrationdataportal.org
- Gluszek, A., & Dovidio, J. F. (2010). The way they speak: A social psychological perspective on accent stigma. *Journal of Language and Social Psychology*, 29(2), 214–237. [doi.org](https://doi.org/10.1177/0261927510381000)

- Government of Alberta. (2023). *Alberta economic indicators at a glance*. Treasury Board and Finance. <https://open.alberta.ca/dataset/51710c00-0277-47e3-b368-c8e1f8955c09/resource/873603d2-7d6f-4877-bd7e-86926ae3a656/download/tbf-alberta-economic-indicators-at-glance-2023-06-30.pdf>
- Government of Alberta. (2024, September 25). *Quarterly population report: Second quarter 2024*. Office of Statistics and Information; Treasury Board and Finance. <https://open.alberta.ca/dataset/6b5d7997-6062-474f-a955-837fbab70a89/resource/4eec18e4-fc55-4824-a04d-c9385801a25d/download/tbf-quarterly-population-report-q2-2024.pdf>
- Government of Alberta. (2025). *Annual population report, Alberta 2024-25*. Treasury Board and Finance. <https://open.alberta.ca/dataset/1050cf0a-8c1d-4875-9800-b7d2f3199e41/resource/840ff40a-b421-4e72-8d57-af884658d680/download/tbf-annual-population-report-alberta-2024-2025.pdf>
- Government of Canada. (2023a, October 10). *Canada's health care system*. <https://www.canada.ca/en/health-canada/services/canada-health-care-system.html>
- Government of Canada. (2023b, August 16). *Research Ethics Board: Consent process*. <https://www.canada.ca/en/health-canada/services/science-research/science-advice-decision-making/research-ethics-board/consent-process.html#a2>
- Grand-Guillaume-Perrenoud, J. A., Origlia, P., & Cignacco, E. (2022). Barriers and facilitators of maternal healthcare utilisation in the perinatal period among women with social disadvantage: A theory-guided systematic review. *Midwifery*, 105, Article 103237. <https://doi.org/10.1016/j.midw.2021.103237>
- Green, M. A., Evans, C. R., & Subramanian, S. V. (2017). Can intersectionality theory enrich population health research? *Social Science & Medicine*, 178, 214–216. doi.org
- Guliani, H. (2015). Mix of maternity care providers in Canada. *Healthcare Policy = Politiques de Santé*, 11(1), 46–60.
- Gushulak, B., Pottie, K., Hatcher Roberts, J., Torres, S., & DesMeules, M. (2011). Migration and health in Canada: Health in the global village. *CMAJ*, 183(12), E952–E958. doi.org
- Hajira, B., Jackson, K., Hawa, R. K., & Shahil-Feroz, A. (2026). Perinatal mental health among South Asian immigrant women in Canada: A scoping review protocol. *PLOS ONE*, 21(7), e0354152.
- Hart, J. T. (1971). The inverse care law. *The Lancet*, 1(7696), 405–412. [https://doi.org/10.1016/S0140-6736\(71\)92410-X](https://doi.org/10.1016/S0140-6736(71)92410-X)
- Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: Critical

- reflections on a methodology for advancing equity. *International Journal for Equity in Health*, 13, Article 119. <https://doi.org/10.1186/s12939-014-0119-x>
- Hankivsky, O., Doyal, L., Einstein, G., Kelly, U., Shim, J., Weber, L., & Repta, R. (2017). The odd couple: Using biomedical and intersectional approaches to address health inequities. *Global Health Action*, 10(Suppl. 2), Article 1326686. <https://doi.org/10.1080/16549716.2017.1326686>
- Hanson, M. A., & Gluckman, P. D. (2014). Early developmental conditioning of later health and disease: Physiology or pathophysiology? *Physiological Reviews*, 94(4), 1027–1076. <https://doi.org/10.1152/physrev.00029.2013>
- Hardeman, R. R., Medina, E. M., & Boyd, R. W. (2020). Stolen breaths. *The New England Journal of Medicine*, 383(3), 197–199.
- Health Canada. (2023). *Canada Health Act: Annual report 2021–2022*. Government of Canada. <https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/canada-health-act-annual-report-2021-2022/canada-health-act-annual-report-2021-2022-eng.pdf>
- Health Canada. (2025, June 25). *About Canada's health care system*. Government of Canada. <https://www.canada.ca/en/health-canada/services/canada-health-care-system.html>
- Henderson, J., Carson, C., Jayaweera, H., Alderdice, F., & Redshaw, M. (2018). Recency of migration, region of origin and women's experience of maternity care in England: Evidence from a large cross-sectional survey. *Midwifery*, 67, 87–94. doi.org
- Heslehurst, N., Brown, H., Pemu, A., Coleman, H., & Rankin, J. (2018). Perinatal health outcomes and care among asylum seekers and refugees: A systematic review of systematic reviews. *BMC Medicine*, 16, Article 179. <https://doi.org/10.1186/s12916-018-1064-0>
- Higginbottom, G. M., Hadziabdic, E., Yohani, S., & Paton, P. (2014). Immigrant women's experience of maternity services in Canada: A meta-ethnography. *Midwifery*, 30(5), 544–559. <https://doi.org/10.1016/j.midw.2013.06.004>
- Higginbottom, G. M., Morgan, M., Alexandre, M., Chiu, Y., Forgeron, J., Kocay, D., & Barolia, R. (2015). Immigrant women's experiences of maternity-care services in Canada: A systematic review using a narrative synthesis. *Systematic Reviews*, 4, Article 13. <https://doi.org/10.1186/2046-4053-4-13>
- Holloway, J. (1997). *Basic concepts for qualitative research*. Blackwell Science.
- Homer, C. S., & Bohren, M. A. (2021). Achieving inclusive and respectful maternity care. *Global Library of Women's Medicine*. <https://doi.org/10.3843/GLOWM.411763>

- Hudon, T. (2015, October 21). Immigrant women. In *Women in Canada: A gender-based statistical report* (7th ed., Catalogue no. 89-503-X). Statistics Canada. <https://www150.statcan.gc.ca/n1/en/pub/89-503-x/2015001/article/14217-eng.pdf?st=MkHqrx3>
- Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between Blacks and Whites. *Proceedings of the National Academy of Sciences*, 113(16), 4296–4301.
- Hyman, A., Stacy, E., Mohsin, H., Atkinson, K., Stewart, K., Novak Lauscher, H., & Ho, K. (2022). Barriers and facilitators to accessing digital health tools faced by South Asian Canadians in Surrey, British Columbia: Community-based participatory action exploration using photovoice. *Journal of Medical Internet Research*, 24(1), Article e25863. <https://doi.org/10.2196/25863>
- Immigration, Refugees and Citizenship Canada. (2023). *2023 Annual Report to Parliament on Immigration*. Government of Canada. <https://www.canada.ca/content/dam/ircc/documents/pdf/english/corporate/publications-manuals/annual-report-2023-en.pdf>
- Immigration, Refugees and Citizenship Canada. (2024, November 21). *An immigration system for Canada's future: Context*. Government of Canada. <https://www.canada.ca/en/immigration-refugees-citizenship/campaigns/canada-future-immigration-system/context.html>
- Immigration, Refugees and Citizenship Canada. (2025). *2025 annual report to Parliament on immigration*. Government of Canada. <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/annual-report-parliament-immigration-2025.html>
- International Organization for Migration. (2017). *World migration report 2018*. https://www.iom.int/sites/default/files/country/docs/china/r5_world_migration_report_2018_en.pdf
- Kentoffio, K., Borba, C. P., & Scoglio, A. A. J. (2016). Use of maternal health services: Comparing refugee, immigrant, and US-born populations. *Journal of Immigrant and Minority Health*, 18(5), 1147–1155.
- Keygnaert, I., Ivanova, O., Guieu, A., Van Parys, A.-S., Leye, E., & Roelens, K. (2016). What is the evidence on the reduction of inequalities in accessibility and quality of maternal health care delivery for migrants? A review of the existing evidence in the WHO European region (Health Evidence Network Synthesis Report No. 45). World Health Organization. Regional Office for Europe.
- Khanlou, N., Haque, N., Skinner, A., Mantini, A., & Kurtz Landy, C. (2017). Scoping review on maternal health among immigrant and refugee women in Canada: Prenatal, intrapartum,

- and postnatal care. *Journal of Pregnancy*, 2017, Article 8783294. <https://doi.org/10.1155/2017/8783294>
- Kim, J., Heazell, A. E. P., Whittaker, M., Stacey, T., & Watson, K. (2025). Impact of health literacy on pregnancy outcomes in socioeconomically disadvantaged and ethnic minority populations: A scoping review. *International Journal of Gynaecology & Obstetrics*, 168(1), 69–81. <https://doi.org/10.1002/ijgo.15852>
- Knobf, M. T., Juarez, G., Shiu-Yu, K. L., Sun, V., & Haozous, E. (2007). Challenges and strategies in recruitment of ethnically diverse populations for cancer nursing research. *Oncology Nursing Forum*, 34(6), 1187–1194.
- Knott, E., Rao, A. H., Summers, K., & Teeger, C. (2022). Interviews in the social sciences. *Nature Reviews Methods Primers*, 2, Article 73.
- Kuhnt, J., & Vollmer, S. (2017). Antenatal care services and its implications for vital and health outcomes of children: Evidence from 193 surveys in 69 low-income and middle-income countries. *BMJ Open*, 7(11), Article e017122.
- Koch, T. (2006). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing*, 53(1), 91–100.
- Lane-Cordova, A. D., Khan, S. S., Grobman, W. A., Greenland, P., & Shah, S. J. (2019). Long-term cardiovascular risks associated with adverse pregnancy outcomes: JACC review topic of the week. *Journal of the American College of Cardiology*, 73(16), 2106–2116. <https://doi.org/10.1016/j.jacc.2018.12.092>
- Lee, J., Howard, K. J., Leong, C., Grigsby, T. J., & Howard, J. T. (2026). Delayed care during pregnancy and postpartum linked to poor maternal mental health: Evidence in the United States. *Journal of Reproductive and Infant Psychology*, 44(1), 79–91. <https://doi.org/10.1080/02646838.2024.2353091>
- Leinweber, J., & Stramrood, C. (2024). Improving birth experiences and provider interactions: Expert opinion on critical links in maternity care. *European Journal of Midwifery*, 8, Article 53. <https://doi.org/10.18332/ejm/191742>
- Lin, L.C. (2009). Data management and security in qualitative research. *Dimensions of Critical Care Nursing*, 28(3), 132–137.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications.
- Lognos, B., Oude Engberink, A., Gonzalez, L., Leandri, J., Charlot Pisoni, C., Rachedi, N., Clary, B., Bourrel, G., Bayen, S., & Million, E. (2024). Meeting the needs of pregnant women in socially vulnerable situations: A phenomenological qualitative study. *Heliyon*, 10(3), Article e24881. <https://doi.org/10.1016/j.heliyon.2024.e24881>

- Malebranche, M., Nerenberg, K., Metcalfe, A., & Fabreau, G. E. (2017). Addressing vulnerability of pregnant refugees. *Bulletin of the World Health Organization*, 95(9), 611–611A. <https://doi.org/10.2471/BLT.17.193664>
- Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, 26(13), 1753–1760.
- Markopoulou, P., Papanikolaou, E., Analytis, A., Zoumakis, E., & Siahianidou, T. (2019). Preterm birth as a risk factor for metabolic syndrome and cardiovascular disease in adult life: A systematic review and meta-analysis. *The Journal of Pediatrics*, 210, 69–80.e5.
- McLemore, M. R., Altman, M. R., Cooper, N., Williams, S., Rand, L., & Franck, L. (2018). Health care experiences of pregnant, birthing and postnatal women of color at risk for preterm birth. *Social Science & Medicine*, 201, 127–135. <https://doi.org/10.1016/j.socscimed.2018.02.013>
- Mehrara, L., Olaug Gjernes, T. K., & Young, S. (2022). Immigrant women's experiences with Norwegian maternal health services: Implications for policy and practice. *International Journal of Qualitative Studies on Health and Well-Being*, 17(1), Article 2066256. <https://doi.org/10.1080/17482631.2022.2066256>
- Meldgaard, M., Gamborg, M., & Terkildsen Maindal, H. (2022). Health literacy levels among women in the prenatal period: A systematic review. *Sexual & Reproductive Healthcare*, 34, Article 100796. <https://doi.org/10.1016/j.srhc.2022.100796>
- Milroy, J. (2001). Language ideologies and the consequences of standardization. *Journal of Sociolinguistics*, 5(4), 530–555. <https://doi.org/10.1111/1467-9481.00163>
- Molina, K. M., & James, D. (2016). Discrimination, internalized racism, and depression: A comparative study of African American and Afro-Caribbean adults in the US. *Group Processes & Intergroup Relations*, 19(4), 439–461. <https://doi.org/10.1177/1368430216641304>
- Moreno-Santillan, A., Martínez Adame, L., & Cunningham, B. (2025). Language barriers in maternal healthcare: Effects on prenatal care access, perinatal outcomes, and strategies for equitable care. *Health*, 17, 1443–1458.
- Naderifar, M., Goli, H., & Ghaljaie, F. (2017). Snowball sampling: A purposeful method of sampling in qualitative research. *Strides in Development of Medical Education*, 14(3), Article e67670.
- National Institutes of Health. (n.d.). Intrapartum. In *HIV/AIDS glossary*. ClinicalInfo.HIV.gov. <https://clinicalinfo.hiv.gov/en/glossary/intrapartum>
- Nestel, S. (2012, February). Colour coded health care: The impact of race and racism on Canadians' health. Wellesley Institute. <https://www.wellesleyinstitute.com/wp-content/uploads/2012/02/Colour-Coded-Health-Care.pdf>

- Ng, E., Quinlan, J., Giovinazzo, G., Grundy, A., Rank, C., Syoufi, M., Ponka, D., & Garner, R. (2021). All-cause acute care hospitalization rates of immigrants and the Canadian-born population: A linkage study. *Health Reports*, 32(9), 3–14.
<https://www150.statcan.gc.ca/n1/pub/82-003-x/2021009/article/00001-eng.pdf>
- Ogilvie, L. D., Burgess-Pinto, E., & Caufield, C. (2008). Challenges and approaches to newcomer health research. *Journal of Transcultural Nursing*, 19(1), 64–73.
- Parikh, N. I., Gonzalez, J. M., Anderson, C. A. M., Judd, S. E., Rexrode, K. M., Hlatky, M. A., Gunderson, E. P., Stuart, J. J., Vaidya, D., & American Heart Association Council on Epidemiology and Prevention, Council on Arteriosclerosis, Thrombosis and Vascular Biology, Council on Cardiovascular and Stroke Nursing, and the Stroke Council. (2021). Adverse pregnancy outcomes and cardiovascular disease risk: Unique opportunities for cardiovascular disease prevention in women: A scientific statement from the American Heart Association. *Circulation*, 143(18), e902–e916.
<https://doi.org/10.1161/CIR.0000000000000961>
- Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). SAGE Publications.
- Plaisimond, J., Corona, E., M'bangha, M., & Gagnon, M. P. (2025). Exploring barriers and facilitators to digital health literacy among immigrant mothers in Quebec City. *Health Promotion International*, 40(6), Article daaf152. <https://doi.org/10.1093/heapro/daaf152>
- Pontin, D. (2000). The research process in nursing. In D. F. S. Cormack (Ed.), *The research process in nursing* (4th ed.). Blackwell Science.
- Provencher, C. (2025, November 13). *The contribution of foreign-born mothers to Canadian births from 1997 to 2024* (Catalogue No. 91F0015M2025004). Statistics Canada.
<https://www150.statcan.gc.ca/n1/pub/91f0015m/91f0015m2025004-eng.htm>
- Raatikainen, K., Heiskanen, N., & Heinonen, S. (2007). Under-attending free antenatal care is associated with adverse pregnancy outcomes. *BMC Public Health*, 7, Article 268.
<https://doi.org/10.1186/1471-2458-7-268>
- Race Forward. (n.d.). *What is racial equity?* <https://www.raceforward.org/what-racial-equity-0>
- Ramraj, C., Pulver, A., O'Campo, P., Urquia, M. L., Hildebrand, V., & Siddiqi, A. (2020). A scoping review of socioeconomic inequalities in distributions of birth outcomes: Through a conceptual and methodological lens. *Maternal and Child Health Journal*, 24(2), 144 - 152. <https://doi.org/10.1007/s10995-019-02838-w>
- Ray, A. (2021). *Empowering midwives and obstetric nurses*. IntechOpen. doi.org
- Reppen, K., Henriksen, L., Schei, B., Magnussen, E. B., & Infanti, J. J. (2023). Experiences of childbirth care among immigrant and non-immigrant women: A cross-sectional

- questionnaire study from a hospital in Norway. *BMC Pregnancy and Childbirth*, 23, Article 394. <https://doi.org/10.1186/s12884-023-05725-z>
- Risnes, K. R., Vatten, L. J., Baker, J. L., Jameson, K., Sovio, U., Kajantie, E., Osler, M., Morley, R., Jokela, M., Painter, R. C., Sundh, V., Jacobsen, G. W., Eriksson, J. G., Sørensen, T. I., & Bracken, M. B. (2011). Birthweight and mortality in adulthood: A systematic review and meta-analysis. *International Journal of Epidemiology*, 40(3), 647–661. <https://doi.org/10.1093/ije/dyq267>
- Riza, E., Lazarou, A., Karnaki, P., Zota, D., Nassi, M., Kantzanou, M., & Linos, A. (2021). Using an IT-based algorithm for health promotion in temporary settlements to improve migrant and refugee health. *Healthcare*, 9(10), Article 1284. <https://doi.org/10.3390/healthcare9101284>
- Rodrigues, J. (2024, September 12). *Immigration fuels Alberta's record-breaking population growth*. CIC News. <https://www.cicnews.com/2024/09/immigration-fuels-albertas-record-breaking-population-growth-0946423.html#gs.hvlchf>
- Rogers, H. J., Hogan, L., Coates, D., Homer, C. S. E., & Henry, A. (2021). Cross Cultural Workers for women and families from migrant and refugee backgrounds: A mixed-methods study of service providers' perceptions. *BMC Women's Health*, 21, Article 222. <https://doi.org/10.1186/s12905-021-01368-4>
- Rosa, C. Q., Silveira, D. S., & Costa, J. S. (2014). Factors associated with lack of prenatal care in a large municipality. *Revista de Saúde Pública*, 48(6), 977–984. <https://doi.org/10.1590/S0034-8910.2014048005283>
- Rosenthal, L., & Lobel, M. (2011). Explaining racial disparities in adverse birth outcomes: Unique sources of stress for Black American women. *Social Science & Medicine*, 72(6), 977–983.
- Ruiz, R. J., Gennaro, S., O'Connor, C., Marti, C. N., Lulloff, A., Keshinover, T., Gibeau, A., & Melnyk, B. (2015). Measuring coping in pregnant minority women. *Western Journal of Nursing Research*, 37(2), 257–275. <https://doi.org/10.1177/0193945914527176>
- Ryan, F., Coughlan, M., & Cronin, P. (2007). Step-by-step guide to critiquing research. Part 2: Qualitative research. *British Journal of Nursing*, 16(12), 738–744.
- Ryan, F., Coughlan, M., & Cronin, P. (2009). Interviewing in qualitative research: The one-to-one interview. *International Journal of Therapy and Rehabilitation*, 16(6), 309–314. <https://doi.org/10.12968/ijtr.2009.16.6.42433>
- Sacks, E., Brizuela, V., Javadi, D., Kim, Y., Elmi, N., Finlayson, K., Crossland, N., Langlois, E. V., Ziegler, D., Parmar, S. M., & Bonet, M. (2024). Immigrant women's and families' views and experiences of routine postnatal care: Findings from a qualitative evidence synthesis. *BMJ Global Health*, 8(Suppl 2), Article e014075. <https://doi.org/10.1136/bmjgh-2023-014075>

- Saldaña, J. (2013). *The coding manual for qualitative researchers* (2nd ed.). SAGE Publications.
- Salm Ward, T. C., Logsdon, M. C., & Myers, J. (2013). African American women's experiences of racial discrimination in prenatal care. *Journal of Midwifery & Women's Health*, 58(5), 522–529.
- Saluja, B., & Bryant, Z. (2021). How implicit bias contributes to racial disparities in maternal morbidity and mortality in the United States. *Journal of Women's Health*, 30(2), 270–273.
- Sanchez, M. C., Nyarko, D., Mulji, J., Džunić, A., Surti, M., Mangat, A., Mainali, D., & Spitzer, D. L. (2023). Health care for all: Undocumented migrants and the COVID-19 pandemic in Alberta, Canada—A scoping review. *Journal of Migration and Health*, 7, 100192. <https://doi.org/10.1016/j.jmh.2023.100192>
- Schmidt, N. C., Fagnoli, V., Epiney, M., & Irion, O. (2018). Barriers to reproductive health care for migrant women in Geneva: A qualitative study. *Reproductive Health*, 15, Article 43. <https://doi.org/10.1186/s12978-018-0478-7>
- Schulich School of Medicine & Dentistry. (2025). *Understanding anti-racism*. Western University. https://www.schulich.uwo.ca/edid/antiracism/understanding_antiracism/index.html
- Small, R., Gagnon, A., Gissler, M., Zeitlin, J., Bennis, M., Glazier, R., Haelterman, E., Martens, G., McDermott, S., Urquia, M., & Vangen, S. (2008). Somali women and their pregnancy outcomes postmigration: Data from six receiving countries. *BJOG: An International Journal of Obstetrics & Gynaecology*, 115(13), 1630–1640.
- Small, R., Edge, D., Riggs, E., Deng, C., Frayne, J., & Yelland, J. (2014). Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries. *BMC Pregnancy and Childbirth*, 14(1), 152.
- Stahl, N. A., & King, J. R. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. *Journal of Developmental Education*, 44(1), 26–28. <http://www.jstor.org/stable/45381095>
- Statistics Canada. (2022a, November 9). *Disaggregated trends in poverty from the 2021 Census of Population*. *Census in Brief*. <https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-X/2021009/98-200-X2021009-eng.cfm>
- Statistics Canada. (2022b). *Focus on Geography Series, 2021 Census of Population: Immigration, place of birth, and citizenship*. Government of Canada. [https://www12.statcan.gc.ca/census-recensement/2021/as-sa/fogs-spg/alternative.cfm?topic=9\(=E&dguid=2021A00054802034&objectId=2_2](https://www12.statcan.gc.ca/census-recensement/2021/as-sa/fogs-spg/alternative.cfm?topic=9(=E&dguid=2021A00054802034&objectId=2_2)

- Statistics Canada. (2022c, October 26). *Immigrants make up the largest share of the population in over 150 years and continue to shape who we are as Canadians. The Daily.* <https://www150.statcan.gc.ca/n1/daily-quotidien/221026/dq221026a-eng.htm>
- Statistics Canada. (2023a, September 26). *Births, 2022. The Daily.* <https://www150.statcan.gc.ca/n1/daily-quotidien/230926/dq230926a-eng.htm>
- Statistics Canada. (2023b, December 29). *Classification of admission category.* Government of Canada. <https://www23.statcan.gc.ca/imdb/p3VD.pl?Function=getVD&TVD=323293&CVD=323294&CLV=0&MLV=4&D=1>
- Stoll, K., Hodge, K., Reddy, B., Gagnon, R., Tremblay, R., Lévesque, S., Phillips-Beck, W., Malhotra, N., D'Souza, R., Tatum, A., & Vedam, S. (2025). *Disparities in autonomy during pregnancy in Canada: Findings from the national RESPCCT study.* medRxiv. <https://doi.org/10.1101/2025.08.01.25332643>
- Sturrock, S., Williams, E., & Greenough, A. (2020). Antenatal and perinatal outcomes of refugees in high-income countries. *Journal of Perinatal Medicine*, 49(1), 80–93. <https://doi.org/10.1515/jpm-2020-0389>
- Sudhinaraset, M., Kolodner, R. A., & Nakphong, M. K. (2023). Maternity care at the intersections of language, ethnicity, and immigration status: A qualitative study. *Women's Health Issues*, 33(6), 618–625. <https://doi.org/10.1016/j.whi.2023.04.004>
- Tait, R. C., & Chibnall, J. T. (2014). Racial/ethnic disparities in the assessment and treatment of pain: Psychosocial perspectives. *American Psychologist*, 69(2), 131–141. <https://doi.org/10.1037/a0035204>
- Taylor, J. K. (2020). Structural racism and maternal health among Black women. *Journal of Law, Medicine & Ethics*, 48(3), 506–517. <https://doi.org/10.1177/1073110520958875>
- Tsindos, T. (2023). Triangulation. In D. Ayton, T. Tsindos, & B. Berkovic (Eds.), *Qualitative research: A practical guide for health and social care researchers and practitioners* (pp. 247–253). Council of Australian University Librarians. <https://oercollective.caul.edu.au/qualitative-research/chapter/28/>
- UNHCR Canada. (n.d.). *Refugees are good for Canada.* <https://www.unhcr.ca/in-canada/refugees-are-good-for-canada/>
- United Nations Department of Economic and Social Affairs, Population Division. (2021). *International migration 2020: Highlights: Ten key messages.* United Nations. https://namibia.un.org/sites/default/files/2021-01/International_Migration_2020_Highlights_Ten_key_messages.pdf

- United Nations High Commissioner for Refugees. (n.d.). *About UNHCR in Canada*. UNHCR Help. <https://help.unhcr.org/canada/about-unhcr-in-canada/>
- United Nations High Commissioner for Refugees. (1951). *Convention and protocol relating to the status of refugees*. <https://www.unhcr.org/media/convention-and-protocol-relating-status-refugees>
- United Nations High Commissioner for Refugees. (2016, March 16). 'Refugees' and 'migrants' – *Frequently asked questions (FAQs)*. <https://www.unhcr.org/news/stories/refugees-and-migrants-frequently-asked-questions-faqs>
- United Nations High Commissioner for Refugees. (2018). *Projected global resettlement needs 2018*. <https://www.unhcr.org/media/unhcr-projected-global-resettlement-needs-2018>
- United Nations High Commissioner for Refugees. (2023, June 14). *Global trends report 2022*. <https://www.unhcr.org/global-trends-report-2022>
- United Nations High Commissioner for Refugees. (2024, October 9). *Mid-year trends 2024*. <https://www.unhcr.org/media/mid-year-trends-2024>
- United Nations Population Fund. (2024). *Maternal and newborn health fund annual impact report 2024*.
- Urquia, M. L., Glazier, R. H., Blondel, B., et al. (2007). Healthier on arrival? Further insight into the “healthy immigrant effect.” *Canadian Medical Association Journal (CMAJ)*, 176(13), 1841–1843.
- Urquia, M. L., Glazier, R. H., Gagnon, A. J., et al. (2015). Severe maternal morbidity associated with maternal birthplace in three high-immigration settings. *Journal of Obstetrics and Gynaecology Canada*, 37(11), 977–985.
- Väisänen, H., Remes, H., & Martikainen, P. (2022). Perinatal health among migrant women: A longitudinal register study in Finland 2000–17. *SSM - Population Health*, 20, Article 101298.
- van den Akker, T., & van Roosmalen, J. (2016). Maternal mortality and severe morbidity in a migration perspective. *Best Practice & Research: Clinical Obstetrics & Gynaecology*, 32, 26–38. <https://doi.org/10.1016/j.bpobgyn.2015.08.016>
- Vang, Z. M., Sigouin, J., Flenon, A., & Gagnon, A. (2017). Are immigrants healthier than native-born Canadians? A systematic review of the healthy immigrant effect in Canada. *Ethnicity & Health*, 22(3), 209–241. <https://doi.org/10.1080/13557858.2016.1246518>
- Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, 18(1), Article 148.

- Vicente-Díaz, E. I., & Alvariñas-Villaverde, M. (2025). Health literacy in pregnant women and its associations with personal, socioeconomic, and health-related factors in primary care. *Nursing Reports*, 15(12), Article 436. <https://doi.org/10.3390/nursrep15120436>
- Weinreb, C., & Sun, D. S. (2023). To dismantle structural racism in science, scientists need to learn how it works. *Neuropsychopharmacology*, 48(4), 579–582. <https://doi.org/10.1038/s41386-023-01534-2>
- Wikipedia. (2026, July 14). *Southern Alberta*. https://en.wikipedia.org/wiki/Southern_Alberta
- Williams, B. (2024, December 2). *Qualitative exploratory research explained*. Insight7. <https://insight7.io/qualitative-exploratory-research-explained/>
- World Health Organization. (n.d.-a). *Health equity*. <https://www.who.int/health-topics/health-equity>
- World Health Organization. (n.d.-b). *Maternal health*. https://www.who.int/health-topics/maternal-health#tab=tab_1
- World Health Organization. (1992). International statistical classification of diseases and related health problems (10th ed.). World Health Organization.
- World Health Organization. (2017). *Promoting the health of refugees and migrants: Framework of priorities and guiding principles to promote the health of refugees and migrants* (pp. 1–4).
- World Health Organization. (2018). *Improving the health care of pregnant refugee and migrant women and newborn children* (Technical guidance on refugee and migrant health). WHO Regional Office for Europe. <https://iris.who.int/server/api/core/bitstreams/3dfae3b9-b743-42eb-b935-92d6b6c85a29/content>
- World Health Organization. (2022). *World report on the health of refugees and migrants*. <https://www.who.int/publications/i/item/9789240054462>
- Zhang, T. (2025, January 14). *Troubling diagnosis: Comparing Canada's healthcare with international peers*. C.D. Howe Institute. <https://cdhowe.org/publication/troubling-diagnosis-comparing-canadas-healthcare-with-international-peers/>
- Zhu, C. (2023). Barriers and challenges of immigrant women's access to and experience of optimal maternity care. *The Columbia University Journal of Global Health*, 13(1), Article 10690. <https://doi.org/10.52214/cujgh.v13i1.10690>

University of
Lethbridge



Date

Subject: Invitation to participate in a study that explores factors that support or deter migrant and refugee women's access and utilization of perinatal health services in Southern Alberta.

Dear *[Name of Organization]*,

My name is Rudeen Laing, and I am a Master of Public Health student in the Faculty of Health Sciences at the University of Lethbridge. This letter is a request for *[name of organization]*'s assistance with a project I am conducting as part of my master's degree under the supervision of Dr. Wendi Lokanc-Diluzio.

The purpose of this study is to explore possible factors that may support or deter migrant and refugee women's access and utilization of perinatal health services in Southern Alberta. Knowledge and information generated from this study may help other researchers, community members, program and policy developers and advocates to support migrant and refugee women's perinatal needs.

I am writing to this association to invite members to voluntarily participate in this research project. I believe that the participants and families of your organization may have unique experiences and stories relating to healthcare access and use during and/or after pregnancy and childbirth. During this study, I will be conducting interviews with participants to gather their stories and experiences based on the research topic. At the end of this study and the publication of this thesis, I will share the findings from this study with the collaborating organization.

To respect the privacy and rights of the *[name of organization]* and its participants, I will not be contacting the individuals or families directly. I will provide the *[name of organization]* with information flyers to be distributed by the *[name of organization]* at their discretion. Contact information for me and my advisor will be contained on the flyers. Your assistance in sharing recruitment materials on your bulletin board, social media platforms and/or during cultural and religious events will be greatly appreciated.

Participation is completely voluntary. Each participant will make their own independent decision as to whether they would like to be involved in this research. All participants will be informed and reminded of their rights to participate or withdraw before any interview, or at any time in the study. Each participant will receive an information letter which will include information about

this study, as well as a consent form. All participants of this study will receive a \$20 gift card in appreciation of their time and participation in this study.

To support the findings of this study, quotations and excerpts from the stories will be labelled with pseudonyms to protect the identity of the participants. Names of participants will not appear in the thesis or reports resulting from this study. Participants will not be identifiable and only described by gender. If *[name of organization]* wishes the identity of the organization to remain confidential, a pseudonym will be given to the organization. There are no known or anticipated risks to participants in this study.

I would like to assure you that this study has been reviewed and received ethics clearance through the University of Alberta Research ethics Board. If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact me by email at *rudeen.laing@uleth.ca*. You may also contact my supervisor Dr. Wendi Lokanc-Diluzio at the faculty of Health Sciences, University of Lethbridge (*email: wendi.lokancdiluzio@uleth.ca*) or the University of Alberta Research Ethics Office (*phone: 780-492-2615 or email: reoffice@ualberta.ca*).

I look forward to speaking with you and thank you in advance for your assistance with this research project.

Yours sincerely,

Rudeen Laing

Master's Student

Faculty of Health Sciences

University of Lethbridge

Dr. Wendi Lokanc-Diluzio

Assistant Professor

Faculty of Health Sciences

University of Lethbridge

Organization Permission Form

We have read the information presented in the information letter about a study being conducted by **Rudeen Laing** of the **Faculty of Health Sciences** at the University of Lethbridge, Alberta, under the supervision of **Dr. Wendi Lokanc-Diluzio** at the University of Lethbridge.

We have had the opportunity to ask any questions related to this study, to receive satisfactory answers to our questions, and any additional details we wanted. We are aware that the name of our organization will only be used in the thesis or any publications that comes from the research with our permission.

We were informed that this organization may withdraw from assistance with the project at any time. We were informed that study participants may withdraw from participation at any time without penalty by advising the researcher.

We have been informed this project has been reviewed by and received ethics clearance through a University of Alberta Research Ethics Board and that questions we have about the study may be directed to **Rudeen Laing** by email [**Rudeen.laing@uleth.ca**] and **Dr. Wendi Lokanc-Diluzio** at (403) 332-4650 or by email at **wendi.lokancdiluzio@uleth.ca**.

If you have questions for the Ethics Board, please contact the University of Alberta Research Ethics Office (**phone: 780-492-2615 or email: reoffice@ualberta.ca**).

Rudeen Laing

Master's Student
Faculty of Health Sciences
University of Lethbridge

Dr. Wendi Lokanc-Diluzio

Assistant Professor
Faculty of Health Sciences
University of Lethbridge

We agree to help the researcher recruit participants for this study from among the members and/or families who are within our organization and/or users of our programs and services of the **[name of organization]**.

☐ YES ☐ NO

We agree to the use of the name of the **[name of organization]** in any thesis or publication that comes of this research.

☐ YES ☐ NO

If NO, a pseudonym will be used to protect the identity of the organization.

Director Name: _____ (Please print)

Director Signature: _____

Board of Directors Representative Name: _____ (Please print)

Board of Directors Representative Signature: _____

Witness Name: _____ (Please print)

Witness Signature: _____

Date: _____



RESEARCH PARTICIPANTS NEEDED

**Immigrant women's access and utilization
of maternal health services in Southern Alberta**

To participate in this study

Are you at least 18 years old?

Are you an immigrant woman?

Have you had a child or been pregnant?

Lived in Southern Alberta for at least six months?

Comfortable in speaking the English language?

This study examines the health experiences of immigrant women who have a child/children or have been pregnant in Alberta. Participants must be 18 years of age or older to participate. *It will assist in highlighting the experiences and healthcare utilization of immigrant women.* Participants will share their experiences with a researcher through in-person interview or Microsoft Teams. The interview will be audio recorded for transcription purposes.

Participants will be compensated with a \$20 gift card for their time. The interview will last between 60 and 90 minutes.

This study has received ethical approval from the University of Alberta's Research Ethics Board, Clearance # (Pro00150987).

Please contact the researcher, Rudy at [rudeen.laing@uleth.ca], for more details on this study.



study specific phone



rudeen.laing@uleth.ca



Appendix C: Informed Consent Form

REB ID (Pro00150987)



PARTICIPANT CONSENT FORM

Title of Study: Immigrant women's access and utilization of maternal health services in Southern Alberta

Contact Information

Principal Investigator: Rudeen Laing

Address: Faculty of Health Sciences, University of Lethbridge

Email: rudeen.laing@uleth.ca

Supervisor: Dr. Wendi Lokanc-Diluzio

Address: Faculty of Health Sciences, University of Lethbridge

Email: wendi.lokancdiluzio@uleth.ca

Invitation to participate

You are being invited to participate in a research study. Your participation in this study is entirely your choice so it is up to you to decide whether to take part in this study or not. IF you decide to participate, you will be asked to sign this form. Consent is an ongoing process. If at any time during this study you decide not to participate any further, you are still able to withdraw at any time and without any given reason for your decision.

Purpose of the research study

Immigrant women may experience difficulty when accessing and navigating the Canadian healthcare system especially during the perinatal period. The purpose of this study is to explore and understand possible factors that may support or deter migrant and refugee women's access and utilization of perinatal health services in Southern Alberta. By exploring the perspectives of immigrant and refugee women, I hope that this research will lead to improved perinatal care for this study group. The findings from this study may help other researchers, community members,

program and policy developers and advocates to support migrant and refugee women's perinatal needs.

What you will be asked to do

If you decide to participate in this research, you will be invited to a one-on-one interview where I, the researcher, will inquire about your experience(s) accessing healthcare during the perinatal period. The conversation will be recorded and transcribed word-for-word by the researcher. The interview, which will take the form of a conversation will last between 60 – 90 mins.

For this interview, your comfort and privacy are most important. This interview may be done in person or take place virtually, using Microsoft Teams. If the interview is done virtually, you may choose to turn off your camera at any time. If the interview is conducted in person, you may choose a location that is convenient and ensures your privacy.

Once transcription has been completed, the written transcript will be returned to you via email. You will have *two weeks* to review and/or make revisions as you see fit. After the two weeks have elapsed, the researcher will confirm with you that the transcript is accurate, after which it will become a part of the data set for the study.

What are the possible risks and benefits

Possible risks: There are no anticipated risks from you taking part in this study. However, as the interview deals with your experience during the perinatal period and how it influenced your access and utilization of health services, it is possible that it may raise issues or feelings that you would like support in dealing with. If this happens, the researcher can refer you to resources in the community that can help you. You can leave the interview at any time, and you do not have to answer any questions that make you feel uncomfortable. You can also withdraw your participation in the project at any time. By agreeing to participate in this research you are not giving up or waiving any legal rights.

Possible benefits: There is no guarantee that you will benefit directly from participating in this study. However, the interview will provide you with the opportunity to voice your

opinion on your experiences. I hope that the information learned from conducting this study can be used in the future to benefit immigrant and refugee women when they access and utilize health services during the perinatal period.

What happens if you decide to withdraw your consent to participate

Your participation in this research is entirely voluntary. You may withdraw at any time before data analysis. Prior to data analysis, if you decide to withdraw, there will be no penalty for doing so.

If you choose to enter the study and withdraw after data collection but prior to data analysis, all data collected from you during your enrollment in the study will be destroyed. To withdraw from the study, please contact Rudeen Laing (rudeen.laing@uleth.ca) and/or her supervisor Dr. Wendi Lokanc-Diluzio (wendi.lokancdiluzio@uleth.ca).

How will I be compensated / reimbursement

You will not be paid for your participation in this research. To acknowledge the time that you have taken to be involved in this project, each participant will receive a \$20 gift card. If you consent to participate, but change your mind before coming to the session, you will not receive this money. If you consent to participate but change your mind during the session, the compensation will be provided regardless of your decision to withdraw.

Privacy and confidentiality

Your confidentiality will be respected and prioritized. You will be assigned a unique study number or name as a participant in this study. Only this number or name will be used on any research-related information collected about you during the study. This is to ensure that your identity as a participant in this study is kept confidential.

All hard copies of documents and recordings will be identified only by code number. You will not be identified by name in either the recording or interview transcript. Hard copies of the interview notes and transcripts will be stored in a locked filing cabinet at the University of Lethbridge. Copies will be kept on the local hard drives of the primary researcher's computer – which is password protected. There will be no identifiers in the finished and published research. After completion of the study, data will be held for approximately 5-years. Any physical transcripts or audio recording will be stored in locked filing cabinet at the University of Lethbridge. These data will be securely shredded and disposed of at the end of the study.

Open Access: The completed research, utilizing deidentified data collected from you the participant will be available online at the University of Lethbridge repository. The information provided will be used as part of public or academic presentations, conferences and publications where it will be accessible to other researchers, students and health professionals. Participants will not be identified by name in any reports of the completed study. As such, there is no risk of re-identification to participants. Please note that once data is made publicly available, the participant will not be able to withdraw their data from the study.

Who do I contact if I have questions or concerns about the study during my participation?

If you have any questions, concerns or desire further information about this study before or during participation, you can contact the principal investigator Rudeen Laing (rudeen.laing@uleth.ca) or her supervisor Dr. Wendi Lokanc-Diluzio (wendi.lokancdiluzio@uleth.ca).

Who do I contact if I have questions or concerns about my rights as a participant during the study?

If you have any questions or concerns about your rights as a research participant and/or your experiences while participating in this study, you may contact the University of Alberta Research Ethics office at reoffice@ualberta.ca or 780-492-2615. This office is independent of the study investigator.

This consent form is **not** a contract, and you have **not** given up your legal rights by participating in this study or by signing this consent form.

By signing this form, you are indicating that you have read the above information, have understood it and anything that was not clear to you has been thoroughly explained to your satisfaction. As such the first-person pronoun (“I”) will be used for this section.

- I have had the opportunity to ask questions about the information provided in this consent form and have had satisfactory responses to my questions
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw at any time from this study without consequence
- I understand that I am not waiving my legal rights by participating in this study or by signing this consent form
- I have read this form and freely consent to participate in this study
- I have been told that I will receive a dated and signed copy of this form
- I agree to the data created by my participation in this study being stored as part of a data repository

SIGNATURE OF STUDY PARTICIPANT

Name of Participant

Signature of Participant

Date

NAME and SIGNATURE OF PERSON OBTAINING CONSENT

Person Obtaining Consent (principal researcher)

Email

Research Question

What are the healthcare experiences of migrant and refugee women and how does it support or deter their access and utilization of perinatal health services in Southern Alberta?

INTERVIEW GUIDE

Date: _____

Time: _____

Interview Duration: _____

Location: _____

Interviewee Unique Identifier: _____

This interview is part of a study to explore the possible factors that may influence health care access and utilization among immigrant and refugee women in Southern Alberta. Your participation in this study is 100% voluntary and you can withdraw at any time without providing reason. You can choose not to respond to a specific question, and you may also choose to provide as many details in your response as you feel comfortable disclosing. The information you provide today is strictly confidential and your name and any other identifier will be removed to maintain your privacy.

Introduction/Pre-screening Questions

1. Can you please tell me a bit about yourself such as your name and where you were born?
2. What year did you immigrate to Canada?
3. Which country did you immigrate from?
4. How long have you lived in Alberta or your current city?
5. What would you say is your ethnic background?
6. What would you say is your English language reading and writing level?
7. Do you feel comfortable having everyday conversations or communicating your needs to others in English?
8. What is your highest level of education?
9. What is your marital status?
10. How many children do you have?
11. (If yes) What are their ages?

Probing Questions

12. Since living in Southern Alberta, have you been pregnant and/or given birth?
13. How many children were born in [Southern] Alberta?
14. Did you receive perinatal health care?
15. [If yes] At what stage of pregnancy or at how many months of pregnancy did you start receiving maternal health care?
16. Where did you access these services? Was it at a clinic or with your primary care/family doctor?
17. What things helped you to access maternal health care?
18. What things made accessing maternal health care harder?
19. What would help make accessing these services easier?
20. Please describe your experiences when interacting with healthcare providers. Tell me about the positive and not so positive experiences and encounters.
21. How did the health provider's interactions with you make you feel?

22. What did you perceive their attitude towards you to be?
23. Is there an encounter with your healthcare provider that stands out in your memory? If yes, can you please tell me about it?
24. Did you feel as if your concerns were heard, and/or your needs were met?
25. Did you understand the treatment that was recommended?
26. Do you feel as if your healthcare provider was considerate of your cultural beliefs or views surrounding your pregnancy and postpartum treatment?
27. How would you describe the quality and appropriateness of care you received during pregnancy?
28. How would you describe the care you received during birth and after giving birth?
29. Was the care you received what you expected? Was it similar to what you would have received if you had given birth back 'home'?
30. Based on your overall experience, are there any factors that supported or prevented you from accessing healthcare services during or after pregnancy?
31. What do you think healthcare providers, or the health system should consider when caring for immigrant/refugee women?
32. Based on your experiences, what do you think would make these services more accessible and more utilized by immigrant/refugee women?

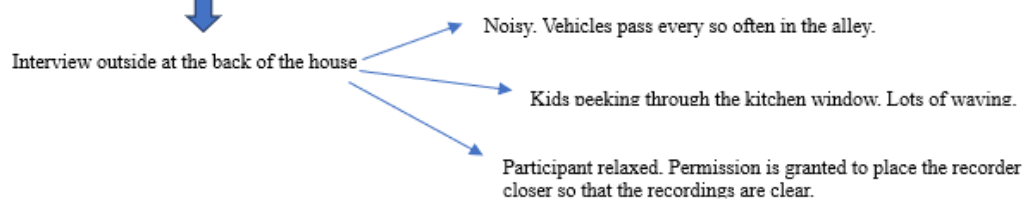
Appendix G: Analytical Progression

Location: Participant's home

Date: A month in 2025

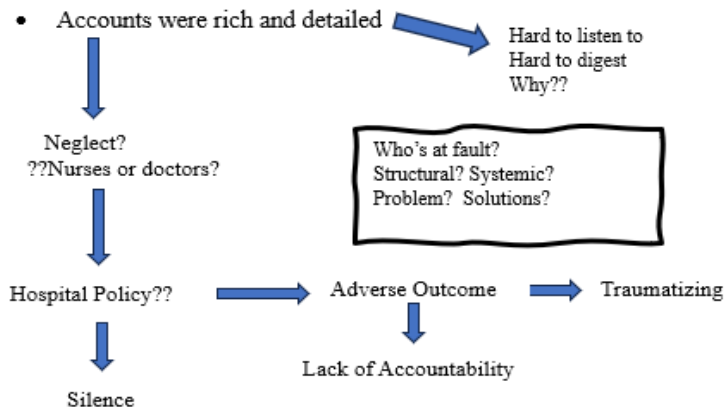
Time: After 4:00 pm

- Spouse leaving for work upon arrival
- Participant friendly & welcoming
- Pregnant
- Kids around - cute; younger=friendly; older = more reserved
- Participant selected the location



- Very thorough in her responses
 - Impressive account of events
 - Speaks without a lot of emotion
- Cultural?
 - Still processing trauma??
 - Very monotonous
 - ??unsure??

LOTS of pauses and heavy sighs when speaking about some aspects of pregnancy, such as miscarriages, traumatic deliveries, being blamed, etc.



The atmosphere surrounding the participant seemed 'very heavy' after speaking about details of her birth. Heavy sighs throughout the account. I allowed her time to pause, and I did not rush. There were moments of silence. I was unsure how to proceed. I did not want to rush her. The details are overwhelming **BUT** should I have been better prepared to know when to push the interview along or was waiting the right choice? This interview was very long. Conflicted.

Step 2: Transcript Excerpts

Interviewer: OK, so when it was time to give birth... You said it was hard to get, like, a family doctor?

Participant: Yeah. Here, I just, I just go to that clinic and then they say we will take care of you until the time you will give birth. And then after you give birth, then you will go back and look for your own family doctor. Yeah. So that's what I did.

Interviewer: OK, makes sense... How many months pregnant were you when you started going to the doctor with them?

Participant: I came when I was already 8 months.

excerpt

Participant: The first one was almost about 3 months... when I go to the emergency they said the opening of the baby drop... So what they did, they give me some tablets. I swallow in the hospital. Then they said go home, the baby is going to come out there... The baby come out when I come home.

Interviewer: Did they give you instructions on what to expect with the baby coming out at home, or did they just tell you to go home?

Participant: They just told me like that. They just give me those medicine and then they said if that baby gonna come out and then after three weeks go to the scan... Going to emergency is not easy. You have to be on the line for long... If you go at 8:00, you can come at home at one or three.

excerpt

Interviewer: In terms of **city**, what do you think made it harder in terms of getting services?

Participant: I don't know. Again, I have the same clinic as the one because I don't have my own gynecology to take care of. Yeah, those different doctors are the one who going to deliver me... So I don't know if I will get the good Doctor who can see very well and not leaving me with the nurse... The doctor remove the placenta and everything, but what they didn't did to me... They didn't squeeze my umbilical cord so that the blood can come out... The blood start clotting, clotting... I thought I will die that day, but God was there.

Interviewer: So did they apologize after, or anything?

Participant: They didn't; they keep telling me that maybe the uterus is lazy. I said how come the uterus is lazy and then why the baby come out? Then why is it uterus is lazy when it is blood to come out? But you did. You guys didn't press my stomach so that the blood can flow. So but 'cause they didn't want to accept, we just keep quiet. Yeah, either they didn't intend to, or they forgot. That's what I don't know, but that's what happened.

Coding Progressions

No Access – Conditional Access – Temporary Perinatal Care – No doctors - Broken Care – Gap in care – No Care after Delivery

- **Extract:** *"I just go to that clinic and then they say we will take care of you until the time you will give birth. And then after you give birth, then you will go back and look for your own family doctor."*
 - Participant advanced in pregnancy and was unable to find a family doctor in *city*. She received temporary support from the hospital prenatal clinic but was instructed to find a family doctor after delivery. The hospital functioned as a safety net – structural. It filled a temporary gap for the participant. The participant's perinatal care ends after delivery. Will need to find a family doctor for follow-up. Will have to repeat care history.

Managing Miscarriage – Alone – At Home – Emergency- Long Wait Time

- **Extract:** *"They just give me those medicine and then they said... the baby gonna come out there... the baby come out when I come home."*
 - Reported previous miscarriages. Shows how the system dealt with her early pregnancy loss. Medication given, then sent home. Isolating. Were there other ways this could have been dealt with? Participant dealt with the physical loss and emotional loss at home. Alone.

Postpartum Bleeding – Fear – Facing own Mortality - Faith - Blame – Deflection – Silence – Lazy Uterus- Patient at Fault- No Accountability

- **Extract:** *"They keep telling me that maybe the uterus is lazy... I said how come the uterus is lazy... but they didn't want to accept..."*
 - Systemic → Shows how doctors/nurses/system can shift accountability. Deflection. They didn't want to accept blame or acknowledge they made an error. Hospital error? Participant's body blamed for the adverse outcome.
- **Extract:** *"Because they didn't want to accept, we just keep quiet."*
 - Participant spoke up but then was inadvertently silenced. Vulnerable situation → just gave birth plus birth complications. Understandable. Power imbalance, a precarious situation; observed the pushback and lack of accepting blame. She probably chose to remain silent because of the dynamics of who was 'in charge' at that moment. Also, feeling powerless to change the outcome.