Migrant Reproductive Justice: Experiences of Uninsured Pregnant People in Manitoba, Canada

Summary Project Report
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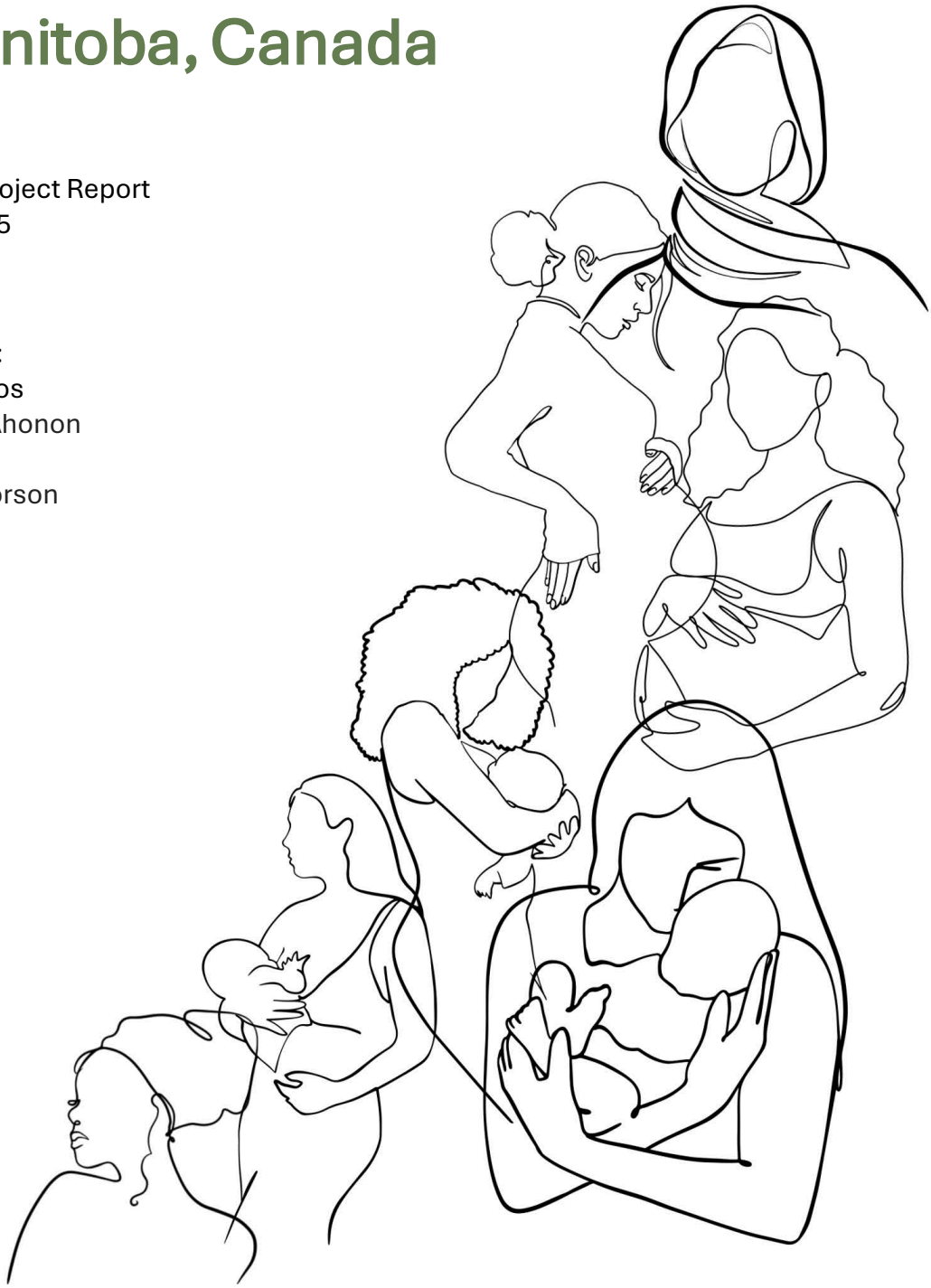

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Introduction

This research project explores the experiences of medically uninsured pregnant migrants accessing healthcare in Manitoba, to illuminate the ways in which precarious migration impacts reproductive healthcare and the overall well-being of families. Although there are a growing number of studies examining issues of access and health outcomes associated with not having public health insurance during pregnancy, childbirth, and postpartum, the vast majority of this research focuses on large urban centres with extensive migration histories, community networks, and formal support infrastructure (Darling et al., 2019; Ridde et al, 2020). Smaller cities, such as Winnipeg and Brandon, however, host increasing numbers of precarious migrants with barriers to health insurance, but thus far do not have the same established support networks and pathways for navigating this issue. We know very little about how pregnant medically uninsured migrants navigate the Manitoba health system and what their experiences are.

As such, this exploratory qualitative project aimed to:

1. Understand and document the state of perinatal care for uninsured migrants in Manitoba, including the policies, care settings (community/non-profit, public, and private), and actors involved;
2. Uncover key gaps and challenges (both formal and informal) to accessing pregnancy-related healthcare for medically uninsured people (including abortion, prenatal care, labour and delivery, and postpartum and newborn care); and
3. Unpack the wider implications of being medically uninsured for migrants navigating pregnancy and childbirth, not only on their health, but immigration trajectory, finances, employment, education, and family life.

We engaged in policy and community resource mapping, narrative interviews with medically uninsured migrants who have been pregnant in the previous five years while living in Manitoba, and informational interviews with health and community sector service providers.

Overall, findings document similar challenges faced by pregnant, medically uninsured migrants in other provinces. Like in other provinces, medically uninsured people in Manitoba face considerable difficulty navigating the system and gaining access to needed services and the direct costs of care paid out-of-pocket represent a significant challenge. These conditions result in a lot of fear, uncertainty, and stress and can lead to delays or forgoing necessary care. As seen in other provinces, as well, individual service providers, community advocates, and policy makers who have professional discretion in their work can be key facilitators or gatekeepers to access. Interviews with health and community service providers in Manitoba indicated that a wide range of service providers and organizations are concerned about this issue and want to play a role in facilitating care, but identify a considerable lack of information, resources, or places to refer to. This can be contrasted with larger urban centres with larger migrant populations where specific health programming has developed to attend to the unique needs of this uninsured migrant population. Another key point, specific to Manitoba and this project, is the impact of recent policy changes limiting access to public health insurance – in particular, international students losing access to public health insurance, recent changes to refugee claimant applications, and lengthy work permit processing times (exacerbated by the COVID-19 pandemic). Lastly, concerns related to the disclosure of personal health information to Canadian Border Security Agency (CBSA) were raised including an emerging practice of hospitals threatening to report people to border authorities if their bills are not paid in a

timely manner. This has been an issue in other health systems across the country, though legal protections related to disclosure of private health information and the adoption of access-without-fear policies have seemed to curb this in some other provinces.

What follows is a brief overview of existing research on this topic, our project methodology, and overview of the Manitoba context, and a summary of the research findings, broken down into abortion care, prenatal care and childbirth, and postpartum and newborn care. Based on these findings, recommendations are presented.

Background on Perinatal Care for People without Public Health Insurance in Canada

Universal access to necessary healthcare is widely regarded as a fundamental human right and a key Canadian national value; however, there are increasing numbers of people who reside within Canada's borders but do not meet the eligibility criteria for public healthcare insurance due to their immigration status. Since the mid-2000s, Canada has accepted more people into its borders on a temporary basis than as permanent residents. This shift away from permanent settlement or status upon arrival leads to intensified experiences of precarity for migrants both in terms of their long-term residency within a given state and their ability to access basic resources and services provided by that state (Goldring et al., 2009). Medically uninsured migrants are a heterogeneous population, including international students and their families, migrant workers, refused refugee claimants, visitors or those awaiting family sponsorship, as well as individuals without formal immigration status.

For some groups, such as migrant workers and international students, eligibility for health insurance may depend on the length of their work or study permit or the province they are residing in. Furthermore, any lapse in their permit may also result in a lapse in healthcare coverage. Migrants who are ineligible for public health insurance are encouraged to purchase private coverage prior to arrival; however, private insurance can be costly, is rarely comprehensive, and may not cover pre-existing conditions. Many individuals and families have few choices but to forego insurance and pay medical costs directly. People without formal immigration status (e.g., because they have overstayed their visa) are the most precarious group of medically uninsured migrants. They are unable to legally work and therefore struggle with financial stability and to afford basic necessities, including medical costs (Hanley et al., 2020; Magalhaes et al., 2010). These financial challenges associated with migration burdens can increase health disparity among the migrant population (Cloos et al, 2020; Hamel-Smith Grassby et al., 2021; Hynie et al., 2016; Ridde et al, 2020).

In a global context where female-led precarious migration is on the rise (International Organization for Migration, 2020), it becomes increasingly important to understand the gendered impacts of these challenges to access – especially as they inform experiences of pregnancy, childbirth, and reproductive healthcare more broadly. We know that access to quality perinatal care is a key component of maternal health and associated with positive longer-term health outcomes for both mother/birthing person and child (World Health Organization, 2016).

Barriers to perinatal care for people without public health insurance

Financial costs: The most cited barrier to accessing reproductive and perinatal care is financial (Burton & Bennett, 2013; Chabot, 2021; Hamel-Smith Grassby et al., 2021; Munro et al., 2013; Ridde et al, 2020; Rousseau et al., 2014). Without insurance, perinatal care and other healthcare services can only be accessed by paying out of pocket, and the costs are frequently exorbitant. People pay separate fees for prenatal appointments, labs, and ultrasounds. Many hospitals request deposits made in advance of labour and delivery; if this is not paid in advance, hospital and physician fees are billed out after. Private insurance may cover some of these costs, but perinatal and obstetric care are frequently not covered under these plans.

Complexity & unfamiliarity of the system: Another barrier to care is information gaps and complex administrative processes (Hamel-Smith Grassby et al., 2021; Munro et al., 2013; Pelaez et al., 2017). Uninsured pregnant migrants find it challenging to know where or how to access care in Canada. Language barriers and overall unfamiliarity with a new health system can exacerbate these challenges (Small et al., 2014). These circumstances contribute to misunderstandings with medical professionals, and many migrants have reported experiencing discrimination or coercion in health care settings and general mistrust of the health system (Larios, 2020).

Precarious work & immigration conditions: Precarious migration status is often inseparable from precarious employment and workers in these situations find protections under labour laws difficult to access and fear employer repercussions when pregnancies are disclosed (Hanley et al., 2020; Larios, 2023). As such, migrants face difficulty getting time off for prenatal appointments or taking a full maternity leave, and they may risk employment termination for asking. Both workers and students who are granted time off are likely to return to work shortly after giving birth in order to maintain their status. This pressure to limit time off from work or studies is also linked to the requirements of many immigration programs in Canada to work or study a certain amount of time with a temporary status before being eligible for permanent residency or family reunification (Larios, 2023).

Fear of detention & deportation: Another major barrier to accessing care is fear, particularly the fear of deportation (Hanley et al., 2020; Magalhaes et al., 2010; Rousseau et al., 2014). Uninsured migrants, especially those with more precarious forms of status or no status, may avoid accessing care unless their situation is urgent, fearing they will be required to disclose their immigration status and that this will be reported, potentially leading to their deportation. Furthermore, deportation and travel may be medically inadvisable for a pregnant individual, especially during the final trimester.

Uncertainty and refusal of care: Lastly, existing research demonstrates that health care providers have a wide range of perspectives on providing care to uninsured pregnant migrants. Some health care providers decline to provide care to uninsured pregnant patients fearing potential legal repercussions, added administrative burden, tensions with other providers, or personal values related to deservingness (Munro et al., 2013; Ruiz-Casares et al., 2013). They may also be concerned about an uninsured patient's ability to pay them for their services. Other health care providers feel it is their professional responsibility to provide care regardless of a patient's immigration or insurance status; and most health care providers feel obligated to provide care only in an emergency (Jarvis et al., 2019; Munro et al., 2013) . Uninsured people are often uncertain about whether they will be able to access the care they need because so much of this depends on the discretion of individual hospital staff or care providers.

Health impacts of barriers to perinatal care

Delayed, inadequate, or no prenatal care: Due to these barriers, uninsured migrants access care much later in their pregnancies than Canadian-born pregnant individuals (Hamel-Smith Grassby et al., 2021; Hynie et al., 2016). Predominately, people forgo care because they can't afford it. Fear of deportation, negative interactions in health facilities, and uncertainty of where to go also contribute. For example, a large Montreal-based mixed-methods study examining hospital and clinic casefiles of uninsured and refugee claimant pregnant patients found that 78% of uninsured patients had no ultrasounds or blood work throughout their pregnancies and 66% had no prenatal visits (Rousseau et al., 2014). This finding is consistent with other studies, for example the Toronto-based finding that four out of five uninsured pregnant patients received substandard perinatal care (Wilson-Mitchel & Rummens, 2013).

Maternal and newborn health risks and outcomes: Inadequate prenatal care, among other factors, are connected to a range of unmet health needs and poorer health outcomes for both the parent and their infant(s) (Hamel-Smith Grassby et al., 2021; Hynie et al., 2016; Ridde et al, 2020). Uninsured migrants may resort to unassisted births due to financial concerns and other fears (Darling et al., 2019). In the event of a medical emergency, the birth may end up being even more expensive than a standard hospital birth, with the same fears of being reported and deported. When births do not proceed as planned, uninsured pregnant patients are 14.3% more likely to experience complications requiring an emergency c-section than other pregnant patients (Gagnon et al., 2013). Other complications may include poor reactions to anesthetics, damage to organs, hemorrhaging, infections, abdominal adhesion, blood clots, increased pain, longer recovery time, and even death (Almeida et al., 2013; Gagnon et al., 2013; Khanlou et al., 2017; L. Merry et al., 2016). Researchers also point to a range of neonatal health concerns linked to immigration or health insurance status, including stillbirth and neonatal death (Gagnon et al., 2013; Wilson-Mitchel & Rummens, 2013).

Postpartum health concerns: Even after the birth, the expenses associated with healthcare continue to impact health. Research demonstrates an increased risk of postpartum depression (Dennis et al., 2017) and pain (Mahon et al., 2017). Other work cites concerns related to social isolation and general lack of assessment, support, and referral for psychosocial supports (L. A. Merry et al., 2011). Financial concerns and other stressors deters mothers from seeking out postpartum care (Larios, 2020) and limit their budget for other essential expenses (Rousseau et al., 2014).

Methods & Analysis

This project was guided by reproductive justice as a conceptual framework that expands analysis beyond individual choice to consider the social, economic, and political conditions that enable or constrain reproductive autonomy with respect to having children or not and parenting those children in safe and healthy environments (Ross & Solinger, 2017). We first mapped the community, institutional, and policy contexts that shape migrant access to healthcare in Manitoba, which then provided a backdrop for narratives shared in interviews with medically uninsured migrants about

their own experiences accessing perinatal and reproductive care.[1] Informational interviews with community and health practitioners provided a deeper understanding of the processes involved. This approach allowed for a holistic understanding of the impacts of being medically uninsured while pregnant on various dimensions of a person's life, as well as the structural factors and processes that shape these experiences.

Data collection

In 2023, we conducted 11 semi-structured narrative interviews with medically uninsured people who have experienced pregnancy while living in Manitoba within the previous five years to gain an understanding of their experiences navigating access to the care they needed. Although a small group, participant experiences, backgrounds, and immigration trajectories were diverse. Participants arrived in Manitoba between 2015 and 2023. At the time of their pregnancies, participants were international students (5), refugee claimants (3), visitors (2), and temporary workers (1). Their racial/regional identities included Black/African (4), South Asian (3), South American/Latino (2), White/European (1), and Middle Eastern/Arab (1). Two interviews included partners, and three were conducted with assistance from an interpreter.

Additionally, 20 informational interviews were conducted with 24 individuals across 17 organizations. Participants were community, health, and social service providers within Manitoba, identified through local-level resource mapping. These interviews were conducted to contextualize the narratives, to gain an understanding of the strategies that have been employed to negotiate, resist, or circumvent policy barriers, and to gain insights into institutional processes. Informational interviews were conducted with staff from immigrant- and/or family-serving organizations and health facilities, including frontline social or community workers (12) and managers or directors (7); as well as health professionals such as physicians and midwives (5).

Data analysis

All interviews were audio-recorded, transcribed, and then analyzed using NVIVO qualitative coding software applying a thematic narrative analysis (Riessman, 2008). Each interview was coded thematically by an individual research team member who then led the team in a collaborative coding session for further discussion. Through this process, we were able to include perspectives and knowledge from all team members, as we interpreted the interview and identified broad theoretical connections across the data set.

[1] As much as possible, we verified policy and procedure regarding health care provision as discussed in the interviews. Through this process we encountered challenges obtaining clear information from Manitoba Health Insured Benefits and Shared Health. An access to information request was submitted to Shared Health in 2023, and after much back and forth, the requested documents were not made available.

Being and Becoming Medically Uninsured in Manitoba

Who is eligible for healthcare insurance (including coverage for perinatal care), and under what conditions, varies by province. Under *The Health Services Insurance Act*, conditions of eligibility for Manitoba Health insurance include:

1. Being a Canadian citizen, permanent resident, a work permit holder with a permit valid for a minimum of 12 months or of any length under the Seasonal Agricultural Worker Program (SAWP), or a spouse/dependent of an eligible work permit holder; and

2. Demonstrating residency in Manitoba for at least 6 months of the calendar year.

Refugee claimants receive coverage under the federal government's Interim Federal Health Program (IFHP). Refugee claimants can also apply for Manitoba Health once they receive a work permit of 12 months or more. IFHP remains active and can be utilized if a medical service is not covered under Manitoba Health but covered under the IFHP. Those not eligible for Manitoba public health insurance include tourists, 'transients', visitors, work permit holders with permits under 12 months and their families, international students and their families.[2]

Temporary residents are defined as individuals who hold neither Canadian citizenship nor permanent residency, but who are legally permitted to be in Canada. According to the Manitoba Bureau of Statistics (2024), Manitoba's non-permanent resident population was estimated at 71,458 people, which includes those with a work or study permit and refugee claimants. Rates of temporary migration have steadily increased across Canada, including in Manitoba. There is no official data on the number of people in Manitoba who have entered Canada without documentation or who have overstayed their visa (usually the latter).

While certain groups of temporary residents are eligible for provincial public healthcare, all temporary residents live in Canada in a state of immigration precarity where their presence in the country and access to health and social services is conditional. Given the consistent increase in people entering Manitoba via these temporary residency pathways, the challenges and impacts of not being eligible for public coverage will also continue to grow, along with the uniquely gendered costs of becoming pregnant under these circumstances.

Healthcare for international students

Service providers we interviewed frequently discussed the removal of provincial health insurance for international students and their families in 2018 and referred to this group as the most frequently encountered uninsured or underinsured group. As one service provider noted:

[2] Residents of other Canadian provinces cannot access Manitoba Health, but health coverage is maintained in their province of residency.

> "A good number of the people that we see, who come, who are pregnant without coverage, are students. […] And that's just the reality of life – like, sometimes you get pregnant. So yeah, I don't think it's helpful that they removed Manitoba Health for students."

Although international students are required to purchase private health insurance, this health insurance is often not comprehensive, leaving them underinsured. They may also experience gaps in coverage when delays in processing their study or post-graduate work permits occur. When Lydia[3] first arrived in Manitoba as a student, it was prior to 2018 and she was able to access Manitoba Health, but she had a different experience with her second child:

> "When I had my first child born [we were] covered. Manitoba Health was covering us, so there was no problem. This [second birth] was bit different because when Manitoba stopped covering international students, it was a lot of chaos. And even when we use [private] insurance, […] they only cover very little."

Hani, also an international student, was also frustrated:

> "Well, what can I do about this? I only feel upset and discriminated. Because you are being [determined] by your nationality and your health is being [determined] by your nationality."

Healthcare for migrant workers

Workers with permits that expire in under 12 months are also not eligible for provincial health insurance (with the exception of SAWP workers). In 2022, an estimated 1,435 workers had permits under 12 months in length and were not eligible for Manitoba Health.[4] Workers' health insurance coverage can also be shaped by paperwork processing delays. Gaps between the expiry of a work permit and acquiring a new one, even if the new work permit is also 12 months or longer in length, can also lead to periods of being medically uninsured. Temporary extensions for workers in this situation can be requested by contacting the Ministry.

This was the case of one participant, Kim. She was living in Manitoba with a 12-month work permit when she found out she was pregnant. She was thrilled about the pregnancy, but had concerns because her permit was set to expire midway through her pregnancy, and she could not confirm that her permanent residency application would be approved before the birth. As she explained, "that makes me very worried because the cost for labour is so high for international workers here", referring also to the experience of her friend who had a $30,000 hospital bill after her delivery. Kim called and emailed Manitoba Health and the Immigration office regarding the status of her application and implications for her health coverage: "I said that it's an emergency and SOS!" In the end, she experienced one month without health coverage, in her third trimester, but had coverage re-instated for her labour and delivery.

Kim also discussed the issues her partner was experiencing with healthcare access, noting that when he renewed his work permit – while it was originally approved for 12 months, the 10 days it took to process the permit were subtracted from this time resulting in a work permit under 12 months,

[3] Pseudonyms used to protect the confidentiality of participants.

[4] An IRCC data request show 1,900 work permit holders with a permit duration for less than 12 consecutive months expiring in calendar year 2022. Of these, 465 are SAWP workers, and the others are ineligible for Manitoba Health insurance.

making him ineligible for Manitoba Health insurance. This practice was also confirmed by other service providers:

> "I don't know [if] purposely or by mistake - we have seen a lot of work permits that are issued for 364 days. And this is one day short for Manitoba Health to issue a Manitoba Health card. So, the work permits - if you have a work permit for a year or 365 days, you are eligible to apply for Manitoba Health coverage, along with other supporting documents. But people have like 9 months, 10 months or like 11 months and 29 days of work permit – no, you are not eligible, which is not fair."

Other issues for work permit holders who become pregnant include the likelihood of being fired for being pregnant, or defacto fired when an employer chooses not to renew a closed work permit because of a pregnancy. As one community worker described:

> "Specific to experiences of pregnancy amongst the organization's target population, many of the workers are usually fired from work. These individuals experience discrimination, in addition to financial, emotional, and physical stress."

Healthcare for refugee claimants

Generally, refugee claimants across Canada are entitled to health coverage under the IFHP from the time of claim submission until their claim is approved or denied. If approved, they become a protected person and are eligible to apply for provincial healthcare. If denied, they can appeal the refusal and can continue to access the IFHP during this time. Adult refugee claimants can access a temporary work permit while awaiting determination of their claim and can access Manitoba Health coverage just like any other work permit holder of 12 months or more. IFHP remains active and is used if Manitoba Health does not cover something.

A refugee claimant who is pregnant may have to wait until after delivery to safely have the required x-ray to complete the Immigration Medical Exam that is part of refugee claim determination. While healthcare during this time should be covered under the IFHP or Manitoba Health, there was uncertainty among interviewed service providers regarding how this works, and they offered stories suggesting people had challenges using their coverage. Importantly, not every service provider or healthcare access point is aware of the program or will accept it (although all hospitals do).

> "They do give them the IFHP; however, not every service provider knows the IFHP. I know people had gone, they went to the hospital for emergency, while they didn't have their health card, yet they need the procedure. They have the IFHP and the hospital refused to take the IFHP."

Refugee claimants and service providers can access information on which providers accept IFHP online via the Interim Federal Health Program – Provider Search website. Basic information on refugee claimant healthcare access in Manitoba has been compiled by MANSO and is publicly available online.

For claimants who enter Canada irregularly from the US, the 2023 changes to the STCA mean that they cannot make their claim until 14 days after entering Canada without risking being returned to the US. This also means would-be refugee claimants do not have health coverage during this time. Even when in health crisis, people are scared to go to the hospital because of the costs and fear of

deportation. Refilling a prescription for an essential medication is almost impossible, and together with neglect of routine, has landed people in hospital in critical condition.

Frontline responses

Settlement and other community service providers highlighted how their first response to assisting someone who is pregnant and medically uninsured is to investigate if there is any pathway available to receiving coverage and engaging in case advocacy with Manitoba Health. As one service provider explained:

> "We've been having a few cases where a pregnant woman is having more challenges in accessing health care. Mostly what we do is, we communicate with Manitoba Health and try to find someone to see if they can help the woman that is facing challenges."

Others described how challenging this process can be:

> "We actually, we apply for health cards here with people. So, we have a fair bit of experience of what they want and don't want. It's frustrating though, because they tend to change the rules every once in a while, without telling us, and so then we find out when somebody can't get their health card, and they say there's another requirement or whatever."

Even with advocacy and assistance navigating the system, gaining access to public coverage isn't always possible and families have to make hard decisions about how best to move forward with the pregnancy and family separation.

> "Another case is a temporary resident; her husband is a student. And for her – it was like, through e-mail – she wanted to come [to Canada]. She was pregnant. She wanted to come, but she was not sure if it's covered. [Another social worker] and I tried hard. Like, we connected her, but finally it didn't work, and she stayed there to have her baby and came after that. So yeah, these are the kind of issues that people are experiencing in different immigration statuses."

A number of service providers expressed support for more widespread policy changes on public health insurance eligibility.

> "We've seen the governments in the past - not right now, in the past, they've extended healthcare to farm workers. Those kinds of initiatives have happened and they're successful. And this has helped people within that community fully, you know, do the work that they can do while being safe to access healthcare. So, they can extend healthcare, it's possible. It's been done before and there are other provinces that are doing it currently."

In addition to trying to facilitate access to Manitoba Health, the following sections highlight a range of other frontline responses, including service provision and advocacy, engaged in by a range of service providers across health, settlement, and other community sectors in Manitoba.

Abortion Care without Public Health Insurance

Abortion services, both medication and surgical, are offered at select health facilities across the province. Medication abortion (using the medication Mifegymiso) is available up to 9 weeks gestation and requires a prescription and appointment with a prescriber. Surgical abortion is available in Winnipeg at the Women's Health Clinic (WHC) until 16 weeks gestation and Health Sciences Centre (HSC) until 19 weeks and 6 days, and in Brandon at the Brandon Health Centre until 12 weeks. Individuals who have a Manitoba Health card can access abortion care services free of charge. Some private insurances fully or partially cover abortion care, but not all of them. For people without public health insurance seeking abortion care, costs are generally paid out of pocket and fees vary by health facility. Costs will range depending on the clinic, the type of abortion care received, and other personal and medical factors. Pre- and post-counselling services are offered to all people who undergo abortion procedures at no additional cost.

Navigating systems and access to information

Participants who sought abortion care for themselves, whether covered by private insurance or uninsured, highlighted the difficulties they encountered when looking for information and navigating the healthcare system in Manitoba. Finding reliable information about what services are available for uninsured patients was confusing and frustrating, especially for a healthcare issue already highly stigmatized.

For example, a new international student named Daniela shared the stress she felt trying to figure out what to do when her birth control failed and she realized she was pregnant, especially as someone without a doctor or insurance:

> "It was in between my [high school] graduation and the first year of my university that I actually got pregnant. There were not, like, many choices that I could have. You know, as an international student, I don't have a medical doctor. Not even now. It was very frustrating time because I didn't know what to do. I didn't know where to go. I didn't know how much [...] this [abortion] is going to cost me. And I have to explore a lot because any option that I could find was going to cost me money. As an international student, I don't have any insurance."

This is also reflected in Lydia's experience. As a former international student who was uninsured due to a delay in processing her post-graduate work permit, Lydia recalled:

> "I went to [Health Sciences Centre]. They told me, we can't do the abortion because you don't have Manitoba Health... A nurse told me go to downtown [to Women's Health Clinic]."

Even after identifying an appropriate health facility, Lydia was turned away and referred elsewhere due to her insurance. HSC's capacity for abortion services decreased during the COVID-19 pandemic and they stopped taking patients without public insurance, referring them instead to WHC. In some ways, WHC is better equipped to offer accessible care to uninsured patients (depending on their medical needs) because they can cap the fees they charge patients. However, WHC was also far over capacity, leading to longer than usual wait times. Importantly, this context was not communicated to Lydia. She was only told that she couldn't get care at HSC because she didn't have insurance.

Healthcare and social service providers also noted challenges and confusion. Many service providers were also not certain how uninsured people could access abortion care without a Manitoba Health card. As one community frontline worker noted:

> "I'm not sure about abortion. That would be a very good question for Women's Health Clinic, which is the institution that offered those services. I think they're pretty welcoming, but I'm not sure what happens when they don't have the Manitoba Health card."

The barriers faced by uninsured pregnant people while navigating the healthcare system in Manitoba can result in significant delays in seeking care. Having the right information on time is crucial for abortion care, especially when as more time passes and the pregnancy progresses, where you go and at what cost changes as medical needs become more complex. As one service provider noted: "That, I think, is the biggest challenge, that we can get people in, in a good time." Difficulty finding the right information about where to go can mean delayed or postponed appointments or simply missed appointments all together. After going to HSC and being referred to WHC, Lydia was put on a waitlist. By the time she received her appointment, she felt her pregnancy had progressed too far and she no longer felt comfortable getting the abortion.

People also don't have information on what to expect and if they will be safe in certain spaces because of their immigration status.

> "Part of the challenge is people are afraid to come forward, right? And so, they'll come too late to us ... then it's beyond the weeks that we can do. And then they have to go to the hospital and the hospital costs between $5,000 and $10,000 more and there's no movement on that..."

Financial costs of abortion care

People without public health insurance pay out of pocket for abortion care. As a non-profit community health centre, WHC has the ability to set their fees in a way that aligns with their clinic values of equity and accessibly. WHC cannot use the public funds they receive from the province for abortion care to assist people without public health insurance; however, they maintain an emergency fund which can be used to help cover the costs. This allows them to cap the costs to the patient at $500. As an abortion clinic, they are also situated within a broad network of reproductive rights organizations [5] that raise funds through donations and fundraising to help facilitate accessibility and assist with outstanding costs. As one healthcare provider noted, "this is significantly below cost compared to many other places." However, because this emergency fund relies on donations and fundraising, it is also limited, which means it can run out before all needs are met and it's difficult to predict future capacity.

Additionally, depending on how far along the pregnancy is (and potentially other risk factors), going to the hospital may be the only option. As noted above, service providers have seen bills for abortion care at HSC as high as $10,000. A healthcare provider broke it down:

[5] For example, Abortion Care Canada (formerly the National Abortion Federation Canada) and Action Canada for Sexual Health & Rights. Importantly, federal funding for these organizations was either not renewed or significantly decreases in 2024, despite increases in demands for support.

> "They are for up to $4000 for the [operating room] fee, not counting the physician fees, and potential anesthesia, so it's really expensive…"

Even though Daniela was able to access care early on in her pregnancy, because of complications and the need for multiple ultrasounds and tests (which are additional costs), she still spent over $3000 for abortion care.

Service provider interactions and institutional approaches

Participants who sought abortion care had a range of experiences with service providers. They were very aware of their own positionality as racialized women who were temporary residents without insurance, and this informed their interactions with service providers and their reflections on those experiences.

Lydia's experience of being turned away at HSC is one she describes as discrimination because of her temporary residency and insurance status. For her, this was the beginning of a chain of events that started with her not getting the abortion she initially chose and eventually led to a very expensive and traumatizing labour and delivery. Even if discrimination was not the intention, the way in which this referral was made was experienced as a refusal of care and the language used was disempowering and not supportive to Lydia's situation.

Daniela also reported feeling stigmatized while interacting with healthcare workers and navigating intake procedures. She was repeatedly asked about her immigration status and required to present her immigration documents at each appointment, adding an extra layer of stress to an already difficult situation. She recalled:

> "I need to bring my documents. So, and also like some questions like, 'What race are you? How long have you been here? What's your status in Canada?' Like that's the first thing that they usually ask me. So, like, 'Do you have the PR or not?' So, I understand, but obviously that's one thing that I always relate, like the money and what status I have in Canada. I need to show more documents."

However, Daniela did also talk about more positive interactions, in particular during and after her surgical abortion. She described how she appreciated having the choice between medication and surgical abortion, how each process was explained, and the comfort of having someone who spoke her first language as a care provider.

Prenatal Care and Childbirth without Public Health Insurance

Routine prenatal care can be provided by midwives, family physicians, obstetricians, and some nurse practitioners in Manitoba. Those with Manitoba Health insurance can access these service providers by self-referral and without charge, as well as routine and diagnostic lab work and imaging. Most labour and delivery care is provided in 10 major hospitals across Manitoba and accessible

without charge for those with Manitoba Health.[67] The IFHP will cover these costs for refugee claimants. Other migrants, in particular international students and temporary workers, may have private health insurance via companies such as Blue Cross and guard.me that may cover all or portions of their prenatal care and delivery. Some care providers may be able to direct bill the private insurance provider, while others will require full payment up front, which the patient can later submit to their insurer for reimbursement. Not all private insurance plans will include costs of prenatal care and childbirth as an eligible benefit; in fact, many do not. Travel health insurance available to visitor visa holders does not include prenatal or childbirth coverage. The free-standing birth centre in Winnipeg, Ode'imin, is exclusively for use by clients of midwives of the Winnipeg Regional Health Authority (WRHA) with public health insurance. Midwives can provide labour and delivery care at Ode'imin, in hospital, or at home births.

People without public health insurance or whose private insurance does not cover prenatal care and childbirth pay all medical costs out of pocket. Physicians, as fee-for-service care providers, can set rates for their services for those without provincial health coverage. Hospital fees can vary based on facility, length of stay, and services received. Hospital and diagnostic lab work and imaging fees follow a rate structure set by Manitoba Health.[8] Fee schedules for midwives are set by the regional health authorities they are employed under. Some health regions have a fee schedule for midwifery services, which allow uninsured clients a pathway to midwifery care. These fees typically cover prenatal and postnatal appointments and labour and delivery care, but not lab work, imaging, or hospital charges. However, WRHA does not have a fee schedule for midwifery services and does not accept clients into care without public health insurance.

Navigating systems and accessing information

People who do not have public health insurance generally have more difficulty accessing care at all stages starting from how to find information, where to go, and how to find a healthcare provider willing to provide care for them. This can be the case, even for people with private insurance coverage. These conditions are exasperated by challenges common to a range of newcomers, including unfamiliarity of the healthcare system and not having a family doctor. This can lead to delayed care or people forgoing care altogether, resulting in a range of negative emotional and medical consequences.

Christina, an international student with private insurance, shared her difficulty finding a doctor that would accept her as a patient and follow her pregnancy:

> "I went to a walk-in clinic after I found out I was pregnant and they said, 'Okay, we're going to try to refer you' [...] Two months after I got, finally, someone calling... We did try through the Women's [Health] Clinic... We tried everything. [...] Women's [Health] Clinic referred me to this doctor, the one that eventually saw me, because the one from the walk-in clinic did not accept my case."

[6] This does not include smaller health centres which may be able to accommodate emergency labour and delivery care.
[7] Separate charges may be incurred, for example, for upgrading to a private postpartum room at St Boniface Hospital in Winnipeg. Some private insurance plans may cover such fees.
[8] Confirmed by Shared Health (personal communications).

Another international student, Nisha, whose private insurance would not cover any of the expenses of her pregnancy or labour and delivery, also shared this challenge. Concerned about costs and the type of care that would best fit her needs, Nisha sought out midwifery care for her pregnancy but found that the WHRA, the health region she lives in, does not permit midwives to take on uninsured clients. As she described:

> "We were willing to pay, but they won't accept uninsured patients for the midwifery services they provide, at all. So, we thought about going to either Brandon or Winkler. Yeah. Or we [thought] of shifting to another province like BC, Ontario, and Alberta. They are providing this free midwifery services for the international students."[9]

In the end, Nisha was able to connect with a supportive doctor through Mount Carmel Clinic and felt lucky to have that connection.

Other participants described circumstances where they or someone in their community struggled to navigate the healthcare system, which led to not receiving timely care. Hani, an international student with private health insurance, described supporting another international student during pregnancy and after the stillbirth of her baby, recalling: "She didn't even know how things work in the emergency ward... that she can access services anytime." Another case was shared, involving an uninsured woman who "tried to go to the hospital, and they had turned her away because she didn't have money." She fell sick, experienced a lot of bleeding, and eventually miscarried at home.

Communication issues and language barriers exacerbate challenges experienced navigating the healthcare system. Some participants reported that healthcare providers did not always explain medical procedures in detail, leaving them anxious and uncertain about what was happening. Others used different translations apps and interpreters. Through an interpreter, Bethel, a refugee claimant with severe health issues, recalled how her difficulties navigating the system led her to being late for her prenatal appointment. When she arrived, her interpreter was no longer available and she did not receive care that day, including a necessary medical procedure. Just before her delivery, complications arose due to her untreated condition, leading to a difficult delivery that put her life as risk and caused long-term medical issues.

Community health clinics and migrant-serving community organizations take on the role of assisting with navigating the system, trying to connect with appropriate medical professionals, and individual case advocacy with Manitoba Health, regional health authorities, or hospitals and clinics. Service providers from a range of sectors repeatedly described an utter lack of resources, information, and established courses of action to assist people without public health insurance. As described by service providers from a range of sectors including health, mental health, and settlement:

> "A big problem is just a lack of support and information for people who get pregnant and not knowing where to turn, what's available. There's just no information at all, which organizations are even there to help you try to figure it out. There's really nothing."

> "So there are no resources where you can feel confident that – 'Oh, there is this problem, I'm going to refer this client and be confident that this client is going to be helped.' That is a

[9] Midwives in Ontario do provide perinatal care free of charge to uninsured migrant clients. In Alberta and BC, international students can access public insurance (though, still for a fee in BC) for midwifery services and other healthcare needs.

> frustration in itself when there are no structures or no services in place where you can refer your clients."
>
> "We've worked with many people actually who, let's say, came as international students and lost their status. There's nothing, there's nothing available."
>
> "Our positions are not funded to work with this group of people. So we're all doing this kind of on top of other things and just squeezing it in as we can. So, none of us probably know what we need to know to be able to respond well to people."
>
> "Manitoba Health is very inconsistent about when the coverage begins, what coverage they're receiving, and it seems like there's kind of different - it depends on who you talk to, type of thing, which can be very difficult. [...] It's a system that I don't even understand and I'm from here. So, I can't imagine that added, extra stress. So I feel like there's almost just so many limitations that I don't even know how they navigate, to be honest."

Service providers mobilize their informal networks to find information and identify clinics or practitioners who are able to assist:

> "There's a lot of communication between people in those networks within the sector, to kind of figure out supports for each other's participants and clients and things like that."

Service providers describe both successes and setbacks with this type of approach. Certain community health clinics or doctors have been able to assist on a case-by-case basis, but capacity to intervene is also limited or not always available. Although there have been important successes, overall service providers expressed frustration and feelings of powerlessness, especially when people's health is on the line.

> "The amount of advocacy and intervention it takes to try to access service for these folks, it's too much. That in itself takes so much time, and if any one of us in that drops the ball, we don't see the e-mail or whatever, or we move to a different job or something, then you're out of luck. So, this one is just a patchwork that's terrible, right? And it's not even secured. It's not even guaranteed that they might get some help, right? And most often they're not."

Unfortunately, because resources are so scarce, providers and clinics who do provide care for reduced rates are hesitant to advertise that information, as they are already at capacity. This makes it even harder to find information and care providers unless a person is already tapped into these informal networks.

Financial costs of perinatal care

When people are uninsured, it means they must generally pay for healthcare services out of pocket. Similar to findings in other provinces, the financial costs involved in receiving healthcare services when publicly uninsured serve as a key barrier to receiving care and shape perinatal decision making. This can be the case, even when people have private insurance, which may not at all, or only partially cover costs pertaining to perinatal care and which may still require high co-pays or that costs are paid in full and reimbursed later.

Manitoba Health provides a fee structure, but costs associated with prenatal care and labour and delivery can vary from hospital to hospital, across regions, and across practitioners. Participants describe considerable uncertainty concerning how costs are being calculated and what is covered or not. This also extends into labour and delivery costs, including the costs of staying overnight at the hospital, obstetrician fees, anesthesiologist fees, surgical costs, medications, and testing. Furthermore, hospitals in Winnipeg are now requesting prospective patients pay large deposits during the third trimester. As Hani expressed, "the thing is we are not getting clear information. Its stressing our mind, that if I go to hospital, they going to charge me. As international students, I don't know how much I will be charged."

It is possible to call hospital finance departments and receive this information; however no participants or service providers described getting information this way. A call to HSC revealed that birthing parents are charged $7,116 and babies $3,441 per night if uninsured, which doesn't include physician fees or costs of additional procedures. The deposit amount requested by HSC in the third trimester is based on costs of birthing parent and baby staying for 3 nights, totaling $31,671 requested prepayment.[10]

Participants generally reported paying $80-100 per prenatal visit with a physician. Fees for lab work and other tests are separate fees, also reported to be $80-100. For participants with private insurance that did cover prenatal care, a portion of these costs were covered, but it depended greatly on the details of the plan – for example, Lydia reported only having a small portion of her blood work covered,[11] and Christina reported having a significant portion covered but had to pay the full costs upfront first. Fetal ultrasounds are also a separate cost, for which participants reported paying around $1,000 per scan.[12]

These costs shape where and from whom participants are accessing care, with participants factoring in costs into all health decisions. As Jasleen, who was on a visitor visa and without insurance covering her pregnancy, recalled:

> "Going from doctor to doctor to find the cheapest one, or having the, you know, treatment. And the other thing at that time that came in my mind was also, 'Okay, who will be the cheapest one? But maybe they are not gonna treat me well?'"

For many participants, these costs were barriers to prenatal care. This dynamic extends into getting treatment for more serious medical concerns and hospital fees related to the birth. As Lydia, an uninsured former international student waiting for her post-graduate work permit, described, the fear of the debt she may accrue due to hospital fees was overwhelming and shaped all her decisions toward the end of her pregnancy. When her physician recommended she be hospitalized early because of a medical complication, Lydia resisted:

> "At that point, I was like, well, you know, if I was going to lose the baby, that's okay, but I don't want to get so much debt or I don't have so much money to pay. Because I know for just

[10] Numbers accurate as of 26 February 2025 and verified by Shared Health. These may be different from the fees charged to participants at an earlier time period.
[11] International students with Blue Cross private insurance (like Lydia) are now fully covered for all labs and blood work for tests deemed medically necessary by Manitoba Health guidelines, as determined by the student's doctor or on a case-by-case basis by Blue Cross doctors.
[12] HSC charges $1,320 for an ultrasound (verified as of 26 February 2025).

> staying one day in the hospital that was like about $4,500. [...] I knew that the complications were gonna keep me in the hospital for a longtime."

Concerns about forgone or delayed care because of financial costs were echoed by service providers. One health sector service provider explained:

> "If they don't have access and they're not receiving prenatal care because it's hundreds of dollars every time they have a 5-minute appointment, I 100% understand why they're not... We're dealing with a medical model, within a system that doesn't work [for them]... It's not that they don't care about their baby, it's not that they don't care about their health... Honestly, we put too many barriers in. [...] It does make me a little bit more mindful of, when I'm referring them to different services or different programs, I am obviously making sure that they are free, because I know that if I refer them to something that they're not going to be able to pay for, they just won't go."

Another unanticipated financial concern shared by participants was the request for large deposits by hospital accounting offices in Winnipeg toward the end of the pregnancy. As with other costs, the deposit amount varies depending on hospital or health region – with deposit requests from Winnipeg hospitals ranging between $20,000-30,000 to $5,000-$6,500 in other health regions, according to interviews.[13] Health sector service providers were familiar with this practice and consistently described it as a "huge barrier" and "very frustrating." Nisha described saving and receiving family support for her labour and delivery costs, which they were anticipating being around $12,000 based on information from their clinic, but within her third trimester received a request from the HSC accounting office for a $25,000 deposit. She described this as a low point in the pregnancy, as this amount was "not within [their] reach". Nisha and her partner panicked and began looking for other options. They considered returning to their home country to deliver, but Nisha was too far along in her pregnancy to safely travel that far. They also considered relocating to another health region with lower costs. Health sector service providers encourage people to pay the deposit, but also note that:

> "When your water breaks, you can present at the hospital, and they have a duty to provide care, and so they can't turn you away. And then they will bill you, right? So that is an option, but that also means you're not necessarily getting perinatal care, right? So, yeah, that's the issue."

If a person has paid a deposit, that amount is applied to the accrued hospital bill with the remainder returned to the patient or costs over-and-above the deposit amount billed out. None of our participants paid a deposit, rather all were billed after services were received. The amounts participants were told by physicians and other healthcare staff to plan for varied – for example, one participant reported she was told to prepare for $4,000 for a vaginal delivery with no complications and up to $10,500 for a caesarean section, while another was told $10,000 for the former and $18,000 for the latter. Participants reported bills ranging from $7,000 to $40,000, with one extreme case at about $170,000. How this billing happened looked different for different participants. Nisha and her partner were able to work out a payment plan and pay their $7,000 bill in installments (paying 25% upfront). Lydia was mailed the approximately $40,000 bill, which was subsequently sent to a collection agency. According to HSC, bills get sent to collections if payments are missed and there is a lack of communication from the patient. HSC policy is that payment plans are available to

[13] This happens in hospitals across the country. For example, in Montreal, as of 2018, these deposits ranged from $5,000 to $16,000. As mentioned above, HSC currently asks for a prepayment of $31,671.

everyone; however, Lydia recalls being told it wasn't possible, suggesting there is perhaps some discretion or miscommunication surrounding this.

For Jasleen, who gave birth alone after her partner's visa was denied, hospital payment was demanded almost immediately after delivery. Less than two hours after giving birth, she was contacted by the hospital's accounting department and told to come downstairs to pay her hospital fees. As she described:

> "I just delivered the baby in the morning, 7:30. And 9:00 o'clock, I got a call from account department of the hospital, that you need to pay the bill... [...] And they said, 'Are you able to come down and pay?' I said, 'Okay.' ... I took the cash - $7,500 - and I just went on the third floor... I just came and then I just give them the money."

Jasleen paid $7,500 in hospital fees, in addition to a $1,500 physician fee.

Several participants and service providers also noted that Winnipeg hospitals have been calling or threatening to call Canadian Border Services Agency (CBSA) in the event that high hospital bills go paid. HSC confirmed this is standard practice if there are missed payments and no communications As Nisha described,

> "After the baby was born, and when we talked to accounting, they're like, 'You know, if you don't go with the payment plan or if you fail to pay what was due ...' Then they would report us to the Border Services, which would have the potential of getting us deported, or causing issues when [we] travel."

Lydia was sent her hospital bill after being discharged and did not have a payment plan worked out in advance:

> "Then suddenly I got an email, it's from Canada Border Services. They send me an email and asked me to see them. You know, I was shocked that – what is happening? I don't have anything due with Canada Border Services. And when I went there, it's all about that hospital bill. They said you only have the option to pay the bills or maybe you have to go back to your country because you are owing a bill."

There is no legal requirement from CBSA or IRCC that stipulates this reporting must happen; rather, this is a discretionary practice implemented by the health region. Some service providers were aware of this practice, described it as "bullying," and raised concerns about the privacy of uninsured patients' personal health information. They also note that this practice could spark more fear and uncertainty for medically uninsured people and may be a major deterrent to seeking out necessary care:

> "Imagine knowing that if you go to the hospital for prenatal care or anything related to pregnancy, once you spend a certain amount of money due to, maybe, complications in childbirth, there's a possibility that your case can be reported to Canadian Border Services Agency."

Not having enough money to pay for the high cost of prenatal care, including doctor's visits, tests, labs, ultrasound, and other relevant care, especially when there are other complications, results in forgoing necessary care that puts themselves and the pregnancy at risk. These high costs of labour

and delivery, as well as fear of CBSA, can also lead to forgoing care, exacerbating stress, and increasing the mental load of accessing appropriate healthcare in a timely manner. For some, this raised questions as to why requested deposits and other charges were so high, with one health sector service provider hearing that "there's a 300% markup for healthcare services, if you don't have Manitoba Health coverage. So, it's not like they're asking to cover costs which, you know, may be reasonable. They just jack it up hugely, right? So, it's very not good." It was confirmed by Shared Health that charges to uninsured patients are roughly three times what is billed to Manitoba Health for insured patients.

Service provider discretion and community resources

As discussed above, established resources and pathways to care for medically uninsured pregnant people are scarce within Manitoba, and individuals end up relying on individual-level negotiations and private one-off arrangements. As a result, service provider discretion regarding sharing information, providing care, and at what cost, can play a significant role in facilitating access to care. It also places an undue burden on individual practitioners and clinics who see this work as aligning with their values and human rights principles, but who are not funded to do it.

Participants shared a range of experiences they found supportive – for example, walk-in clinics and community health clinics assisting them to secure a physician for prenatal visits, and doing follow-up calls to ensure they had access to care (for example, Christina and Nisha). Service providers in health and other community sectors also described doing this work – for example, one service provider described: "We've been referring them to individual doctors that we have relationships with that can visit them." Many service providers noted connections with community health clinics like Women's Health Clinic, Klinic, and Mount Carmel Clinic who they have worked with to help facilitate care. Care provision directly at these clinics can depend significantly on the nature of the care required and capacity. Others described public health nurses as key mediators for navigating access to care.

Uncertainty surrounding labor and delivery, especially in terms of where to go, what to do, how to pay and what to expect, caused significant anxiety for most participants. Participants also found it especially helpful when service providers, including their physicians, were able to provide them with information related to cost expectations, navigating the systems, and strategies to reduce costs. For example, as Jasleen shared:

> "[The doctor] said, 'And you have to pay for hospital charges, and that's going to have to be like $7,500 for a night. Normally, if you are giving birth to a child and it's a normal delivery, then you stay normally for two nights in the hospital. […] after delivery, they can, you know, discharge you quickly, so that you won't need to pay the charge for another night.' So, he was a helping hand for me. It was such a relief for me as well."

Jasleen also expressed gratitude that her doctor was clear about their fees so that she could plan accordingly. Physicians that are fee-for-service can set their own rates for providing care to uninsured patients; sometimes this can include waiving their fee or choosing not to pursue collections. However, there are a wide range of perspectives on this issue within the health system.

> "If I get paid, great, but if I don't, I'm not going to chase them. […] Some people are just like, 'Nope. I don't believe in this. They shouldn't come here and have access to our healthcare.

> They're taking up spots that my daughter would be wanting or like, you know? And we're busy, we shouldn't be encouraging this.'"
>
> "If people have financial hardship, I will often reduce the fee. Cut it in half or whatever they can pay."
>
> "We have a few specialists who will help us out by seeing people out of their own pocket, right. They don't charge them, but then if they need to go to the hospital, which they do to give birth in this province, that's where the real hang up is, right? The specialist is happy to waive her fee, but they can't really do much about the hospital fees."
>
> "We consulted an obstetrician, and then we spoke to them, and we told them that this woman is uninsured and she's paying out of pocket and all that stuff. And two of the obstetricians that I had worked with, they didn't even charge."

It's also not guaranteed that a specific doctor will be on call or available to assist with a delivery when the time comes.

> "I don't charge them, but I can't make all of my colleagues do the same, you know what I mean? So I tell them, 'Listen, the doctor might charge the delivery anywhere from $500 to $1000.' But compared to the hospital fee, it's minimal. But I can't guarantee what's going to happen, right? Yeah, I do ask my colleagues to be as forgiving as possible, but sometimes it is what it is..."

Service providers who do not provide direct healthcare also play a role in advocating for decreased or more manageable costs. One community service provider described advocating on behalf of a pregnant migrant worker with the health authority of the region she resided in:

> "I tried to do a bit of advocacy to show the situation of migrants, etc. And so she came on board, the person within that health authority, and then she got back to me and said, 'Would it make sense that we be charging her, this worker, from a non-resident fee compared to an uninsured resident?' So, I was unfamiliar with this distinction, but [...] it's significantly cheaper, the fees are significantly lower, if you're considered a resident but just without health insurance. So, compared to somebody who's a non-resident, who could just be passing through, it might make sense, right? [...] She said to me, 'How do we demonstrate that they're a resident?' And well, they have an address, right? They have an employer or, in the case of a student, a school. So, all of these things show that they're residents. And she said, 'Okay, I'm going to advocate that then.'"

Within the province, there exist separate fee schedules for the administrative categories "uninsured non-resident" and "uninsured resident". An "uninsured resident" refers to someone who is a Canadian citizen whose Manitoba Health Card is no longer valid – for instance, because they were residing in another country, or failed to apply.[14] "Uninsured residents" are charged lower fees – for example, at HSC an uninsured resident birthing parent is charged $2,373 per day rather than the $7,116 per day charged to "uninsured non-residents". Advocates, such as the service provider above, have tried to make the case that people with valid residency documents, such as migrant workers

[14] This distinction was confirmed in communications with Shared Health and the WRHA.

and international students, should be charged at the lower rates, as they are demonstrably residing in Manitoba. Unfortunately, policymakers have yet to be convinced.

Other service providers have helped to ensure a reasonable payment plan is in place:

> "Well, and I mean, just even people doing the finances, so they know that somebody is in a bad situation, they have to collect this money, but they come up with payment plans or something within their parameters. They tend to really try. So, I found that that's been very helpful for the people that have been through a tough time in that sense."

When financial costs are overwhelming, service providers can also mobilize community support. Some churches, mosques, and ethnic community groups mobilize resources and support, and help pay for medical bills through donations.

> "I know churches are doing that as well. I am sure, because we do partner with churches to see if they can help people that do not have insurance and they not only pay money to provide healthcare to them, but they also provide, you know, food as well."

Unfortunately, service provider and administrative discretion can also present a barrier, as well. As discussed above, Lydia, who was uninsured for the birth of her child because of a lag in processing her post-graduate work permit, was unable to negotiate a payment plan for her hospital bills. Her story indicates that accounting departments have some discretion in making these arrangements.

> "I told [the hospital accounting staff member], I said, 'Can I work this thing out?' He said, 'No, you have to pay the money. It's the taxpayers' money. I was like, 'I paid tax. I paid huge tuition. I'm working in Canada for four to five years.' [...] I said, 'Can I talk to somebody else?' He said, 'No, you can't talk to anyone. I am the only one in charge.' The guy was so depressing. I called him again, he said, 'I sent it to collections.' [...] Yeah, that was it. He was not willing to do anything."

As noted above, this can include practices like sharing information with CBSA – some participants noted that accounting staff had threatened to call CBSA if they default on payments. Several service providers had inquired with the WRHA regarding details of this practice:

> "It seemed to be just at their discretion. They're basically deciding when they want to. There's not any clear policy that we were referred to for, for when they would contact CBSA."

Others in the health sector were uncertain about what policies exist concerning protecting people from reporting to CBSA:

> "We have lots of different turnaround in terms of lots of nurses, healthcare aides, lots of different disciplines. So, I imagine a lot of it is up to personal discretion, I do know that some people would have difficulty knowing that these people are breaking the law and not doing something about it. But I - I think we are not allowed to call, because again this is a place of safety. I would like to say that they're getting care, and getting care in – prenatal care, a safe delivery in a healthcare setting, helping the baby get whatever they need healthcare-wise, would be more important to the staff than calling to report whatever. That's what I would like to think."

Without clear Access Without Fear policies that clearly protect against sharing information with CBSA, there is always a risk that staff members or administrators can use their discretion to report patients to CBSA or raise immigration-related concerns. Although community health clinics also do not appear to have Access Without Fear policies, service providers identified these spaces as "safe space[s] for people to access care without being reported to CBSA."

In general, organizations varied on their policies toward precarious status and medically uninsured migrants. Sometimes there were specific immigration-status eligibility criteria for programs, and other times there was room for flexibility. Even then, it was common to request personal health identification numbers as a confirmation of identity and to track program uptake, which is exclusionary to medically uninsured migrants (even if not intended to be).

Postpartum and Newborn Care without Public Health Insurance

Early postnatal care continues in the hospital for 24-48 hours for most. For some, ongoing care is required for either the birther or infant due to complications. Those without Manitoba Health insurance will pay for these services based on their length of stay and services received during this time. As with labour and delivery, the fees for uninsured newborns can vary significantly. By virtue of having a Canadian birth certificate, infants born in Canada become Canadian citizens; however, eligibility for Manitoba Health includes both citizenship/immigration status and residency requirements. If medically uninsured parents can demonstrate residency requirements, their citizen newborn can access Manitoba Health coverage. All parents (whether insured theor not) must apply for Manitoba Health for their newborn. For parents with Manitoba Health, the newborn's health costs are linked to the personal health insurance number (PHIN) of the birthing parent until they get their own and parents do not get billed. Parents without Manitoba Health may see bills for these costs; however, they can be retroactively covered (however navigating this process and ensuring the reversal of charges requires follow-up with Manitoba Health). For parents who do not meet or cannot demonstrate they meet the residency requirements, their baby will not have Manitoba Health coverage, regardless of citizenship. This can also be a period of isolation, as new parents navigate these stresses, in addition to the regular stresses of caring for a newborn, without their established network of community and family support. Other public services and supports may also require demonstration of both status and residency requirements – for example, the Canadian Child Benefit – or others are simply not available for them – for example, employment and income assistance and housing benefits.[15]

Ongoing costs of postpartum care

Medical costs continue to shape the experiences of medically uninsured migrants postpartum and in the early stages of caring for their baby. As discussed above, one strategy to decrease costs postpartum is to request an early discharge from the hospital, so new parents are only paying for one 24-hr period of hospital fees. Both Jasleen and Nisha had births without any complications and were

[15] A more comprehensive overview of available public services and benefits can be found on the MANSO website.

able to use this strategy, as recommended by their physicians and agreed to by their labour and delivery nurses. Jasleen describes this conversation with her nurse:

> "[The nurse said], 'Okay, we can discharge you, but, today, after all the checkups and everything, all the, you know, basic requirements are done. You can go home, and you can save the extra. Otherwise, you'd have had to pay one more night.'"

One health sector service provider noted, that while staff try to be mindful of this, there are sometimes genuine health risks that make them less comfortable with early discharge.

> "For vaginal delivery, it's 24 hours in hospital. And for C sections, it's between 36 and 48. [...] And oftentimes, if they are uninsured, they're leaving before the required 24 hours because they just can't, they just don't want to stay because they can't afford it. So those are some of the challenges that we have seen."

Following discharge from hospital, routine postnatal assessment of the birther and baby is offered by public health in the community within the first week postpartum. Most physicians will offer a maternal appointment at six weeks postpartum. Midwives provide care for both birther and baby until six weeks postpartum, with typical care consisting of at least six appointments during this period. These services are free if the birther has Manitoba Health coverage and are subject to charges if not.

Some participants reported not receiving any, or receiving very limited, formal follow-ups postpartum. Christina, an international student at the time, who had a C-section that was covered under private insurance, reported only a brief phone call in lieu of a postpartum appointment with her healthcare provider. She shared her frustration:

> "... I did not receive my postpartum appointment with the doctor. [It] was through a phone call. No one checked me. My sister-in-law, like my husband's sister, was pregnant at the same time as me and she is a Canadian citizen. So, she had, different appointments after her pregnancy; she got a check-in for postpartum. And I could see the differences like – Why I'm not getting this? [...] I was very, very angry after. I had a C-section. They didn't even check how my life, my scar was doing, like no. I just came home from the hospital and that's it. That was the last time someone checked my scar."

Although we can't say for sure why Christina did not get postpartum care, it is clear that she interpreted this as related to her insurance status. This feeling of being an outsider in the health system shaped her reluctance to request a more fulsome medical follow-up.

Kim, who experienced a gap in her health coverage during her pregnancy but had Manitoba Health for her delivery, was able to maintain continuity of care with a midwife into the postpartum period. She also highlighted how helpful the public health nurse visits were.

> "A couple days [after the birth] the midwife came to visit, [and continued to come] until six weeks, when my baby turned six weeks. And from the second week, the public [health nurse] came to visit me and tell how to care of the newborn baby and they help. I feel very I feel better a lot and feel warm, feel very touched in my heart."

Midwives in health regions where they are permitted to provide care to medically uninsured people are committed to providing more comprehensive postpartum care and work with their managers to decrease costs – for example, charging one fee for a combined maternal and baby check-up rather than seeing these as two separate appointments.

Likewise, Christina found appointments with the public health nurse and her baby's pediatrician to be helpful:

> "It was very hard. I struggled for months. [...] I had a hard time breastfeeding, so I had a lot of support and a local nurse like just calling me, checking on me. Actually, [my baby's] pediatrician was very good – at every appointment asking me, 'How are you? How are things doing with you?' [...] I did not have a doctor of my own. [...] It took me 6 months probably to just snap out of that depression mode."

Nisha was able to connect with a doula through the Manitoba Association of Childbirth and Family Education who volunteered their services for free, which proved to be a valuable resource. While not a registered health professional who can provide medical treatment or medications, a doula can be a helpful emotional support and general information.

> "That doula, she was with us through that... she was really helpful... just during the pregnancy... and after the delivery as well, she was here to provide the support for me and the baby. And so that was really a blessing for us".

Health sector service providers also made referrals to a range of organizations and programs – for example, Healthy Start, Mosaic Newcomer Family Resource Network, Healthy Muslim Families, Aurora Family Therapy Centre, and Family Dynamics – where people could access information and social supports related to parenting without concern for their health insurance status.[16]

> "I get a lot of postpartum depression – like women concerned about postpartum depression. We see a lot of newcomers who wanted information and resources in community once they're at home."

Newborn care and health insurance

Midwives and public health nurses often check in both on the birther and the newborn during their visits. Additional pediatric care in community is provided by family physicians, pediatricians, and nurse practitioners. If there are complications or concerns regarding the health of the baby, more specialized follow-ups or a stay in the newborn intensive care unit may be necessary. An uninsured infant staying in the intensive care unit at HSC will incur an expense of $17,922 per day.[17] Babies whose parents can fulfil the residency requirement for Manitoba Health are eligible to receive public health insurance – for example, the babies of international students. However, this coverage may also expire if parent residency is not maintained.

As Nisha described,

[16] A list of services for newcomers with temporary immigration status can be found on the MANSO website.
[17] This number accurate as of 26 February 2025 and verified by Shared Health. It may, however, be different from the fees charged to participants at an earlier time period.

> "It's a bit complicated, to be honest. Like, [the baby's health insurance] would be linked to the mother's status – the mother won't be getting any benefits out of it, that health card is just going to be valid until our student permit expires."

Likewise, Jasleen, on a visitor visa at the time of the birth, was told her baby was not eligible because of her status:

> "My child is getting the citizenship and that whole thing, but she was not getting any other benefit. Okay, I said, Okay, I'm not getting any money. That's totally understood. Like, the government isn't going to give me any benefit. But what about her immunization? She won't. Her, at least, immunization should be covered."

As discussed above, parents of newborn citizens must demonstrate residency in order of their child to access Manitoba Health. This policy was not explained to Jasleen and she was discouraged by frontline hospital staff from inquiring further. This policy and the kinds of assumptions that get made regarding a person's status and their motivations ultimately lead to citizen newborns not having health coverage and potentially missing out on important health check and immunizations that could have long-term impacts on their lives.[18]

Christina and her partner, who is Canadian with Manitoba Health insurance, had to pay out of pocket all their newborn's care which was never completely reimbursed even after the baby finally got his Manitoba health card. As she explained:

> "We just went [to the hospital], you know, thinking that somehow everything was going to be covered because the baby is Canadian. [...] Then I got the billing for my son. It was almost $6000 and that was not gonna be covered.... We kept calling Manitoba Health care because we submitted all the paperwork for my son to have a Manitoba Health card. [...] It was just very stressful, like having a newborn at home and having to pay that much money, you know? [...] My husband was very angry that he was having a Canadian child being born in his province, in his country, and he had to pay for that."

Ultimately, these costs incurred can be reimbursed retroactively once the baby's health coverage is processes; however, receiving these bills adds another layer of stress and reimbursement can be difficult to navigate.

As with prenatal and postpartum maternal health, there is concern that newborns may not be getting the check-ups and immunizations they need because of financial barriers, especially if the newborn is left uninsured. One health sector service provider provided an example:

> "I've seen babies that didn't have follow-ups after being born. There were no doctors able to see or willing to see them for free when the budget was really tight. We had one case where Mom really struggled. [...] She had a lot of issues during labour and baby was in NICU after, so they had a huge bill to pay. After that, the baby needed a follow up after 2 weeks, and the

[18] Policies around healthcare insurance eligibility are made at the provincial level and vary across the country. Notable, Quebec recently passed legislation guaranteeing provincial health coverage for all children in the province, regardless of their status or that of their parents.

> doctor wanted them to pay up front before seeing the baby. And they said if you don't pay, we won't see the baby. And baby was preemie, 2 weeks old. So challenging, very challenging."

Parenting supports and resources

Medically uninsured migrants face numerous challenges in their journey through parenthood. From isolation and family separation to childcare costs, language barriers and financial struggle. In the context of this study, which captured the full period of COVID-19 restrictions, these struggles were also exacerbated by these health concerns and the specific measures taken during that time to manage the pandemic.

A significant number of our participants made their journey to Canada alone or just with their partners, without family members to help and support them during their transition into parenthood. Those who came by themselves, whether as students or refugees, faced intense emotional struggles, especially as young first-time mothers. Not having anyone to support them postpartum and help with the baby, they face considerable stress and isolation. Christina, a first time-mother who went through postpartum depression, recounted her experience of having to navigate parenthood without her own family support:

> "Not having my family here. In the pandemic, no one could come and see me, see us, you know? Next time, if I ever have another child, I need someone from my family here. I just can't go through it without anyone, like alone [...] It's very hard."

Nisha's mother applied for a visa to come visit them and help with the baby while she recovered and resumed her studies, but this application was rejected.

> "We showed all the proper documentation, like a letter from the doctor or hospital, saying that I was pregnant, and we were alone. And we showed all the funds required for [my mother to] stay here, and yeah, we did it perfectly like as far as application-wise. It was all done perfectly, and still they decided to reject it, even though we explained the situation to them. So that was really a low point, to be honest."

With family members unable to come support them in Canada, another strategy used by parents (both Lydia and Nisha) was to have the baby or their older siblings stay in their home country with other family members. Lydia shared:

> "... after I had my child, I was actually going to school and at the same time I had my kid with me. At some point when my son was seven months, I took him back to [my home country]. Then I came back to Canada.... he was in [my home country], yes, with my sister"

Similarly, Nisha left her older child behind to come to Canada to study:

> "Our first born is back home with our parents and, yeah, she is now turning a year and a half".

Families still found ways to connect to extended family members in their home countries via WhatsApp, Facetime and social media. Such digital connections offer emotional support and basic parenting advice to new parents, mitigating the stress, isolation and challenges of raising a child alone in a host country. Nonetheless, these separation decisions underscore the difficult measures

some families must take due to their precarious conditions, minimal support, and lack of access to resources.

Given that most participants did not have immediate family near-by, assistance and emotional support from friends, neighbours, and other community connections played key roles, including sharing resources, babysitting, and meal preparation. Having a supportive partner and friend group, was key for Hani:

> "I don't have anyone in Winnipeg. Although I have some friends. [...] They are good and nice, and I got a lot of support from them when I delivered the baby, you know. It came only from friends. So, in the first months they send me food. So, I didn't have to cook because that's so hard with the newborn. It's just nightmare. No sleep, nothing. It's just so hard, but sending food relieved me. It was helpful".

Similarly, Bethel, a refugee claimant at the time of the birth, shared through an interpreter:

> "Someone here helps me a lot – the neighbour. I didn't know her before, but when she saw me here, she was very touched with my story. I had difficulties with everything, so she helped me. For labour, she took me to the hospital. She kept the babies and is still helping me out. And once she kept the babies when I was in the hospital. And she comes and checks on me just because she saw me in trouble."

Apart from family and friends, participants and service providers referenced helpful community programming that provided support and information (discussed above). These programs provided them with information, parenting skills development, and social support. Some participants expressed gratitude and relief at building their network through these programs and finding great support. For example, Sara, a refugee claimant at the time of the birth of her child, shared through an interpreter that:

> "They sent me to Mosaic. [...] They have a program called 'Mom and Me', and I had all the information on what to do during pregnancy and during all this time [after giving birth]. [...] Also, I have a friend that I had from Mosaic. I still have contact with her, and I made more friends living in IRCOM. So, I have a lot of friends. I'm happy."

While community programming provided welcomed supports, public supports for families like the Canada Child Benefit (CCB) are often based on parents' citizenship and/or immigration status and residency, rather than the baby's citizenship status.[19] Temporary residents with work or study permits are eligible for Manitoba childcare subsidies[20] and become eligible for the CCB after residing 18 months in Canada. If one parent is a citizen or otherwise qualified, the family may receive CCB as long as that parent submits the application. Refugee claimants, people without formal status, or those with visitor visas are not eligible.

The costs of childcare, food, and housing remained key concerns for families – in addition to the hospital bills many were still trying to pay off. For example, Hani and her partner were both students. Hani did not take a leave from her studies postpartum in order to maintain her student visa and they

[19] A more comprehensive overview of public services and benefits can be found on the MANSO website.
[20] Confirmed by Manitoba Education and Early Childhood Learning (as of 27 February 2025). Other conditions, such as income assessment, also apply.

could not find affordable childcare or living space to meet her family's growing needs. She described balancing these responsibilities and financial constraints:

> "The first six months we had no privacy except in the bathroom. Even, we were doing our classes online, everything in the bathroom, because we were in a studio [apartment] and we didn't have any bedroom with a closed door. [...] When the baby is sleeping so we had to sit in the bathroom, there was no other place we could sit, or go to the hallway."

This range of pregnancy and parenting challenges is reflective of the limited social rights people with precarious immigration status have in Canada, even when they have lived for years within the country and have contributed to their communities in a multitude of ways. As Jasleen describes,

> "It's kind of a bad experience, or a bitter or a very mentally [exhausting]. [...] It was a painful period for my life. I can see, by talking to you now, I start feeling that, really, it was [my] strength, as well. Like, I'm just looking at myself like, I was a strong lady, that I handled it. Because you don't realize your strength."

Implications and Recommendations

Our findings here are consistent with other studies from across Canada that show that difficulties navigating the health system and finding appropriate care, fears related to costs and potential CBSA involvement, and uncertainty regarding how service providers will treat them, all contribute to increased stress and likelihood of pregnant people not getting the care they need. Pregnant people without public health insurance have to navigate these issues in addition to the feelings of isolation and family separation often experienced by any newcomer, and the stress and uncertainty of any new parent.

Based on these findings and recommendations offered throughout our interviews, we offer the following recommendations:

Expand access to public health insurance

Expansion of public healthcare to a wider range of people living in Manitoba (for example, international students and their dependents, all workers and their dependents, all citizen newborns, and closing gaps in refugee claimant health coverage) would greatly increase accessibility. This is the most direct way to decrease the number of medically uninsured residents of Manitoba and mitigate the barriers discussed above by providing all reproductive services from abortion to prenatal care, postnatal care, labour and delivery without financial constraints.

Make more transparent information available

Across all areas of reproductive healthcare, both pregnant people and service providers identified a lack of clear, transparent information relating to where uninsured people should seek care and the associated costs. For abortion care, when pregnancies are often not detected until about 4 weeks in and the type of care and its cost can shift dramatically at 12 weeks, 16 weeks, and 19 weeks,

accessible, timely information is of the utmost importance. Likewise, for prenatal care, early and timely monitoring and support can play a significant role in supporting a healthy pregnancy and allow for timely interventions that can prevent complications later on. Complications can both negatively impact the health of the mother and the infant, and are also much more costly financially. Currently, limited capacity and not having consistent pathways to care makes providing certain information difficult.

Expand health services available

There are a wide range of service providers with experience supporting the medical and social needs of this population. However, there are very few concrete resources available to support this work. In particular, community health clinics who have expertise serving marginalized communities are well-situated to do this work but face limited capacity and funding constraints. An additional barrier is the limited scope of practice for midwives in Winnipeg to support this population. Midwives' holistic, low-intervention model of care can be an ideal option for people with low-risk pregnancies who face barriers in the broader health system and would expand the range of care providers available to support this work.

Limit costs and humanize billing practices

The costs pertaining to pregnancy-related health needs remain a significant challenge for people without public health insurance. Finding ways to limit out-of-pocket costs is a considerable benefit to reproductive healthcare accessibility in Manitoba. For example, the model used by WHC for abortion care is helpful because it caps costs at a reasonable rate and ensures they are predictable. However, relying on charity models that include limited donations and fundraising, is not a sustainable way to consistently protect reproductive rights and health for all people living in Manitoba. Neither is relying on a small group of physicians to waive or reduce their fees on a case-by-case basis. Currently access to perinatal care at a reasonable cost largely depends on individual service providers, which does not ensure consistent, accessible perinatal care for all who need it. Further, practices of requesting high deposits in the third trimester, not working out reasonable payment plans with patients, and issuing threats must end. Health systems must implement compassionate and humane billing practices for the vulnerable uninsured population by providing clear billing information upfront, allowing payment plans, and delaying payment requests so mothers can focus on their recovery.

Implement clear 'access without fear' policies

Aside from financial cost, fear of being reported to border authorities or facing judgement because of immigration status is a powerful deterrent from accessing timely care. Health facilities can adopt and clearly communicate an "access without fear" policy that prevents staff from asking about or communicating information related to status with a third party. This is a destigmatizing practice that is a crucial part of providing supportive and competent care to migrant and newcomer communities. Fostering health environments that are responsive to the concerns of migrant communities, are culturally competent, and culturally and linguistically diverse can make a big impact in providing this safe space where people feel safe to access care, no matter what their immigration or health insurance status is.

References

Almeida, L. M., Caldas, J., Ayres-de-Campos, D., Salcedo-Barrientos, D., & Dias, S. (2013). Maternal Healthcare in Migrants: A Systematic Review. *Maternal and Child Health Journal*, *17*, 1346–1354. https://doi.org/10.1007/s10995-012-1149-x

Burton, N., & Bennett, N. (2013). Meeting the Needs of Uninsured Women: Informed Choice, Choice of Birthplace and the Work of Midwives in Ontario. *Women's Health and Urban Life*, *12*(2), 23–44.

Chabot, F. (2021). Access to Abortion for Undocumented Persons during the COVID-19 Pandemic. *Statelessness & Citizenship Review*, *3*(1), 142–147.

Cloos et al. (2020). *The negative self-perceived health of migrants with precarious status in Montreal, Canada: A cross-sectional study*. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0231327

Darling, E. K., Bennett, N., Burton, N., & Marquez, O. (2019). Outcomes of uninsured midwifery clients in Ontario, Canada: A retrospective cohort study. *Midwifery*, *77*, 24–31. https://doi.org/10.1016/j.midw.2019.06.009

Dennis, C.-L., Merry, L., & Gagnon, A. J. (2017). Postpartum depression risk factors among recent refugee, asylum-seeking, non-refugee immigrant, and Canadian-born women: Results from a prospective cohort study. *Social Psychiatry and Psychiatric Epidemiology*, *52*(4), 411–422. https://doi.org/10.1007/s00127-017-1353-5

Gagnon, A. J., Merry, L., & Haase, K. (2013). Predictors of emergency cesarean delivery among international migrant women in Canada. *International Journal of Gynecology & Obstetrics*, *121*(3), 270–274. https://doi.org/10.1016/j.ijgo.2012.12.017

Goldring, L., Berinstein, C., & Bernhard, J. K. (2009). Institutionalizing precarious migratory status in Canada. *Citizenship Studies*, *13*(3), 239–265. https://doi.org/10.1080/13621020902850643

Hamel-Smith Grassby, M., Wiedmeyer, M., Lavergne, M. R., & Goldenberg, S. M. (2021). Qualitative evaluation of a mandatory health insurance 'wait period' in a publicly funded health system: Understanding health inequities for newcomer im/migrant women. *BMJ Open*, *11*(8), e047597. https://doi.org/10.1136/bmjopen-2020-047597

Hanley, J., Larios, L., Ricard-Guay, A., Meloni, F., & Rousseau, C. (2020). Pregnant and undocumented: Taking work into account as a social determinant of health. *International Journal of Migration, Health and Social Care*, *16*(2), 189–199. https://doi.org/10.1108/IJMHSC-04-2019-0046

Hynie, M., Ardern, C. I., & Robertson, A. (2016). Emergency Room Visits by Uninsured Child and Adult Residents in Ontario, Canada: What Diagnoses, Severity and Visit Disposition Reveal About the Impact of Being Uninsured. *Journal of Immigrant and Minority Health*, *18*(5), 948–956. https://doi.org/10.1007/s10903-016-0351-0

International Organization for Migration. (2020). *Data: Migration Statistics*. Migration Data Portal. http://migrationdataportal.org/data

Jarvis, C., D'Souza, V., & Graves, L. (2019). Uninsured Pregnant Patients: Where Do We Begin? *Journal of Obstetrics and Gynaecology Canada*, *41*(4), 489–491. https://doi.org/10.1016/j.jogc.2018.10.008

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*. https://doi.org/10.1155/2017/8783294

Larios, L. (2020). *Pregnant and precarious: Canadian immigration through the lens of reproductive justice* [Unpublished PhD Dissertation]. Concordia University.

Larios, L. (2023). The Problematization of Migrant Maternity: Implications of the “Passport Baby” Narrative in the Canadian Context. *Social Politics: International Studies in Gender, State & Society*, *30*(2), 397–421. https://doi.org/10.1093/sp/jxad002

Magalhaes, L., Carrasco, C., & Gastaldo, D. (2010). Undocumented Migrants in Canada: A scope literature review on health, access to services, and working conditions. *Journal of Immigrant and Minority Health*, *12*(1), 132–151. https://doi.org/10.1007/s10903-009-9280-5

Mahon, A., Merry, L., Lu, O., & Gagnon, A. J. (2017). Postpartum Pain in the Community Among Migrant and Non-migrant Women in Canada. *Journal of Immigrant and Minority Health*, *19*(2), 407–414. http://dx.doi.org.subzero.lib.uoguelph.ca/10.1007/s10903-016-0364-8

Merry, L. A., Gagnon, A. J., Kalim, N., & Bouris, S. S. (2011). Refugee claimant women and barriers to health and social services post-birth. *Canadian Journal of Public Health*, *102*(4), 286–290.

Merry, L., Semenic, S., Gyorkos, T. W., Fraser, W., Small, R., & Gagnon, A. J. (2016). International migration as a determinant of emergency caesarean. *Women and Birth*, *29*(5), e89–e98. https://doi.org/10.1016/j.wombi.2016.04.001

Munro, K., Jarvis, C., Munoz, M., D’Souza, V., & Graves, L. (2013). Undocumented Pregnant Women: What Does the Literature Tell Us? *Journal of Immigrant and Minority Health*, *15*(2), 281–291. https://doi.org/10.1007/s10903-012-9587-5

Pelaez, S., Hendricks, K. N., Merry, L. A., & Gagnon, A. J. (2017). Challenges newly-arrived migrant women in Montreal face when needing maternity care: Health care professionals’ perspectives. *GLOBALIZATION AND HEALTH*, *13*. https://doi.org/10.1186/s12992-016-0229-x

Ridde et al. (2020). *Unmet healthcare needs among migrants without medical insurance in Montreal, Canada*. https://doi.org/10.1080/17441692.2020.1771396

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage Publications.

Ross, L. J., & Solinger, R. (2017). *Reproductive justice: An introduction*. University of California Press.

Rousseau, C., Ricard-Guay, A., Laurin-Lamothe, A., Gagnon, A. J., & Rousseau, H. (2014). Perinatal health care for undocumented women in Montreal: When sub-standard care is almost the rule. *Journal of Nursing Education and Practice*, *4*(3), p217. https://doi.org/10.5430/jnep.v4n3p217

Ruiz-Casares, M., Rousseau, C., Laurin-Lamothe, A., Rummens, J., Zelkowitz, P., Crépeau, F., & Steinmetz, N. (2013). Access to Health Care for Undocumented Migrant Children and Pregnant Women: The Paradox Between Values and Attitudes of Health Care Professionals. *Maternal & Child Health Journal*, *17*(2), 292–298. https://doi.org/10.1007/s10995-012-0973-3

Small, R., Roth, C., Raval, M., Shafiei, T., Korfker, D., Heaman, M., McCourt, C., & Gagnon, A. (2014). Immigrant and non-immigrant women’s experiences of maternity care: A systematic and comparative review of studies in five countries. *BMC Pregnancy & Childbirth*, *14*(1), 1–27. https://doi.org/10.1186/1471-2393-14-152

Wilson-Mitchel, K. (1), & Rummens, J. a. (2). (2013). Perinatal outcomes of uninsured immigrant, refugee and migrant mothers and newborns living in Toronto, Canada. *International Journal of Environmental Research and Public Health*, *10*(6), 2198–2213. https://doi.org/10.3390/ijerph10062198

World Health Organization. (2016). *WHO recommendations on antenatal care for a positive pregnancy experience*.