

Exploring the Healthcare Experiences of African Immigrant Women in Winnipeg, Manitoba

by

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A thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

In partial fulfilment of the requirements of the degree of

MASTER OF SCIENCE

Department of Community Health Sciences

University of Manitoba

Winnipeg

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Abstract

This dissertation explores the healthcare experiences of African immigrant women living in Winnipeg, Manitoba. It seeks to understand the barriers and facilitators that they encountered and their perception of the system. Informed by intersectionality, it aims to highlight how the participants' intersecting identities and the social context shape their experiences.

In individual interviews and focus groups, twenty-seven women who were recent immigrants to Canada, discussed their interactions with healthcare providers and the healthcare system. Many women faced barriers navigating the healthcare system, accessing services, and communicating with providers. In contrast, positive healthcare interactions were characterised by being actively involved in their care, and feeling seen and heard. In order to overcome these barriers, concerted efforts are needed at the levels of local community organisations, healthcare providers and healthcare policy.

In a reflective methodology paper, I discuss the complex experience of conducting qualitative research within one's own community and the challenges that arose from interviewing Black women as a Black woman. I draw on interview and focus group transcripts from the primary study, existing literature and my own reflections. I found that while insider status and universalization helped facilitate conversations with participants, challenges were also encountered. A reluctance to speak about negative experiences and hesitancy to name racism hindered deeper exploration of their experiences.

These manuscripts are complementary in the information they provide and contribute to the limited literature on African immigrant women in Canada. Although they use different methods and have differing objectives, they are both informed by a feminist standpoint methodology and take an intersectional approach that privileges the voices of Black women.

Acknowledgements

I am deeply grateful to my supervisor, Dr. Michelle Driedger. Thank you for your continuous guidance, and valuable feedback throughout every step of the research process. Your dedication and insights have been invaluable in shaping the direction of this thesis. I am also grateful to Dr. Deborah Mcphail and Dr. Rob Lorway for their support and feedback as my advisory committee. I am thankful to have had the opportunity to learn from all three of you, and you have all taught me so much. Thank you for inspiring me to think deeply about what it means to be a qualitative researcher and helping me to become a better academic.

This research project would not have been possible without the twenty-one women who took the time to share their experiences with me. I am tremendously grateful to all the participants for their vulnerability and honesty in our conversations. It is not easy to discuss one's personal healthcare stories with another person and I honoured that they trusted me with theirs.

I am extremely fortunate to have a great support network that helped me through my Masters program. I am grateful for the encouragement of my parents, Martin and Gertrude. Their love and belief in me has been a strong and consistent driving force throughout my academic journey. To my brothers, my friends and fellow students thank you for the listening ears and unending moral support

I appreciate the financial support I received through the Manitoba Training Program in Health Service Research Fellowship and through the support of my supervisor, Dr. Michelle Driedger, with a CIHR Grant.

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Chapter 1: Introduction

The number of African-born immigrants in Canada has risen dramatically in recent years, with Africa making up the second-largest source of new immigrants (Statistics Canada, 2017). In particular, immigration to prairie provinces has increased. In Manitoba, 14.3% of the immigrant population is Black (Manitoba Government, 2006). Previous research has shown that though immigrants are often healthier than Canadians upon arrival, this tends to decline the longer they live in Canada (Newbold, 2005; Fuller-Thomson et al., 2011). Further, within six months to two years of immigration, newcomers may develop emotional and mental health problems (Ng et al., 2005). This deterioration in immigrants' health status has been attributed to a complex web of systemic, socioeconomic, and cultural barriers (Bajgain et al., 2020). The process of immigrating itself can be highly stressful. The health of newcomers can also be negatively impacted by the stress of establishing a career, finding a community, and navigating an unfamiliar healthcare system (Ahmed et al., 2016). For immigrants who are members of marginalised communities, these stressors are often compounded by the experience of further based on identity discrimination (Ahmed et al., 2016).

Although inequalities and the challenges of immigration impact all immigrants, immigrant women are particularly marginalised and often disproportionately affected. Several social factors uniquely impact the health and welling of immigrant women in particular ways. These factors include the absence of social and labour protection, household responsibilities, social exclusion, gender discrimination, and cultural expectations (Llácer et al., 2007). Immigrant women take on the responsibility of caregiving and seeking healthcare services for themselves and their families (Tefera & Yu, 2022). In addition, Black immigrant women must contend with gender discrimination and anti-Black racism, putting them in double jeopardy (Tefera & Yu, 2022). However, Black immigrant women's experiences are not well represented in the Canadian health literature. Research is needed into the experiences and perspectives of Black immigrant women to develop a deeper understanding of the issue and address this knowledge gap. For these reasons, this study focuses on the healthcare experiences of African immigrant women living in Winnipeg, Manitoba.

Through semi-structured interviews and focus groups, I engaged with women in this community and aimed to centre their voices as they have been historically marginalised. My primary objectives were to explore African immigrant women's experiences with the

Canadian healthcare system and how these experiences impacted their trust in the system and individual providers. I also aimed to identify their information needs and preferences when making healthcare decisions. Paper 1 in this thesis presents the findings from this study. Following this, informed by reflections upon this research experience, Paper 2 is a methodological paper. Throughout the interview process, it became evident that some women held back in their responses and did not want to discuss issues around race and discrimination. Other topics, such as their experiences related to our shared gender, were easier to discuss. During the interviews our various shared and unique experiences as Black women raised further questions regarding the impact of differences in nationality and personal history on the research process. As a Black woman and qualitative researcher, I aimed to become attuned to how I became a “research instrument and the primary sieve of re/presentation of Black womanhood” (Few, Stephens & Rouse-Arnett, 2003, p. 213). Drawing on the interview transcripts, my reflections and existing literature, this paper seeks to explore my experience and how qualitative research with Black women can be conducted safely and effectively in health research.

Position of Researcher

I come to this work as a Black woman and daughter of Kenyan immigrants. I have lived in Winnipeg, Manitoba for most of my life and have considerable connections in the local Kenyan community. Throughout my undergraduate and graduate studies in health sciences, I have been interested in the healthcare experiences of marginalised people in Canada, especially Black women. My graduate studies have further influenced my perspective that health inequalities are greatly influenced by the pervasive systemic inequalities that exist in society. In my career, I hope to practise medicine and provide a safe space for Black women to be seen and heard.

As a qualitative researcher, I believe that valuable knowledge is created through experience. Therefore, individuals and communities provide a valid and invaluable source of insight and collaboration. I believe in the importance of representing and validating the knowledge claims of communities through my research (Few et al., 2003). Only through exploring and amplifying the voices of the most marginalised can we make systemic changes that benefit all members of society.

Literature Review

To frame this study, I first discuss the structure of the Canadian healthcare system and the importance of health equity as it relates to immigrants in Canada. Then I provide a brief review of the literature regarding the barriers immigrants face when attempting to access healthcare services. I then discuss the methodological literature regarding conducting qualitative interviews with marginalised communities. I discuss the lack of research focusing on African immigrant women and highlight the gaps this thesis aims to fill. Lastly, I discuss feminist standpoint theory and intersectionality as they provide the theoretical framework for this thesis.

The Canadian Healthcare System

The Canadian healthcare system is primarily structured as a publicly funded and administered system known as Medicare. It is based on the principles of universality, accessibility, portability, comprehensiveness, and public administration (Health Canada, 2022). The system is funded through taxes and aims to provide essential healthcare services to all Canadian citizens and permanent residents regardless of their ability to pay (Health Canada, 2022). However, the specifics of healthcare services and coverage for immigrants can vary depending on their immigration status and where they live. Generally, immigrants who have obtained permanent residency or have been granted refugee status in Canada are eligible for provincial or territorial healthcare coverage, similar to Canadian citizens (Health Canada, 2022). This coverage includes access to essential medical services, such as visits to doctors and specialists, hospital care, and emergency services. Additionally, in some provinces, including Manitoba, immigrants and refugees who can demonstrate financial need are eligible for low cost dental services and prescription coverage.

It's important to note that there are gaps in healthcare coverage that make accessing healthcare economically difficult for immigrants. In some provinces and territories - Ontario, British Columbia, Quebec, Saskatchewan, Yukon, Northwestern Territories and Nunavut - there is a three month waiting period before newcomers can access healthcare services (Health Canada, 2023). During this waiting period, immigrants may need to rely on private health insurance or pay out-of-pocket for medical expenses. Many newcomers face difficulties in securing stable employment upon arrival, leading to limited financial resources (Woodgate, 2017; Weerasinghe, 2012). Without a steady income or health insurance provided

through an employer, immigrants may struggle to afford the costs associated with healthcare, such as prescription medications, or specialized treatments (Woodgate, 2017). Further, temporary residents, such as international students or foreign workers, often have limited access to publicly funded healthcare and have to purchase costly private health insurance or rely on insurance provided by their educational institution or employer (Canadim, 2023). In Manitoba, international students are not eligible for provincial health insurance and must purchase the insurance through the Manitoba International Student Insurance Plan (Canadim, 2023).

Health Equity

Health equity has been described as the circumstances under which all individuals can reach their highest possible level of health without facing barriers due to their age, race, gender, class or other aspects of their social location (NCCDH, 2013). In Manitoba, the provincial government has recognized newcomers as one of the populations that face “a disproportionate burden of poor health outcomes and shorter life expectancy” (MHSAL, 2018). Ensuring equal access to appropriate healthcare services for immigrants is vital to achieving health equity in the province. Primary care access increases preventive healthcare services, including cancer screening and immunizations, ultimately improving health outcomes (McIsaac, Fuller-Thomson & Talbot, 2001). Primary care providers have a great deal of influence over the health and wellbeing of their patients and play a critical role in ensuring continuity of care and connecting patients with specialists (McIsaac et al., 2001). However, immigrants have consistently been found to use healthcare services at lower rates than their native-born counterparts (Ahmed et al., 2016). Healthcare systems and providers face challenges in addressing all immigrants' barriers to accessing care (Turin et al., 2015). African immigrant women experience further barriers related to their race and gender - and the intersections between them.

Barriers Healthcare Services

Research suggests that immigrants in Canada have unmet healthcare needs. Barriers at the systemic and interpersonal levels hinder access to healthcare services. Systemic barriers include inaccessible interpreters (Woodgate et al., 2017), limited knowledge of the healthcare system structure, and high healthcare costs (Bajgain et al., 2020). Interpersonal barriers include language barriers, healthcare providers' lack of cultural competence and poor

patient-provider communication (Bajgain et al., 2020; Perez-Urdiales et al., 2019). Immigrants may encounter doctors that lack the time or empathy to listen to their concerns or have opposing understandings of health (Woodgate et al., 2017). The socioeconomic marginalisation of immigrants contributes to their adverse health and healthcare experiences. For example, many immigrants struggle with having their educational credentials recognized upon immigration and end up underemployed and unable to afford safe housing and healthy foods, contributing to high levels of stress and poor health (Woodgate et al., 2017; Asanin & Wilson, 2008). On the other hand, social support has been shown to help immigrant women overcome barriers to healthcare access (Nwoke & Leung, 2020). This support includes transportation, emotional support, and information regarding healthcare services (Nwoke & Leung, 2020).

Gendered Experiences. Immigrant women face barriers related to the gendered expectations placed upon them and the gender biases that may impact their interactions with healthcare providers. Traditional gender roles place expectations upon women, hindering their ability to access healthcare services. These expectations include assuming primary responsibility for feeding the family, raising children and looking after the health needs of their family members while working inside and outside the home (Tefera & Yu, 2022). Putting everyone ahead of themselves may leave them without the time to focus on their health issues (Tefera & Yu, 2022). Due to their culture or religion, immigrant women may prefer female doctors (Bajgain et al., 2020; Woodgate et al., 2017). Women may also feel uncomfortable discussing sensitive topics and reproductive care with male doctors, limiting their options for accessing healthcare providers (Bajgain et al., 2020; Woodgate et al., 2017). All immigrant women may have similar healthcare experiences based on their shared lived experiences of immigration and womanhood. Nonetheless, when grouped with other cultural and racial immigrants, the nuances of African women's experiences and their intersectionalities tend to be overlooked. This study adds to the limited knowledge focusing on this community while examining how factors such as race, class, cultural background, and gender intersect and shape their experiences.

Racism in Healthcare. Further, anti-Black racism (ABR) negatively impacts the health of all Black people in Canada, including African immigrants. Racism in Canada can be linked to British colonisation and Western medicine, which established a foundation for health disparities and limited healthcare accessibility (Byrd & Clayton, 2001). Given the severity of

the issue, ABR has been identified as a “public health crisis” (Dryden & Norom, 2021). Experiencing racism and discrimination in healthcare interactions can lead to poorer patient satisfaction, a lack of trust in the healthcare system and avoidance of the system altogether (Williams & Mohammed, 2009; Adegbenbo, Tomar & Logan, 2006). African immigrants in European studies reported instances of intentional discrimination and being treated like “second-class citizens” (Perez-Urdiales et al., 2019; Mbanya et al., 2019). Similarly, African American patients have been harmed by provider biases and stereotypes regarding Black people having a higher pain tolerance or drug-seeking behaviours (Cuevas, O’Brien & Saha, 2016). Though Black people across the diaspora have a shared experience of racist discrimination rooted in colonialism there is little exploration of these issues in the Canadian healthcare context. Engaging with Black people regarding the experiences and recommendations for change is critical to develop a deeper understanding of the issue and addressing this knowledge gap (Dryden & Norom, 2021).

Qualitative Interviewing

Inadequate Representation. There is limited information regarding African immigrant women's healthcare experiences. There is also little literature regarding how qualitative researchers can conduct research with Black women effectively and culturally appropriately. When conducted in a safe and reflective environment, qualitative interviews can be an effective way to get at the lived experiences of people and yield meaningful and rich data (Gubrium & Holstein, 2001). However, researchers must be sensitive to how the diversity of the Black experience has been misrepresented and marginalised historically and reject these narratives. Research focusing on Black women has historically pathologized and perpetuated harmful stereotypes (Walton et al., 2022). This research is further limited by theories, methods and approaches centring on Whiteness (Walton et al., 2022). In other cases, research that claims to represent women's experiences has excluded Black women from the sample entirely (Few et al., 2003). These issues lead to representations in qualitative research that essentialize and simplify the Black experience (Few et al., 2003). Qualitative researchers are responsible for representing the nuances of Black women's lived experiences and their communities as accurately and ethically as possible (Few et al., 2003). This will require self-reflection, revising research methods, and developing interview guides they use when conducting interviews with Black women research participants (Walton et al., 2022).

Relational Nature of Interviewing. Researchers must reflect on qualitative interviewing as an inherently relational process to conduct compelling interviews with Black women. Power dynamics and insider or outsider status can significantly shape the interview process and should be considered (Walton et al., 2022). The researcher's status as either an insider and outsider - or both - to the communities that the participant is a member of can impact the level of rapport and understanding between the two and help or hinder the flow of the interview and depth of the data collected (Dwyer & Buckle, 2009). Researchers have found that when there is a shared identity between the interviewer and participant, participants from marginalised communities, such as Black people, Latine people, LGBTQIA+ people, can feel a shared understanding and sense of trust and openness (Dwyer & Buckle, 2009).

Recognizing the limitations of an insider's role is essential, as establishing rapport and understanding cannot be taken for granted or automatically accomplished solely based on being an insider (Gubrium & Holstein, 2001). As a researcher who shares an identity, relying on familiarity with the research context can lead to assumptions and limit the depth of the information gained (Shai, 2020). Researchers must not take the research participants' lived experiences for granted. Qualitative researchers should also consider the cultural norms of the participants and the power dynamics present in the interview process (Walton et al., 2022). Corbin and Strauss (2015) recommend managing power dynamics by encouraging participants to take the interview at their own pace, opening up more as trust builds. Ultimately, researchers should reflect on their role as a research instrument. The “researcher-as-instrument” speaks to the fact that the researchers' intersecting identities, knowledge and social location can influence the tenor of the interview and the information gained (Roger et al., 2018).

Previous Research. Researchers have begun to identify and develop techniques that can be used with Black women and other marginalised groups. Much of this research has been conducted in education studies (Walton et al., 2022; Burkhard, 2019; Rodriguez, 2010) and family studies (Few et al., 2003). Few and colleagues (2003) recommended strategies for interviewing Black women from a Black feminist perspective, including contextualising the research, contextualising subjectivity, triangulating multiple sources, monitoring symbolic power and caring in the research process. Further, they recommend practising self-reflexivity and reflecting on one's relationship with the research process and participants, paying

attention to symbolic power, status markers, and language choices and their potential impact on the interview (Few et al., 2003). In their recommendations for conducting research with Black women, Walton and colleagues (2022) stress the importance of establishing the research environment as a safe space through vulnerability and authenticity. Other researchers recommend strategies such as self-disclosure to establish connections with racialized participants during discussions of sensitive topics such as racism (Walton et al., 2022; Burkhard, 2019; Rodriguez, 2010).

There is a lack of similar research examining how to conduct qualitative interviews with marginalised populations in health. Indigenous health researchers have been at the forefront of developing research methods prioritising an Indigenous approach over Western research conventions (Curtis, 2016; Saunder, West & Usher, 2010; Walker et al., 2013). They emphasise direct engagement with Indigenous Peoples and organisations, acknowledging the influence of colonialism, incorporating Indigenous conceptualizations of health and Indigenous knowledge (Patterson et al., 2022) and using culturally appropriate research methods (Wright et al., 2016). This Indigenous-led research provides insights into the importance of considering cultural context and researchers' identities in exploring racialized participants' experiences with the healthcare system. Similar research and the development of new methods would benefit other communities participating in health research, such as Black women. This thesis adds to the limited literature by highlighting the tension when interviewing Black women regarding healthcare experiences. In the second paper, I reflect upon my experiences as a Black woman researcher interviewing Black women about the impact of insider status on the data gathered.

Theoretical Framework

The two manuscripts that make up this thesis focus on the healthcare experiences of African immigrant women and my experience as a Black woman researcher. These issues are multifaceted and shaped by the participants and the researcher's many intersecting identities. The social identities of race, gender, nationality and the overarching social and political context were highly relevant to the research process. Therefore, this thesis draws on feminist standpoint theory and intersectionality as theoretical frameworks.

Feminist Standpoint Theory

The overarching methodology informing this study is feminist standpoint theory, using an intersectional lens. Feminist standpoint theorists claim that knowledge is socially situated, which stands in contrast to traditional epistemologies that claim to access universal knowledge (Harding, 1993; Collins, 2000; Hartsock, 2004). This means that knowledge is not a fixed entity. It is a dynamic and context-dependent construction (Brooks, 2007). This theory contends that all knowledge is created from a specific standpoint, not just a perspective, but rather an achieved collective identity or consciousness (Hartsock, 2004). While identifying as a woman provides a starting perspective, a standpoint goes further than that. A standpoint is earned through the experience of collective political struggle (Hartsock, 2004). Given this perspective, knowers can not - and should not - be separated from their social location as this informs their knowledge. Feminist standpoint theorists privilege the standpoint of women and other marginalised groups and contend that embracing the knowledge generated by these groups can challenge dominant discourses and aid in dismantling systemic oppression (Harding, 1993; Collins, 2000).

Feminist standpoint theory has been used to inform research focusing on the healthcare experiences of Black women (Brantley, 2023; Abrums, 2004). For example, Brantley (2023) argues for incorporating feminist standpoint methodology into the study of Black women's maternal healthcare experiences in the United States. This approach recognizes Black women's experiences as "fact" and necessitates that future research centres on Black women and mothers at all process stages. This would allow for an enhanced understanding of Black women's maternal health experiences and improved measurements of Black maternal health. Further, Abrums (2004) uses Black feminist standpoint epistemology to understand how African-American women used religious beliefs to help them cope with and resist racism in healthcare experiences. She uses this approach to emphasise how African American women in this specific place and time experience and shape their unique reality. Ultimately, as Collins (2000) states there is no universal Black women's standpoint, but there is a Black women's collective standpoint shaped by the experience of everyday tensions and challenges. By working from a feminist standpoint epistemology, I aim to highlight the power structures that shape the specific lived experiences of African immigrant women in Winnipeg, Manitoba, at this time.

Relevant to this study is feminist standpoint theory's recognition of the interconnectedness between knowledge and power. It asserts that knowledge is not neutral but is shaped by the interests and values of those in positions of authority (Brooks, 2007). Society perpetuates and reinforces existing power structures by privileging the knowledge produced by dominant groups (Brooks, 2007). In contrast, feminist standpoint theory asserts that individuals at the margins of society have a more comprehensive and critical understanding of power structures and social dynamics (Harding 2004; Collins 1990). Therefore, research regarding societal power should focus on the lives of the most marginalised (Hesse-Biber, 2007). In this study, I focus on the experiences of African immigrant women, and their experiences of oppression and marginalisation enable them to identify the underlying mechanisms that perpetuate inequality. By adopting this approach, I challenge the dominant narratives that have historically silenced or dismissed these voices and "uncover the knowledge hidden in their experiences" (Hesse-Biber, 2007).

Intersectionality

Along with the feminist standpoint theory, the concept of intersectionality informs the approach to data collection and analysis in both research papers. Black feminists and other feminists of colour have expanded upon the standpoint of women and argued that women inhabit different standpoints across different classes and cultural backgrounds (Hesse-Biber, 2007). This work in expanding the inclusivity of feminist scholarship and focusing on women's experiences beyond the white middle-class has led to the emergence of intersectional feminism, which also informs this thesis. Coined by legal scholar Kimberlé Crenshaw in the late 1980s, intersectionality has transformed feminist discourses, shedding light on the multifaceted nature of discrimination and oppression (Crenshaw, 1991). Intersectionality challenges the idea that gender inequality can be examined in isolation from other social categories, such as race, class, sexuality and disability (Bowleg, 2013). It recognizes that individuals possess multiple identities and are simultaneously subjected to various forms of discrimination and privilege based on these identities. In essence, intersectionality urges us to consider the interlocking systems of oppression that compound and reinforce one another, producing unique experiences and challenges for individuals with multiple marginalised identities (Crenshaw, 1991).

By incorporating an intersectional lens into the research process, emphasis is placed on the contextual factors that shape the lives of African immigrant women. In the primary

study (Paper 1), the intersectional analysis highlights how social contexts and power dynamics shape African immigrant women's unique healthcare experiences. For many participants in the study, access to healthcare services, employment opportunities and health insurance was hindered by policies that impact immigrants. This overarching policy environment affected their day-to-day life. Intersectionality invites individuals to critically examine how systems of power operate and intersect in various social institutions and structures (Rice, Harrison & Friedman, 2019). It prompts questions regarding how social factors shape access to resources, opportunities, and social privileges (Rice et al., 2019). We can identify and challenge the structural barriers that perpetuate inequality by analyzing the intersections of privilege and oppression.

At the individual level, intersectionality highlights how individuals do not experience oppression or privilege in a singular manner but in an overlapping fashion (Bowleg, 2013). Intersectionality scholars have long highlighted how Black women may face racism and sexism simultaneously, with the combination of the two forms of discrimination creating a unique experience that can not be fully captured by examining them in isolation (Crenshaw, 1991; Collins, 2001). Intersectionality has been used to highlight how racism and sexism uniquely impact Black women in the context of reproductive healthcare (Rosenthal & Lobel, 2020), domestic violence (Loncar & Scott, 2023; Robinson, Frawley & Dyson 2021), and mental health (Brown et al., 2020). The women who participated in this study identified barriers to healthcare access related to their identities as women, immigrants, mothers and as Black people as well as the intersections between them. These findings support the usefulness of intersectionality as a framework for understanding social inequalities and other experiences of marginalisation of Black women. Intersectionality provides a path for developing an inclusive feminist movement that addresses the specific challenges individuals face at the intersection of multiple marginalised identities because it explicitly acknowledges these overlapping axes of power.

Insider and Outsider Status. Intersectionality has allowed Black women to contextualise their insider or outsider status when conducting qualitative research (Adams, 2021; Brown, 2012; Bowleg, 2013). For example, in her reflections on the experience of conducting ethnographic research with prisoners and their families as a Black minority ethnic woman, Adams (2021) used an intersectional approach to highlight how her identity influenced the field and the silences she encountered regarding certain topics. Her reflections

focused on how being racialized and sexualized impacted her interactions with male prisoners and prison officers. Adams draws on Rice et al. (2019) to argue that intersectionality can allow researchers to better understand the dynamics between participants and researchers and question power dynamics in the field.

Furthermore, Brown (2012) reflected on her work interviewing Black legislators as a Black woman. Her racial identity was central to recruiting participants, and shared culture helped her build rapport. However, as an academic researcher trying to gain access to legislative spaces, she was inherently an outsider (Brown, 2012). Her experience demonstrates how insider and outsider status does not exist along a strict binary; rather, they can overlap as every person holds multiple identities simultaneously. The existing literature on intersectionality has informed my reflections on how social context and identities impacted the interviews and focus groups conducted as part of this study. In the reflexive methods paper, intersectionality provides a framework for discussing the power dynamics in qualitative interviewing and the complexities of conducting research across shared and unique standpoints as a Black woman conducting research with Black women.

Overview of Manuscripts

This dissertation consists of two distinct and separate research papers that draw on data from the same qualitative research project. The papers are complementary in the information they provide and contribute to the limited literature on African immigrant women in Canada. Paper 1, *Intersectionality in Healthcare: Understanding the Experiences of African Immigrant Women in Canada*, focuses on an in-depth, holistic analysis of African immigrant women's unique experiences seeking healthcare services for themselves and their families. Paper 2, *Finding a Connection: Reflections on Race and Gender in Qualitative Interviewing with Black Women*, presents concerns from this work and considerations for further qualitative research with this population in health sciences. Although they use different methods and have differing objectives, they are informed by a feminist standpoint methodology and take an intersectional approach that privileges the voices of Black women. The studies also highlight further implications for healthcare policy and practice as it relates to African immigrant women and qualitative research practices with this population, which will be described in the concluding chapter of this dissertation.

The manuscripts have been developed to be published in academic journals. *Intersectionality in Healthcare* will be submitted to the *Journal of Immigrant and Minority*

Health. This journal publishes articles related to immigrant health across a variety of fields including, public health, medicine and nursing, sociology and ethics (Springer Nature, 2023). *Finding a Connection* is aimed at the journal *Cultural Studies <-> Critical Methodologies*. This interdisciplinary journal focuses on the relationship between cultural critique, cultural studies and methodical practice (SAGE Publications, 2023). *Cultural Studies <-> Critical Methodologies* publishes works in many different forms including critical, reflective essays that discuss the presence of the author in the text, making it a good fit for this manuscript.

Intersectionality in Healthcare: Understanding the Experiences of African Immigrant Women in Canada

The experiences of African immigrants are rarely discussed in the Canadian research literature. *Intersectionality in Healthcare* employs a qualitative research design to explore the healthcare experiences of African immigrant women accessing healthcare in Manitoba. The women's settlement experiences, healthcare encounters and trust in the healthcare system are discussed in individual interviews and focus groups. The resulting data was analyzed using thematic analysis. The participants' responses fell into three main themes: Navigating the system; Is anyone listening?; and Taking care of ourselves. Generally speaking, an unfamiliar and confusing healthcare system, a lack of cultural competence, racism and discrimination, and not having their health concerns taken seriously hindered healthcare access. In contrast, participants who had positive healthcare experiences attributed this to their strong relationships with their physicians, being actively involved in their care and having their concerns validated. Participants relied heavily on social support systems throughout their settlement experience and when accessing healthcare. Findings suggest better access to healthcare services, interpreters and resources for newcomers. African immigrant women would benefit from increasing the number of physicians, improving the cultural inclusivity of care and increasing the number of Black doctors.

Finding a Connection: Reflections on Race and Gender in Qualitative Interviewing with Black Women

Drawing on the same data as *Intersectionality in Healthcare*, *Finding a Connection* reflects on the experience of conducting research with Black women as a Black woman. Participant responses and researcher reflections are analyzed to understand better how qualitative research with Black women is impacted by social context and the interviewer's

role as a research instrument. This work recognizes that Black women do not have one uniform experience, and tensions arose during the interview. Some participants were reluctant to speak about negative experiences, and the hesitancy to name racism hindered deeper exploration of their experiences. At the same time, insider status and self-disclosure helped facilitate conversations with participants. This paper also draws on literature to discuss how qualitative research with Black women regarding their experiences can be conducted safely, effectively, and empoweringly.

Summary

Following this introductory chapter (Chapter 1), Chapter 2 focuses on *Intersectionality in Healthcare*, exploring the healthcare experiences of African immigrant women accessing healthcare services. Chapter 3 focuses on *Finding a Connection*, reflecting upon the experience of interviewing Black women regarding difficult topics such as racism and gender discrimination. Chapter 4, the concluding chapter, provides a summary of the entirety of the current research and discusses the implications and future directions for research.

Chapter 2: Chapter 2 Abstract

Chapter 2 focuses on the general experiences of African immigrant women accessing healthcare services in Manitoba. This study describes the participants' experiences moving to Manitoba, interacting with healthcare professionals and the overall Manitoban healthcare system. It seeks to understand the barriers and facilitators encountered and their perception of the system. Informed by intersectionality, it aims to highlight how the participants' intersecting identities and the social context shape their experiences. Individual interviews and focus were conducted with women who had immigrated from African nations within the last 10 years and interacted with the healthcare system in Canada. I conducted 22 individual interviews and 2 focus groups with 27 participants. Prior to conducting the interviews I collected demographic information from the participants (i.e. their home country, level of education, time in Canada) in order to identify the socio-demographic characteristics of the sample. I used a convergent interviewing approach and thematic analysis of the interview transcripts started during data collection and continued after. This study found that participants had a range of healthcare experiences. Many African immigrant women face barriers navigating the healthcare system, accessing services, and communicating with providers. In contrast, positive healthcare interactions were characterised by being actively involved in their care, receiving competent service, and empathy. In order to overcome these barriers, concerted efforts are needed at the levels of local community organizations, healthcare providers and healthcare policy.

Intersectionality in Healthcare: Exploring the Experiences of African Immigrant Women in Winnipeg, Manitoba

Introduction

Background and Population

One-fifth (21.9%) of the population of Canada is made up of immigrants, which is projected to increase to up to 30% by 2036 (Statistics Canada, 2017). In 2016, 13.6% of immigrants to Canada were born in Africa. This marked the first time that Africa is the second-largest source continent of new immigrants and is a significant increase over previous years (Statistics Canada, 2017). These immigrants have settled and established strong communities in provinces such as Manitoba, where 14.3% of the visible minority population is Black (Manitoba Government, 2006).

As immigrants comprise a large and growing proportion of the Canadian population, their experiences with the healthcare system should be considered an increasingly important priority. Under the Canada Health Act, immigrants should have access to the same universal and comprehensive primary care services as Canadians (Health Canada, 2006). Yet, researchers identified that immigrants often face obstacles when accessing healthcare, including cultural, socioeconomic and language barriers and discrimination (Bajgain et al., 2020). Further, the lived healthcare experiences of immigrants, their trust in providers and how this impacts their healthcare service use are mainly undocumented (Weersinghe, 2012). Therefore, understanding how immigrants negotiate their interactions with healthcare providers is needed.

For immigrant women, their healthcare experiences are further impacted by various factors, including gender, visible minority status and immigration status and their intersectionalities (Weersinghe, 2012). The aim of this study is to better understand African immigrant women's experiences with and perceptions of the healthcare system in Manitoba. This aim will be pursued through the following objectives: 1) To explore the Canadian healthcare experiences of African immigrant women; 2) To examine how these experiences influence their trust in a) healthcare providers and b) the health system; and 3) To identify the information needs and preferences of African immigrant women when making decisions regarding healthcare for themselves and their families. The findings can be used to inform the actions and approaches to communication doctors can adopt that may result in African immigrant women patients' feeling seen, heard, and as though their healthcare needs matter

Experiences Within the Healthcare System

Previous studies regarding the experiences of immigrant women accessing healthcare have documented various barriers to accessing the healthcare system. These include immigrants being unfamiliar with the system and having limited access to information (Mbanya et al., 2019; Bajgain et al., 2020), the cost of medication and non-basic services (Bajgain et al., 2020), a lack of interpreters (Woodgate et al., 2017), and reluctance to seek care because of fear related to their immigration status (Perez-Urdiales et al., 2019). In addition to system-level barriers, women also encountered interpersonal barriers. These include language barriers, cultural differences, and poor patient-provider communication (Bajgain et al., 2020; Perez-Urdiales et al., 2019). Due to cultural and religious beliefs, some immigrant women prefer a female doctor and reported delaying or avoiding seeking medical treatment because they could not find one (Bajgain et al., 2020; Woodgate et al., 2017). Some immigrants also preferred an immigrant doctor because they felt they would receive more respectful and attentive care (Mbanya et al., 2019). A literature review also found that a lack of cultural competence can negatively impact the healthcare experiences of immigrants in Canada (Ahmed et al., 2016). Immigrants felt frustrated when Canadian doctors did not understand their culture as it relates to health beliefs and the practice of doctors in their home country (Ahmed et al., 2016).

Other studies have also examined how social factors, including social support and socioeconomic status, impact immigrants' health and healthcare experiences. For instance, having little or no social support would leave them with no one to ask health-related questions or give them rides to medical appointments (Woodgate et al., 2017). In some cases, immigrants relied on the help of people in their community who had been in the country for longer to access healthcare services (Woodgate et al., 2017). A meta-ethnography of immigrant women's experiences of maternity services in Canada identified social support as a critical aspect of high-quality maternity care (Higginbottom et al., 2014). An absence of social support during pregnancy and postpartum contributed to postpartum depression among some women because their lack of language proficiency and knowledge of available services left them isolated (Higginbottom et al., 2014). Moreover, lower socioeconomic status intersected with participants' identities as immigrants and racialized, shaping their health and healthcare experiences. Immigrants often face underemployment or unemployment, which makes it hard to afford transportation, childcare, and health insurance (Ahmed et al., 2016),

further impeding their ability to access health services. This can also lead to living in poor quality housing, contributing to further health problems (Woodgate et al., 2017).

While there have been studies examining the experiences of immigrants from various cultural backgrounds, there is a lack of research specifically focused on African immigrant women. In a recent review of immigrant patient experiences accessing primary care in Canada, only eight of the 19 studies included African immigrants in their study population (Bajgain et al., 2020). Among these studies, three focused solely on immigrant women in their study populations and explored maternity care (Mumtaz et al., 2018; Higginbottom et al., 2014) and accessing dental care for their children (Amin et al., 2012). To date, there appear to be no Canadian studies exclusively on African immigrant women's healthcare experiences. The nuances of these women's experiences and their intersectionalities are lost when grouped with immigrants of other cultural, racial, and gender backgrounds. It is important to acknowledge that studying the influence of every possible intersecting identity within this diverse group is impossible. Instead, this study aims to highlight how factors such as race, class, cultural background, and gender intersect and shape these women's unique experiences.

Racism in Healthcare

In addition to the barriers discussed above, immigrants have reported experiencing racism and discrimination in their healthcare interactions. A study that examined the healthcare accessibility of visible minority immigrant women in Canada identified instances of intentional discrimination and cultural ignorance during interactions with healthcare providers and named racism as a health risk factor (Weerasinghe, 2012). Participants observed that the more their accent, body weight, or skin colour differed from the Eurocentric standard, the higher the likelihood of experiencing discrimination. These discriminatory experiences forced them to adapt how they presented themselves and navigated the healthcare system. Women in the study had to learn to cope with racism, such as not being angry, enhancing self-efficacy, knowing their rights and available immigrant services, and improving their English proficiency (Weerasinghe, 2012). Further, the adverse effects of racism in healthcare on Black people in Canada have been studied (Fante-Coleman et al., 2022). This discrimination harms their physical and mental health, erodes their trust in the healthcare system and hinders their access to care (Fante-Coleman et al., 2022).

African immigrant women in European studies shared comparable accounts of racism and mistreatment. For example, a study conducted in Sweden revealed that immigrant women often felt “treated as second-class citizens” in comparison to white patients (Mbanya et al., 2019, p. 7). Several participants reported that healthcare professionals avoided physical contact and would wear double gloves, assuming that they were contagious or had HIV simply because they were African (Mbanya et al., 2019). In a Spanish study, some women connected their negative experiences with healthcare providers to the country’s history of colonialism and anti-black racism (Perez-Urdiales et al., 2019). They discussed how this history shaped how providers treated them and how they saw themselves. However, other participants attributed poor treatment to bad luck or encounters with unprofessional staff (Perez-Urdiales et al., 2019). The fact that women had similar experiences but attributed them to vastly different causes demonstrates the importance of listening to individuals and not assuming all community members will interpret their experiences similarly.

Another barrier that may influence Black African immigrants' health status and healthcare experiences is systemic anti-Black racism (ABR) within the healthcare system. Systemic racism refers to how racism is embedded in institutions' laws, policies and practices, creating advantages for some racial groups while oppressing others (Williams, Lawrence & Davis, 2019). Within the healthcare system, this manifests through stereotyping and provider biases, which are further amplified by the underrepresentation of Black physicians in Canada (Sinai Health Systems, 2020). ABR is such an issue that Toronto’s Board of Health declared it a public health crisis in 2020 (Etowa & Hyman, 2021). Addressing ABR is crucial for achieving health equity for all Black individuals in Canada. It will require initiatives such as collecting race-based data and actively listening to the experiences and suggestions of Black individuals regarding necessary changes within the system (Dryden & Norom, 2021).

Theoretical Perspective

Intersectionality

This paper is informed by an intersectionality approach, a social justice framework that describes how multiple axes of marginalization, such as sexism, racism and immigration status, are mutually created (Crenshaw, 1991; Collin, 2000). An intersectional lens helps explore how the unique experiences of Black immigrant women are affected by the

intersection of overarching systems of oppression (Patterson & Veenstra, 2016). An intersectional lens can analyze power dynamics across different domains - structural, cultural, disciplinary, and interpersonal - (Collins & Blige, 2016). For example, in health and healthcare, racism, sexism, and classism intersect across these domains to create health inequities (Weber & Fore, 2007). Further, the influence of power imbalances on the healthcare system can be obscured by clinical “objectivity”. However, intersectionality allows one to make power visible and potentially address its adverse effects (Weber & Fore, 2007).

Intersectionality was first coined by legal scholar and Black feminist Kimberlee Crenshaw in her 1991 essay *Mapping the Margins*. She explained how the one-dimensional analysis employed in anti-discrimination law and antiracist theory treated race and gender as separate issues. She asserted that discussing one identity at a time did not fully capture how Black women were “othered” or marginalized by society. To address this limitation, Crenshaw (1991) proposed adopting a new analytical framework that acknowledges the distinct experiences of Black women and recognizes that these experiences cannot be fully understood by simply combining the effects of racism and sexism. Subsequently, intersectionality theorists, working from a feminist standpoint, recognized the importance of acknowledging women of colour as uniquely located knowledge holders (Collins & Blige, 2016). This study adopts the same epistemology in exploring the unique experiences of African immigrant women living in Manitoba by privileging their perspective.

Intersectionality is a valuable approach to health research because it emerged from the need to view individuals within their social context and differed from the essentializing perspective of the biomedical model (Weber & Fore, 2007). When intersectionality is used as an analytical tool, researchers can understand social inequality due to the interactions between many social categories (Hankivsky, 2014). Feminist health researchers have used intersectionality to situate health in communities and shift the social construction of health to one that is more inclusive and reflects how people live (Weber & Fore, 2007). Intersectionality has been useful in exploring a variety of health issues, including racism in healthcare (Rosenthal & Lobel, 2020; Roach et al., 2023), domestic violence (Loncar & Scott, 2023; Robinson, Frawley & Dyson, 2021) and the effects of the COVID-19 pandemic (Cleaveland, Lee & Gewa, 2023; Kemei et al., 2023).

Further, intersectionality has been widely considered to have the potential to inform new broader frameworks for health disparities research (Hankivsky, 2014). The need for more research regarding health and intersectionality in the Canadian context has been highlighted (Hankivsky, 2014). In this study, intersectionality provides a lens to critically analyze the connections between race, gender, immigration status and the healthcare experiences of African immigrant women in Manitoba. The intersectional approach is appropriate here because immigrant women face disparities that stem from their multiple axes of oppression. Focusing on these women's first-hand experiences will centre their voices while highlighting how systems of privilege and disadvantage shape their healthcare experiences.

Methods

Participants and Recruitment

The present study used a qualitative approach to explore the healthcare experiences of African immigrant women accessing healthcare services in Winnipeg, Manitoba. This allowed participants to share their experiences based on their reality. Immigrant women from African countries older than 18 who have lived in Winnipeg for ten years or less were eligible to participate in this study. This allowed for an analysis of the experiences of more recent immigrants. Participants were recruited through purposive and snowball recruitment methods. First, research posters were shared through social media and established networks within cultural community organizations. Then snowball sampling was used to further recruitment through the social networks of current participants. Participants were informed of the objectives and the study through an information and consent form distributed before their interview or focus group. Participants were given the opportunity to ask the researcher questions before giving written consent to participate in the study. Interviews were then scheduled based on their earliest availability.

Data Collection

Individual semi-structured interviews and focus groups were conducted from April to June 2022. In total, 21 individual interviews and 2 focus groups - with 3 and 5 participants each - were conducted. These methods allow participants to share in-depth accounts of their experiences living in Winnipeg, accessing healthcare services, and exploring the ideas raised in individual interviews in a group context. All interviews were conducted over Zoom or over

the telephone as a safety precaution due to the COVID-19 pandemic. All interviews were conducted in English.

Before the interviews, participants filled out demographic information forms providing their age, time in Manitoba, whether or not they have a family doctor, marital status, education level, and income. Interview questions started with a focus on participants' experiences moving to and finding community in Winnipeg. Then questions turned to experiences navigating the healthcare system and accessing healthcare services for themselves and their loved ones, including primary care providers, emergency/ urgent care, specialized care and diagnostic testing. Trust and communication within their relationship with their primary care provider and awareness and use of government, social and non-profit support available to immigrants. Finally, participants were asked to identify challenges immigrants face accessing healthcare in Manitoba and propose potential solutions.

An iterative convergent interviewing process was used to explore ideas from earlier interviews with subsequent participants. Developed by Bob Dick (2013), convergent interviewing explores participants' opinions and beliefs using a series of interviews that narrow in scope to focus on key issues (Rao & Perry, 2003). The goal is to identify issues that come up most frequently, allowing for the exploration of those that may be specific to the participant's unique experiences (Driedger, Cooper & Moghadas, 2014). The initial interview began with a broad opening question outlining the topic, while probing questions were used to clarify participants' experiences. Subsequent interviews delved deeper into important topics that were raised in earlier interviews (Driedger et al., 2014). The researcher conducts continuous data analysis and reflection throughout data collection (Dick, 2013). Written reflections in field notes and stream-of-consciousness writings informed the development of new probing questions for each interview.

The interview process is concluded when agreement is reached among participants' responses, any disagreements are resolved, and no new issues are raised (Rao & Perry, 2003). Convergent interviewing allows the researcher to uncover a convergence on critical issues faster than other interview methods (Driedger et al., 2014). This process also allows for the exploration of both positive and negative aspects of the topic. For instance, participants were asked what aspects of services for immigrant thought were working well and which were not working well. As a result of using this approach, the interviews focused on the topics most relevant to each participant and varied in terms of the specific questions asked.

Data Analysis

All interviews and focus groups were recorded and then transcribed verbatim by a professional transcription company. Then the accuracy of the transcripts was verified through voice attribution by the researcher. Transcripts were then analyzed using the qualitative data analysis software NVIVO 12. Consistent with the convergent interviewing approach, analysis of the transcripts started during data collection. Thematic analysis was employed to examine the relationships, similarities, and differences among the data points (Ravitch & Carl, 2021). Initially, line-by-line coding was conducted, resulting in 600 codes. Related codes were then organized into twelve initial themes, which were further reviewed and compared to the coded data. Thematic mind maps were utilized to visualize the data set and ensure theme cohesion, with adjustments made as necessary. Themes were given clear definitions and organized into a cohesive narrative. From these various efforts to organize content categories into themes, three themes were identified into a cohesive narrative. Reflexivity was practiced by completing field notes after each interview and memos throughout the data analysis process. These initial notes were used to inform the subsequent themes.

Results

Through individual interviews and focus group discussions, women expressed their challenges and successes in immigrating to Canada and accessing the healthcare system. The following section describes their experiences in four themes: Navigating the System, Is Anyone Listening, Taking Care of Ourselves. In presenting these themes below, illustrative quotes that capture the essence of each theme are provided.

Navigating the System

Many participants discussed the challenges they encountered navigating a healthcare system different from the one they were used to back home. A big issue was a lack of access to structural support and resources. Finding a doctor, getting a health card and health insurance was difficult for participants as the system seemed like a maze. A lack of knowledge of available healthcare services and services for new immigrants was a significant challenge:

Yeah. I feel like accessibility is the greatest, is the greatest challenge. Like some of these services exist but like you don't even know like that it's there, right. So, what's, what's the benefit like I don't know like how do I access it, right. (RA, FG2)

Physically getting to and from appointments could also challenge some women, especially when they first arrived. Many women had to rely on public transportation, taxis, walking or rides from friends and family to get to their doctor's offices. In addition, many women were mothers and had to manage to bring their children to and from their own appointments because they could not get childcare at that time.

There were still many unexpected challenges for women who could access healthcare services, including long wait times in emergency rooms and for appointments with their family doctors and specialists and unexpected costs for non-primary care services and medications. In addition, they found that compared to the healthcare system in their home country, the Canadian healthcare system is rigid and often moves slowly. Women wanted to talk to healthcare professionals and have their concerns addressed but found the lack of immediate action to be frustrating and differing from their expectations.

One participant spoke of her experience travelling back to her home country to see a gynecologist after waiting months to see one in the province. She felt that it was easier to have her concerns addressed elsewhere:

And then when I came back, four months later that's when I got a call from the gynecologist saying that. "Oh, we have a time. You can now go and do your schedule for a gynecologist." So basically, it's just that it takes a long time here for your concerns to be heard and it was literally easier going overseas and being able to see a gynecologist overseas and get your feelings heard than using the health care system here. (SI2, FG1)

Healthcare costs were an issue for women who came to the province as international students. Paying for healthcare on top of steep international student fees proved difficult for many women. They also could not access clear information regarding what they needed to pay for out of pocket and what their insurance covered.

I guess when I was a student not really, I know – because when I initially came there was – I'm trying to remember what it's called. International students were entitled to

the same health care coverage as permanent residents or citizens here in Manitoba. But then obviously the new government came in and they changed things. So for me that was challenging because another thing is I had to now pay for my doctor's visits. So I wasn't very clear on what I'm going to have to pay for, what I'm not going to have to pay for. So it was a bit confusing, yeah. (CN)

Is Anyone Listening?

This theme reflects the reality that for many women, the experience of accessing healthcare services could be an isolating and frustrating experience. In their interactions with healthcare providers, they faced communication barriers, not feeling listened to and racism. Though all the women who participated in the study spoke English, they described the experiences of their family and community members needing interpreters to communicate with their healthcare providers. Participants described instances when translating for a family member helped that person feel more confident and comfortable in their appointments. Through their translation, their loved ones were able to ask more questions and be more actively involved in their care. In the quote below LO describes how translating for her mother and cousins helps lessen their anxiety during appointments and helps them have a better understanding of what their doctor is saying.

...there've been times when there's so much anxiety related to going to the doctor's office because they would misinterpret what the doctor is saying. So having to go with someone who can actually integrate in the language usually helps address such anxiety. And sometimes even after the appointment, I ask them questions just to be sure that they really understand what's going on and what they have to do. And they tend to ask more questions most of the time and yeah. (LO)

Even though the women in this study spoke the same language as their providers, it did not mean they could communicate effectively. The women did not feel their providers' responses were appropriate or their concerns were being addressed. Women reported not being taken seriously or listened to by their healthcare providers.

But in our experience like chest pain sometimes but just like she wasn't taking me seriously. And so whenever I go on subsequent visits I kind of dial back on like my

complaints. Because I'm like well, there's no point in telling her about it. Because she didn't seem to take me seriously. So I've kind of gotten used to the fact that I would not be taken seriously if it was not something like extreme. (FO)

For Black women, in particular, the issue of not being listened to is worsened by racial stereotypes and perceptions that they are more robust and can handle pain better than people of other races. Therefore, their pain is taken less seriously. This harmful belief was evident in the following participant's narrative. She describes her frustrating experience giving birth at the hospital and having to wait a long time for the epidural.

One thing I noticed during my birth experience is that they didn't give me my pain medication on time. I was in pain. I was in pain for a very long time. I think they kept stalling, maybe because they need like the -- I don't know if it's the acute pain service to OK it. Or it wasn't yet time for epidural? Because these things are timed... Maybe it's the general idea that we don't feel pain? Some people think we don't feel pain. We're strong so we don't feel pain. Maybe, I'm not saying that for sure 100%. But I know they stalled for a very long time. And I found that frustrating. (KG)

Some women spoke openly about the racism they experienced in the healthcare system or their apprehension to seek care because they worried about the possibility of experiencing racism. This concern stemmed from a perception that Canadian providers would not treat Black women well because they lacked the knowledge or the interest needed to do so. This is demonstrated in JJ's worry that if she were hospitalized with COVID-19 during the pandemic, she would not be able to get on a ventilator.

...I don't want to be in a situation where I'm giving a doctor a choice. Like, this is a Black African woman and this is a white Canadian woman, you know, like who goes to the ventilator? That is one of the things I was telling myself, like I don't want to be in such a situation. Because, most likely, I will lose, you know. It's very sad but that was the conversation in my head, like I better be very careful, you know because I don't want to be in a situation like that. (JJ)

Further, NS, a nursing student and immigrant from Nigeria, expressed her belief that there is systemic racism in the Canadian healthcare system. For example, after experiencing a miscarriage, NS had this interaction with a doctor who was aggressive and racist:

So, I feel like there's, there's like, there's systemic racism in healthcare. It's there. You know it's there. Sometimes you, like I had this one doctor that she outright told me "you're going to die because you're not doing this... because you...", I'm like "I'm not going to die". She's like "yeah, that's what everyone who died said, you're going to die." But that was wrong. I was going through a process. I was grieving. That's not how you talk to a patient. (NS, FG2)

Taking Care of Ourselves

This theme focuses on how women coped with the previously mentioned systemic and interpersonal barriers and the changes that they felt would improve the situation. Negative healthcare experiences affected how participants interacted with the healthcare system, causing them to ask fewer questions, avoid accessing the healthcare system or self-medicate at home.

Actually, I don't ask much questions, because I know what she says. What she's going to say. So I don't usually ask too much. I just go for the reason that I went and I ask and talk to her. Either she's going to give me a short answer or, you know – it's just if I'm not comfortable with what she says I just Google it, or I just – either it's I Google it or I talk to someone else. (LK)

When support was unavailable elsewhere, community and family support played an important role in women navigating their new life. Many women could access healthcare and other services through connections with family and friends who lived in Canada longer. The majority of study participants were married and had children and described the helpfulness of having a community that could support them in finding childcare:

Oh well everything from getting accommodation to getting kids into school and daycare to getting furniture, a way to get furniture, a way to get food, transportation, getting a car, you know, getting work and all that. So yes, family and friends and

community have definitely been – without them, then you're almost lost trying to look for, you know, whatnot, but they've been there. (AA)

Discussions included questions of how participants would define a positive healthcare experience and how they would describe a good healthcare provider. Descriptions of positive interactions offer insight into what all providers should be doing. For example, the women described a good healthcare provider as someone who advocates for their patients, is empathetic, knowledgeable and a good listener. Also expressed that a good provider would allow them to be actively involved in their care:

So, we actually, she takes time to discuss the pros and cons of whatever decisions we're making, so we're actually making that decision together; it's not just her telling me, oh, I think you should do this, just because, yeah. (TA)

Participants offered many ideas for how the healthcare system could be more responsive to the needs of new immigrants. Their suggestions included the internet and social media to get information out and connect with more people in the immigrant community. Various community organizations have social media pages that they are already using to share community news and relevant information with newcomers. Accounts such as these could be used to spread information regarding healthcare resources. Alternatively, new social media accounts could be established to help provide newcomers with this information, as suggested by the participant quoted below.

I just thought of something. When you asked what resources do I think would be good for people who are just coming in? I think that probably some pages on Instagram or Facebook, but like some sort of social media hub with - just as a general guide to newcomers.

Because I think that's one of the first few places people go when they are going to a new place, "OK, what page, what resource can I find? Where can I get information" and if it's just like in those - you know, just like little cute short bits, just enough to get them searching for more I think that would be good. (CN)

Participants also highlighted the need for improvements to medical education and more representation of Black people in the healthcare system.

I think medical schools, they really have a small quota and it's not available for international students. So I think that's part of why there is a really big gap, why it's mostly white people who are specialists or really doctors. Because even when the immigrants, when they come in, like I heard a couple of people that came in through [Permanent Residency] and then they still have to go through exams and that before they can practice... So hopefully the barrier will close over time. (FS, FG1)

I feel we need more [Black] people in healthcare too. Because maybe the more they see us it will help, you know, bring about the changes that we so want. (NS)

Discussion

Navigating the System

Study participants encountered various barriers when seeking healthcare services, such as limited transportation options, a shortage of available doctors, lengthy wait times, unexpected expenses, and a complex and frustrating healthcare system. Some participants attended E-Learning Workshops provided by the newcomer service agency Manitoba Start. However, these workshops primarily focused on career development, cover letter writing and other aspects of the settlement experience. The orientation guide on the Manitoba Start website provides a brief overview of healthcare information for immigrants (Manitoba Start, 2023). There is no formal program specifically designed to familiarize newcomers with the Canadian healthcare system. Manitoba Start could offer a dedicated workshop or e-course covering healthcare more in-depth. Previous research has shown that a lack of knowledge poses a significant barrier to accessing healthcare services (Marshall et al., 2010; Donnelly, 2008). Community-led health workshops have been proposed as interventions to orient new immigrants to the existing healthcare services and the structure of the healthcare system (Turin et al., 2021). Several organizations offer settlement support to immigrants in Manitoba and could facilitate these workshops.

For participants who managed to find a family doctor, transportation to and from medical appointments was often challenging, particularly in the early days when participants did not have a Canadian license or personal vehicle. In previous studies, lack of reliable transportation and poor weather have made it difficult for immigrant families to attend

appointments (Woodgate et al, 2017; Tefera & Yu, 2022; Roberts et al., 2021). Moreover, as primary caregivers, women participants in this study faced the added challenge of bringing their children to appointments or having to bring their children to their appointments due to a lack of childcare. Navigating getting children to appointments without a car was a challenge that kept some people from attending their appointments in other studies (Stewart et al., 2006; Woodgate et al., 2017). Though these are challenges that impact all low-income Canadians, for immigrants, it is compounded by the challenges of lacking an established social support network and learning to navigate life in a new country. Bringing healthcare closer to areas where immigrants reside has been proposed to alleviate these access barriers (Roberts et al., 2021). For example, accessing care was significantly easier for women living near their doctors.

Another common barrier identified by many participants was the long waits they faced in the emergency room and for appointments with their family doctors and specialists. Previous research with immigrants in Canada demonstrated that long waits could discourage people from accessing healthcare services and opting to treat severe issues at home (Kalich, Heinemann & Ghahari, 2016; Turin et al., 2021) For immigrants these lengthy wait times compound other issues such as a struggle to maintain work-life balance (Setia et al., 2011; Ahmed et al., 2016) and make accessing healthcare difficult. This issue demonstrates how system-level dysfunction can negatively impact how individual patients experience the healthcare system. Increasing the number of healthcare facilities and extending clinic times to make them more accessible could reduce the wait times impacting immigrants and all Canadians (Turin et al., 2021).

Accessing healthcare was further complicated for women who immigrated to Canada for university as international students. Before 2018, international students in Manitoba had universal healthcare coverage but now must pay out of pocket for non-primary care visits and expensive health insurance (Bergen, 2022). Healthcare costs and high tuition fees have made it difficult for many international students to afford to complete their education in the province (Lilley, 2021). Participants in the study faced challenges in finding providers who would accept their insurance and obtaining coverage information. Additionally, underemployed or unemployed immigrants lack employer-based insurance and must cover the costs of medication, dental care, and other uninsured services (Woodgate et al., 2017). While Canadian literature generally does not focus on insurance-related barriers for immigrants, a review of healthcare access for immigrants in the United States revealed that

changes to insurance policies and exclusionary regulations made healthcare unaffordable and forced some individuals to return to their home countries for care (Tefera & Yu, 2022). Reinstating universal healthcare access for international students would help alleviate a significant burden on international students and help keep them in the province.

Is Anyone Listening?

All interviews were conducted in English, indicating that study participants are proficient in the language and comfortable with English-speaking doctor's appointments. However, participants shared their experiences as translators for friends and family members during healthcare interactions. Access to professional translators and healthcare professionals who speak their language would greatly benefit immigrants like these in accessing healthcare services independently. Previous research has emphasized the importance of linguistically and culturally appropriate healthcare services for immigrants (Stewart et al., 2006; Ahmed et al., 2016). Researchers have shown that professionally trained interpreters improve patient satisfaction and understanding of diagnosis and treatment options in primary care settings (Heath, Hvass & Wejse, 2023). As noted by participants, it is crucial to ensure that language services are culturally appropriate, including the availability of same-gender translators for patients and ensuring the confidentiality of patients during interpretation.

Communication barriers extended beyond language for the study participants. Many women expressed feeling unheard and not taken seriously by their healthcare providers. This issue has been explored in the literature, particularly for female patients (Clareus & Renstrom, 2019). It may also stem from the perception that Black people have a higher pain tolerance, leading to biases in assessing patient concerns such as pain (Hoffman et al., 2016; Mende-Siedlecki, 2019). The subjective nature of assessing patient concerns allows racism to operate subtly, making it challenging to detect (Fante-Coleman et al., 2022). Racism, even if implicit, affects the care that racialized individuals receive within the Canadian healthcare system (Penner et al., 2009). Similar experiences of healthcare providers not listening to concerns or ensuring understanding of proposed treatments have been reported by African American women, resulting in perceived discrimination, decreased trust in healthcare providers, lower adherence to medical care recommendations (Cuevas, O'Brien and Saha, 2016; Husbands et al., 2022) and fewer interactions with the healthcare system (Fante-Coleman et al., 2022).

Instances of racism in the healthcare system have been documented in the literature (Black Health Alliance, 2020; Husbands et al., 2022) and reported by Canadian news outlets (Bowden & Cain, 2020; Trinh, 2020; Orr et al., 2023). Study participants described firsthand experiences of racism and perceived discrimination that negatively influenced their perception of the healthcare system. These experiences are influenced not only by the participants' race but also by their status as recent immigrants. This intersection of race and immigration status can be particularly challenging for Black immigrant women, who navigate the new identities of "Black" and "immigrant" in Canada. Participants emphasized the importance of knowing their rights to protect themselves from mistreatment and discrimination. In previous studies, immigrant women discussed frequently experiencing discrimination and poor healthcare since they are seen as undocumented and a drain on the system. Those with legal status also encounter these biases and are denied access to healthcare services, despite the issue being particularly severe for undocumented immigrants (Armenta & Sarabia, 2020; Quesada, 2011). Although it is difficult to know if these experiences are motivated by participants' statuses as "black women" or as "immigrants," it is clear that this treatment has adverse effects. Studies have shown that perceived discrimination has been associated with poorer health outcomes among immigrants (Rodriguez et al., 2013; Perez-Urdiales et al., 2019).

Study participants may feel like their appointments are rushed and transactional due to other factors, including the competing priorities and models used by providers to deliver care. For example, the traditional fee-for-service model requires physicians to bill for each service, which can encourage shorter clinical interactions and tests, resulting in less time spent with patients (Linzer et al., 2015). However, this can also make physicians more likely to rely on harmful stereotypes to be more efficient (Chapman et al., 2013). These limitations can make it difficult for providers to establish strong relationships with their patients and address their complex needs (Linzer et al., 2015). This can be frustrating for physicians and patients who find rushed interactions unsatisfying and inefficient in meeting their healthcare needs (Olukotun et al., 2020). This can be especially difficult for women who come from countries where they have a close relationship with their provider and could spend a long time with them. Therefore, there is a need for system-level interventions to allow doctors to spend more time with their patients.

The race of the physician was not always important to participants, as they valued effective communication, having a knowledgeable provider and good relationships more.

According to Jacobs et al. (2006), these aspects of culturally competent care have been suggested as a solution to the healthcare inequities that marginalized individuals face in accessing healthcare. Culturally competent care refers to care that values diversity, is aware of power dynamics, includes cultural knowledge, and is adapted to meet the needs of diverse patients (Fante-Colman et al., 2022). To be more responsive to the needs of increasingly diverse patient populations, physicians should move away from a strictly biomedical model that considers social and cultural context. Instead, they should focus on cultural humility, which involves reflecting on their social position and power and learning about the cultures of their patients (Fante-Colman et al., 2022; Juarez et al., 2006). This approach can potentially improve equitable access to care for African immigrant women and patients of other marginalized backgrounds.

Taking Care of Ourselves

The theme “taking care of ourselves” explored how negative healthcare experiences impacted participants. These experiences often kept them from seeking further healthcare services. Study participants often relied on their community and family to navigate their transition to life in Canada and the healthcare system, especially immigrants who had lived there longer and had more experience navigating the system. This reflects similar research findings that social support was critical in allowing people to access healthcare (Woodgate et al., 2017). In addition to this instrumental support, immigrants rely on community members for emotional support to help with the stress of the immigration process and stressful healthcare experiences (Higginbottom et al., 2014). The importance of informal community networks can not be understated, and they present an excellent opportunity for improving connections between new immigrants and formal social services.

Participants offered solutions, including leveraging existing community groups to support newcomers and using social media to connect with more immigrants. Newcomers are already going to community associations, churches, mosques, and other cultural and religious institutions to find community. These avenues offer potential opportunities to raise awareness about existing programs, such as English classes provided by the Immigrant and Refugee Community Organization of Manitoba and career development courses offered by Manitoba Start. In their study of immigrants' perceptions of ways to improve healthcare accessibility for Bangladeshi immigrants in Ontario, Turin and colleagues (2021) identified several community-level approaches to improving access to healthcare services. They

suggested community-based information workshops to help raise awareness of existing resources and improve health literacy. Another suggestion was to identify community volunteers who could pair up with new immigrants and help them access newcomer and healthcare services. Similar approaches could be used in Manitoba to reach immigrants struggling to navigate the healthcare system or unaware of existing support.

Several participants proposed changes that they thought would help improve healthcare accessibility. Increasing the number of doctors and healthcare facilities was a common suggestion. A shortage of family physicians across Canada and Manitoba has been widely reported (Doctors Manitoba, 2022). Manitoba has one of the lowest family doctor-to-patient ratios in Canada and is facing the reality that 43% of those doctors are planning on retiring, leaving the province or reducing their clinical hours; this dire shortage impacts not only immigrants but all patients (Doctors Manitoba, 2022). Participants pointed out that changing these rules, making it easier for internationally-trained health professionals to practice in Canada, would help address the shortage of doctors and increase the representation of doctors of colour in the healthcare system.

Foreign-trained professionals, including physicians, face a lengthy process of having their international credentials recognized before they can practice in their trained profession upon relocating to Canada. This process often entails completing 2 to 6 years of postgraduate medical training at a Canadian university (Alcoba, 2005). However, only a tiny percentage of foreign-trained physicians are accepted into postgraduate training programs, leading to a substantial pool of internationally trained physicians unable to practice medicine in Canada and forced to rely on unskilled jobs for their livelihood (Bauder, 2003). To address this issue, the federal government should collaborate with regulatory bodies (i.e., The College of Physicians and Surgeons of Manitoba) to expedite the certification process for foreign-trained physicians. A potential solution is to align the assessment processes for immigration to Canada with the assessment for medical practice in the country. This would ensure that necessary education and work experience requirements are met before accepting a foreign physician for immigration. Such an approach can potentially accelerate the assessment process conducted by regulatory bodies, enabling physicians to start practicing sooner after they arrive in Canada (Asanin & Wilson, 2008). In addition, increasing the number of foreign-trained physicians who can practice medicine in Canada would result in a subsequent increase in the number of family physicians accepting new patients and the number of physicians who are culturally and linguistically similar to patients (Stewart et al., 2006).

The race and gender of their providers were important to some participants and less so to others. For example, having a female physician was more important for participants from more culturally conservative countries. For participants who preferred a Black doctor, their reasons included a belief that they would better understand the healthcare issues that impacted Black people, that they would be able to communicate more easily and that they would not have to worry about implicit biases. This reflects the findings of American researchers who found that African American patients preferred doctors of the same race because they felt they were better communicators (Cuevas, O'Brien & Saha, 2016). Evidence also shows African American patients receive better care when Black physicians are treating them (Jacobs et al., 2006). In addition to facilitating the training of internationally-trained physicians in Canada, medical schools should consider creating more opportunities for Black medical students (Fante-Coleman et al., 2022).

Not all participants cared about the race or gender of the healthcare providers. Regardless of their providers' backgrounds, all participants valued having a provider who was competent and a strong communicator. Participants with strong relationships with their family doctors described their concerns as being met with empathy and taken seriously. Many participants also valued being actively involved in their care. Incorporating patient perspectives into the care process has been strongly correlated with improved healthcare outcomes, and patients who have shared control over their care are more likely to adhere to treatment (Cuevas, O'Brien & Saha, 2016). Therefore, physicians should adopt an egalitarian approach to delivering care in collaboration with their patients. Participants' positive interactions with healthcare providers also provide important insight into how providers can provide immigrant women with healthcare services that are effective at meeting their needs.

Conclusion

As the number of immigrants from African countries living in Canada continues to grow, so does the need to understand their healthcare experiences. This study explored the experiences of African immigrant women accessing healthcare in Manitoba. It contributed to the small body of research focusing on the needs and perspectives of this population. It aimed to highlight how immigration status, gender, race and family/community status intersect in how they experience the healthcare system. There is no universal African woman experience, but by investigating the study participants' experiences and the related literature, this study has added new insights and highlighted common barriers these women face.

This study found that African immigrant women face significant barriers in accessing healthcare services. The participants shared their experiences navigating a new life in Canada as they tried to find a doctor, work and childcare and establish a community. While many participants accessed newcomers' services, others struggled to determine what was available. Many felt they weren't being listened to in their healthcare interactions, and communication breakdowns led them to avoid the healthcare system or search for new providers. Experiences of discrimination and racism also harmed the participants as they tried to access healthcare services. Community and family networks were a substantial source of support for the participants in overcoming the negative experiences and finding their way through the system. Many felt that immigrants were alone when they questioned how the system worked. Participants who did have a strong relationship with their physicians noted the importance of clear communication, empathy and opportunities for active participation in their care.

The findings of this study can be used to improve immigrants' access to healthcare services in Manitoba and across Canada. Agencies should connect with existing community networks to better reach immigrants who may not be aware of the existing social and health services for newcomers. Further, there is a need to address the lack of culturally and linguistically appropriate care available to immigrants. Increasing the number of healthcare providers and facilities, using social media and community groups to reach more people, extending insurance coverage to newcomers and making it easier for internationally-trained medical graduates to practice in Canada were common suggestions for addressing this issue. Further investigation is needed to determine how medical education and healthcare services can be delivered to best address the needs of African immigrant women and their families in Manitoba.

Chapter 3: Chapter 3 Abstract

Chapter 3 explores the complex experience of conducting qualitative research within one's own community and the challenges that arose from interviewing Black women as a Black woman. The data presented here comes from a larger study exploring the experiences of African immigrant women accessing healthcare services in Winnipeg, Manitoba. While insider status and universalization helped facilitate conversations with participants, challenges were also encountered. A reluctance to speak about negative experiences and hesitancy to name racism hindered deeper exploration of their experiences. The analysis and discussion in this project were informed by the theoretical framework of feminist standpoint theory and intersectionality.

Finding a Connection: Reflections on Race and Gender in Qualitative Interviewing with Black Women

Introduction

Qualitative interviewing is an active process where the dynamics shape each interview between the interviewer and the participant and the larger social context (Bayeck, 2021). Existing literature suggests that women conducting research with women and Black people conducting research with Black people is the ideal research scenario and allows these researchers to establish stronger connections with research participants (Summerville et al., 2021). But this oversimplification does not tell us how to go about doing good work as Black women conducting research with Black women. Black womanhood is a unique identity and not simply a result of the additive identity of “Black + woman” (Summerville et al., 2021).

There is a lack of literature regarding the mediating effects of the intersection of race and gender on the interview process when Black women interview other Black women. In particular, there is limited insight into how to conduct research regarding sensitive and potentially triggering topics such as racism and gender discrimination. As a Black woman and a researcher doing qualitative research with Black women participants, I seek to identify how this work can be conducted safely and effectively. This paper explores the challenges I encountered by engaging African immigrant women regarding their experiences with the healthcare system in Winnipeg, Manitoba. Situating this work within the frame of intersectionality, I examine how factors including race, gender and immigration status shaped the research context and results. This work and the existing literature can inform and improve subsequent qualitative research with Black women in the field of health sciences.

Literature Review

There have been few attempts to show how researchers use particular techniques to center participants' intersecting identities and to establish trust, rapport, and authentic connections during individual interviews with Black women, despite the strong conceptual and empirical evidence in qualitative research demonstrating the advantages, disadvantages, and uses of individual interviews (Walton et al., 2022). The pathology and culture of poverty interpretations of people of colour are frequently reflected in research models that have succeeded in establishing themselves in mainstream social science research, reinforcing dominant Eurocentric perspectives (Rodriguez, 2010; Curtis, 2016). A critical examination of

racism and race, as well as an examination of how race influences the research process, are absent from these works (Rodriguez, 2010). There is still a significant gap in how qualitative research approaches issues of race and conducting research with marginalized populations. Most qualitative method textbooks confine race to footnotes, specific chapters, or special issues (Lopez & Parker, 2003; Rodriguez, 2010). Given this knowledge gap, this paper adopts a reflective approach to examine how social factors and the identities of researchers and participants affect the process of qualitative research. Specifically, it explores this phenomenon within the context of a Black woman conducting research with Black women.

Standard qualitative texts recognize the importance of the researcher's role as an instrument in the interview process. The researcher is an important tool who plays a key role in shaping data collection, interpretation and presentation (Creswell, 2009). The concept of “researcher-as-instrument” takes into account the researchers' complex identities (i.e. their race, knowledge, gender, level of expertise), which can influence the research quality (Roger et al., 2018). Despite the importance of the researcher's role in qualitative research, there has been little inquiry into how Black women researchers' identities influence the process of qualitative research. Further, the social context that shapes Black women's lives impacts the interview context and the relationship between the two is not well understood. At the same time, the number of Black women involved in qualitative research - as both participants and researchers - is increasing (Summerville et al., 2021) and there is a growing need for interview methodology that can be employed during these studies (Few, Stephens and Rouse-Arnett, 2003; Walton et al., 2022).

Previous research has discussed the relevance of the identity of the interviewer and interviewee to the research process and the impact of “insider/outsider” status. An insider in qualitative research is someone who conducts research with participants who share their identity (Dwyer & Buckle, 2009). The insider position has clear advantages, including a stronger sense of legitimacy and faster acceptance from study participants. Brown (2012) discusses the benefits of insider status in her reflections on interviewing Black state congresswomen as a Black woman. She mentions that the congresswomen were much more willing to participate in her study when they discovered she was also a Black woman. She also bonded with participants over shared experiences, such as Black hair trauma, that allowed her to establish rapport and gather more in-depth data (Brown, 2012). Specifically, regarding the context of Black women interviewing other Black women, researchers have identified the benefits of what Few and colleagues (2003) termed “sister-to-sister talk”. They

define this as “Afrocentric slang to describe congenial conversation or positive relating in which life lessons might be shared between Black women” (2003, 205). Obasi (2012), also identifies this connection and describes it as a bond that “exists but cannot always be quantified or explained in any corporeal way” (p 65). This unspoken knowledge through experience can benefit and enhance the research process to varying degrees from interview to interview.

It is important to acknowledge that an insider's role is not without its limits. Rapport and understanding cannot be assumed or automatically achieved purely based on insider status (Gubrium & Holstein, 2001). For example, Rodriguez (2010) documented that though she shared the gender and cultural background of her interview participants, they were reluctant to discuss race with her. She faced challenges making sense of participants' hesitancy to share regarding certain topics and their choice of words. Explanations were withheld, likely because of an assumed understanding that arises from insider status. In a similar experience working with Black students discussing their experiences of racism in the college classroom, Boylorn (2011) found that she was initially met with silences and discomfort. Through multiple sessions and honest communication, the author was able to get the students to open up and share their experiences. She notes that by intentionally creating a space outside the classroom to have these discussions “Black kids” could connect with one another over their shared experiences (Boylorn, 2011). Despite being insiders, these researchers had to work harder to find understanding and ask more probing questions (Rodriguez, 2010).

Multiple intersecting factors such as class, nationality and sexuality are critical in a society shaped by many intersecting hierarchies (Shai, 2020; Sue, Nunez & Harris, 2022). Insider and outsider are unstable labels that shift depending on context, time, and space. For example, Johnson-Bailey (1999), a Black women and education studies researcher reflects upon the qualitative interviews she conducted with Black women. She found that though race and gender coordination facilitated conversation, differences in colour and class created tension and silences between her and the participants. These research experiences demonstrate the complexity of the researcher-participant dynamic and how researchers can simultaneously be both insiders and outsiders. To be an effective research instrument, one must acknowledge and reflect upon aspects of their identity, such as race and class, and how it impacts the research process (Mizock et al., 2011; Dwyer & Buckle, 2009). This will allow

for developing and implementing research protocols that are better tailored to the research context and the participants' lived experiences (Walton et al., 2022).

Additionally, previous researchers have used strategies such as self-disclosure to connect with racialized participants when discussing experiences of racism (Walton et al., 2022; Burkhard, 2019; Rodriguez, 2010). Burkard (2019) conducted research with transnational Black women in America, considering the political tensions around race and immigration following the 2015 election. Using a storytelling approach, she added her story and experience to the discussion to help encourage participants to share. While personally uncomfortable for her at times, it was a critical part of the process of co-creating knowledge and a valuable approach to interviewing (Burkhard, 2019). Likewise, in her research project discussing instances of racism in higher education with Latina college students, Rodriguez (2010) used self-disclosure to “disrupt the racist messages that students receive” and create a safe space for students to share. She shared her experiences of racism in academia and found that this contributed to transforming the interview and affirming and empowering space for both the interviewer and interviewee (Rodriguez, 2010). Sharing experiences with other women has proven an effective strategy for women of colour to cope with and survive marginalization. By sharing stories with other community members, we begin a collective consciousness-raising and lay the groundwork for collective social action (Rodriguez, 2010).

In response to the lack of information regarding conducting research with Black women as Black women, Few and colleagues (2003) developed strategies based on their experiences and literature review. These included: contextualizing the research process, contextualizing subjectivity, triangulating multiple sources, monitoring symbolic power and caring in the research process (Few, Stephens and Rouse-Arnett, 2003). They argued that it is vital to be attentive to and educated on the history and culture of the research participants - African American women in their case, African immigrant in mine - to help with data collection and analysis. A strong understanding of the social context helps avoid misunderstanding in the interview and distortions of the participants' narratives (Few, Stephens and Rouse-Arnett, 2003).

Similarly, they recommend the practice of self-reflexivity and reflection upon one's relationship to the research process and participants, including attentiveness to symbolic power, status markers and language choices regarding how these may impact the interview. A caring approach to research that recognizes the impact of sharing sensitive information with

the researcher is also helpful, such as providing resources for addressing distress from interviews and being attentive to signs of distress during the interview. Finally, Few and colleagues (2003) recommend using multiple sources to allow participants multiple ways to reflect upon the questions being asked. This may mean approaching the same topic in different ways and with differently worded questions during an interview. Or researchers can collect data from nontraditional sources, such as a participant's journal, pictures or letters allowing insight into how they felt during a specific time or event.

Recently, Walton and colleagues (2022) contributed to the knowledge base in this area with their recommendations for conducting research with Black women. They advise researchers to validate participant responses as affirmations of their interpretations of personal narratives and their expertise in their lived experiences (Walton et al., 2022). Taking the time to build rapport with participants and establish the interview as a safe space through vulnerability and authenticity is also important (Walton et al., 2022). Overall, scholars agree that researchers should be held accountable for representing Black women in their work as close to the reality of our diverse experiences as possible. Intentional methods that explicitly address the impact of race, power and social context on the research process can help researchers act as better instruments and achieve these representations.

The existing body of published literature is useful in discussing the impact of race/racism, gender/sexism and other social factors on the interview process, but there is little existing research concerning the impact these factors have on qualitative research in the field of health research. Much of the work in this area comes from Indigenous health researchers who have developed research methods and paradigms that prioritize an Indigenist approach over Western research conventions (Curtis, 2016; Saunder, West & Usher, 2010; Walker et al., 2013). In a comprehensive review of Indigenous maternal health research conducted by Patterson et al. (2022), it was suggested that researchers should actively involve Indigenous women and Indigenous organizations, recognize the impact of colonialism on the subject, and endeavor to appreciate and integrate Indigenous perspectives on health and Indigenous knowledge. Research methods such as story-telling, photovoice (Wright et al., 2016) and yarning (Walker et al., 2013) have also been identified as culturally appropriate, methodologically rigorous approaches to data collection with some Indigenous populations. The emergence of these methods has helped to privilege Indigenous voices in health research and allows Indigenous researchers to conduct research in ways that honour their values and traditions (Saunder et al., 2010). This suggests that similar research and development of new

methods would be beneficial for other communities participating in health research, such as Black women.

Further exploration of effective and culturally appropriate research methods in the context of health sciences is needed. Racism and gender discrimination have negative effects on racialized women's treatment adherence, healthcare experiences and trust in the healthcare system (Weber & Fore, 2007; Nwoke & Leung, 2020). This contributes to the health disparities that impact racialized women (Weersinghe, 2012) and broader immigrant communities (Hyman, 2009; McKeary & Newbold, 2010). Social context and identities impact the researchers' ability to openly discuss and understand racialized participants' experiences with the healthcare system (Cuevas et al., 2016). With this in mind, this paper presents a set of considerations that surfaced through the process of discussing racial and gendered experiences with Black women in the context of seeking healthcare. The following section discusses the theoretical frame that informs this study, then I provide further information on the context of the larger study and the issues encountered during data collection.

Intersectionality

This study employs an intersectional approach in its exploration of the healthcare experiences of Black African immigrant women. Intersectionality is a social justice framework that focuses on individuals intersecting identities and how they connect to interlocking systems of oppression. An intersectional lens helps explore the experiences of women of colour affected by the intersection of race/racism and gender/sexism and other identities and systems of oppression (Rosenthal & Lobel, 2018). Developed by Black Feminist scholars working in the United States, this framework has primarily been applied to study the experiences of African American women (Crenshaw, 1991). It emphasizes that the unique experiences of women of colour cannot be reduced to the experiences of their race or gender and that in the intersection of the identities, a new identity is formed (Rosenthal & Lobel, 2018). Therefore, one identity, such as gender, cannot explain social disparities without the intersection of various other social identities, including race, sexuality, nationality etc. (Bowleg, 2013). Importantly this approach asks for societal systems that oppress marginalized groups to be changed, laying the groundwork for translating knowledge into action in order to eliminate inequities (Rosenthal & Lobel, 2018).

Further intersectionality theory asserts that social identities are constructed within specific social, political, and environmental contexts. Therefore, the experiences of individuals should be understood within the context of the power relations that shape their identity categories. Incorporating intersectionality into the research process supports a focus on the contextual factors that shape Black women's lives. The research process itself is shaped by the power dynamics inherent in the relationship between the researcher and participants (Adams, 2021). Even when Black women researchers conduct research with Black women as participants, these hierarchies exist and need to be addressed. As academics, we have the power to shape how participants' experiences are interpreted and translated to the audience. Researchers can allow participants to dictate the pace of the interview, which in turn allows the participant to build trust and feel comfortable enough to share more private information (Walton, 2022).

Walton and colleagues (2022) identified several techniques they used as Black women conducting research with Black women participants. Among them is “universalization,” which Black women used when conducting research with other Black women and bonded over the universal issues faced by all Black women. The feeling that one's experiences are shared with others allows for access to a deeper “connection, relationship or universal truth” (Walton et al., 2022). Overall, a collaborative approach to interviewing based on universalization, connection and humility helped them minimize the impact of power dynamics and elicit more profound responses from participants.

A major aspect of the social hierarchies discussed in the qualitative research literature is the positions of outsider and insider. Intersectionality also offers insight into the concept of insider/outsider status in the research process (Adams, 2021). As argued by Couture (2012), the separation between insider and outsider is not that rigid, and one can be both simultaneously as identities shift and overlap. For instance, Brown (2012) discusses how her identity as Black woman researching Black women legislators shaped the research process. As an insider, sharing the same race and gender as the research participants helped her gain access to them and establish strong relationships. At the same time, she also faced scepticism from her colleagues in academia, who questioned the validity of her work within a community of which she is a part (Brown, 2012). As a Black woman in academia, she had to contest the assumption that her research was biased by her identity. Drawing on Patricia Hill Collins' (2000) *Black Feminist Thought*, she identifies herself as an “outsider-within” in academia. Outsider-within is the term Hill Collins' (2000) coined to describe how Black

women are no longer wholly excluded from spaces of power - including academia but are now subject to surveillance within these same spaces. While Black women may be considered insiders in some limited capacity, this critical observation and subsequent social control also rendered them outsiders (Young, 2004). Browns' (2012) experience both in the field and with her White colleagues in academia demonstrates the shifting and socially dependent nature of outsider and insider status and how they impact the research conducted by Black women in academic institutions.

In addition to offering a framework through which researchers can reflect upon their position as insiders/outside, intersectionality and feminist research recognize women as experts on their own experience and values their perspectives (Anderson et al., 2009). This is a pivotal shift for Black women, specifically, for whom the qualitative interview process has historically marginalized. Researchers from a white worldview have taken an approach that pathologized Black women's behaviour and perpetuated harmful stereotypes (Walton et al., 2022; Few, Stephens and Rouse-Arnett, 2003). Black women have been represented through comparisons to white women and associations with all undesirable feminine traits, including aggression, promiscuity and inferior intellect (Few, Stephens and Rouse-Arnett, 2003; Hill Collins, 2000). In other cases, studies that have claimed to focus on women's experiences have excluded Black women altogether. In opposition to this practice, this study takes the voices of the most underserved as the subject and builds on that to connect their experiences to the local, national and global context. The extensive history of research and social justice work in the field of intersectionality has informed my process in writing this reflexive methods paper reflecting on the interviews I conducted with Black women as a Black woman researcher. By drawing on the foundations of intersectionality and feminist theory, this paper will contribute to understanding the experience of discussing race in the social context of research with Black women.

The Project

Immigrants make up a large and growing proportion of the Canadian population with immigration from African nations currently at its highest rate ever. As the numbers of immigrants increase, so do the number of instances of racism, discrimination and other barriers to services within the healthcare system and outside of it (Hyman, 2009). These barriers have a significant impact on the health and wellbeing of immigrants from African countries. Despite universal access to healthcare, inequities have been documented in the

health status of immigrants (Patterson & Veenstra, 2016). However, the lived healthcare experiences of immigrants, their trust in providers and how this impacts their health service use remain largely undocumented (Carrasco et al., 2009). Further exploration of these issues is needed in order to reduce health inequities.

While this paper is about lessons learned from being a Black woman researcher conducting research with Black women, it is part of a larger project aimed at examining the healthcare experiences of African immigrant women in healthcare. In order to meet this aim certain characteristics were included as part of the inclusion criteria. Participants had to be recent immigrants who were 18 years old or older and had recent interaction with the healthcare system. The sample was purposive and consisted of African immigrant women ages 18 - 51 who have lived in Canada for 10 years or less. Participants immigrated to Canada from several countries including Nigeria, Ivory Coast, Eritrea, Somalia and Kenya. Data collection was conducted in the form of 21 individual interviews followed by two focus groups (with three and five participants each). Discussions covered topics such the participants' settlement experience, trust in the healthcare system and their positive and negative healthcare interactions.

During the data gathering procedure, a modified convergent interviewing approach was used. Convergent interviewing, developed by Bob Dick (2013), uses a series of interviews that are focused on certain topics to study participants' thoughts and beliefs (Rao & Perry, 2003). The first interview opened with a general question that briefly introduces the subject without directing the participant towards a specific response. Probing questions are then employed, in order to delve deeper into the experiences and viewpoints of the participants on the study issue. Aspects identified from earlier interviews are further explored in later interviews with different participants with an aim to unpack additional details and identify the most prominent issues in the subject area (Rao & Perry, 2003). In addition to asking probing questions, I validated participants' feelings especially when they discussed difficult healthcare experiences. I also built rapport through our shared identity as Black women, which often helped open up the discussion. This is beyond the level of rapport that is usually established in convergent interviews but it reflects the emphasis on non-hierarchical and relational interviewing in feminist research (Brooks, 2007; Walton, 2022).

Sharing experiences and perspectives from other interviews with participants reflects the technique of universalization recommended by Black feminist researchers (Walton,

2022). Participants were often more willing to share when they heard that others had similar experiences. It also allowed individual interview participants to contribute to co-constructing reality and knowledge with other participants even though they were not speaking directly with one another. Further, convergent interviews are conducted with key experts who are able to contribute to an under-studied area of research (Dick, 2013). Therefore, in this study, African immigrant women made up the study sample as they are experts on their own healthcare experiences. This process provides a structured approach to analyzing and understanding the perspectives of women, shedding light on the nuances and intersections of their experiences.

The convergent interviewing process usually often involves two interviewers who compare and contrast their interviews to develop further interview questions (Driedger et al., 2006). As the sole interviewer in this study, I instead kept a journal where I made notes after each interview. I compared the notes and transcripts from the interviews and developed new interview questions this way. This process project enables gradual data analysis and collection and adds objectivity by reflecting on the response following each interview (Rao & Perry, 2003). Finally, saturation is reached and the data collection process is complete when further interviews do not introduce new topics (Rao & Perry, 2003). After individual interviews were completed, focus groups were used to discuss the significant issues raised during the individual convergent interviews. Focus groups are ideal for studying the opinions and experiences of a specific group and allow for the co-creation of new understandings through participants' interactions with one another - asking each other questions, sharing stories and building off previous answers (Ravitch & Carl, 2021). This method allows for the group discussion of common experiences and cultural norms, which is not possible in individual interviews (Ravitch & Carl, 2021).

Interviews and focus groups included discussions of participants' experiences settling in Canada, accessing social and institutional support and resources, navigating the healthcare system and interacting with healthcare providers. The questions aimed to elicit the intersecting identities of the participants and to better understand the impact of those intersectionalities on their healthcare experience. Questions explored with participants included: "As a Black woman, how has life been for you since immigrating to Manitoba?", "How comfortable are you with asking your provider questions during appointments?", "Are there any services that aren't currently available that you believe could be helpful to newcomers?". Probing questions were posed after each general question to further explore

the participants' thoughts. Given the iterative nature of this interview method, no two interviews consisted of the exact same set of questions. Instead, each interview diverged and followed its own unique pace depending on the participants' responses. This approach is consistent with feminist methodology which aims to create knowledge through the experiences of women (Brooks, 2007). Each woman possesses unique knowledge shaped by her perspectives and interactions within her surroundings, resulting in diverse insights (Brooks, 2007). As a result, the emphasis lies less on asking identical questions to every participant and more on exploring the same broad subjects during the discussions (Hesse-Biber, 2007).

Reflections on the Research Process

While gathering and analyzing the data for this project, it became evident that certain obstacles prevented participants from fully articulating their viewpoints. Participants who were otherwise forthcoming in their responses became shy and reluctant to share when the questions were explicitly about race and racism. In contrast, issues related to gender were easier for participants to discuss. The gender coordination between the researcher and participants helped facilitate a more open exploration of gendered experiences. Quotes from individual interviews and two focus groups are explored here as they reflect not only the healthcare experiences of African immigrant women living in the province but also the impact of social context on the research process itself.

Positionality of the Primary Researcher

I am a second-generation Black Kenyan immigrant woman. I grew up in a middle-class family in Winnipeg, Manitoba. I have spent most of my life around African immigrant women, especially in the local Kenyan community. I found that my shared gender identity and cultural background did help me build rapport and connect with participants during some conversations. I also benefited from understanding certain expressions and the racial and cultural implications of some experiences. However, I equally acknowledge my privilege as a Canadian citizen and that my experiences with healthcare providers may differ from those of first-generation immigrant women. As will be further discussed in this paper, my “insider” status as a fellow Black woman was not always enough to ensure the women would be comfortable discussing sensitive topics, particularly experiences of racism within the healthcare system.

Nonetheless, my motivation for this research speaks to my longer-term professional goals. Although I am a graduate student, I am applying to medical school. I dream of becoming a physician committed to patient-focused care. Ultimately, I want all my patients, especially Black women, to feel comfortable discussing their health concerns with me and that their care matters. This work matters to me because a critical first step toward addressing this population's needs is listening to and understanding their perspective. While I have never had negative experiences with healthcare in Manitoba, I have heard negative accounts from other Black African women. I am invested in ensuring all women have access to appropriate, safe care that recognizes their unique needs.

Interview Reflections

The following section contains the reflections of the lead author in conducting interviews with Black immigrant women as a Black Canadian woman. First, the factors that facilitated open and effective communication in some areas between the participants and the first author, namely insider status and universalization are discussed. My shared identity as a Black woman allowed for a level of trust and assumed understanding when participants expressed experiences regarding these identities. Universalization facilitated an environment in which participants were able to speak more freely on their own experiences. Then the factors that hindered open communication are explored including reluctance to speak about negative experiences and hesitation when it comes to discussing racism. Seeking healthcare services is an inherently exposing experience, made even more complicated by the vulnerabilities of one's social location. The ways in which their social location as Black immigrant women may contribute to their unwillingness to discuss negative or racist healthcare experiences is discussed. The accounts of individual interviews with participants SE, FS, RI, FM and two focus groups are discussed here to illustrate the reflections of the lead investigator. These conversations demonstrate both areas of silence and breakthrough in the conversations that informed that study.

Facilitators

Insider Status of Lead Researcher. While my insider status was more evident sometimes than others, it helped me connect with participants. Participants often started their statements with “you know how it is” or “as Black women...” and referenced a collective “we” or “us Africans”. As a fellow Black woman and child of immigrants myself, I felt included in this group. While some participants were more shy and slower to open up than

others, many of the interviews involved moments of laughter and casual back and forth as participants and I joked about not being made for cold Canadian winters and bonded over discussing busy work and school schedules. I understood what participants meant when they referred to the countries they emigrated from as “back home” even when they had lived in Winnipeg for several years. In particular, with issues regarding gender, participants shared openly. They mentioned being more comfortable with female doctors, especially regarding reproductive healthcare. For example, FM, a 42-year-old woman from Nigeria, shared this sentiment: were common:

FM: And the possible solution is if we women, like black women, in the healthcare system, professionals, if we can raise awareness. Like OK, every woman who comes to Canada, please speak up. Speak up. Let people hear what is happening. Speak up even if nobody listens.

Our shared gender and racial identities allowed us to engage in “sister-to-sister talk”. The parts of our discussions that focused on gender-related issues flowed easily and demonstrated an assumed understanding. Participants were able to look past our different lived experiences to our commonalities as Black women. Obasi (2012) and Johnson-Bailey (1999) found that they were similarly able to bond with the Black women they interviewed based on this “sisterly” bond. The ease with which we discussed these topics suggested that the women trusted me based on our shared identity as Black women living in Canada.

Universalization. The relationship between the researcher and research participant can be hierarchical, in which academics have control over the interpretations of participants' thoughts and experiences (Few, Stephens and Rouse-Arnett, 2003). By sharing the experiences discussed in previous interviews and my own experiences, I often fostered an environment where participants were more comfortable exploring these topics. Walton and colleagues (2022) refer to the process of sharing the experiences of other participants in order to empower the participant to share more of their experiences as universalization. In the context of Black women interviewing other Black women, the power dynamic can be minimized, allowing for a deeper exploration of the issues that are faced by many in the community (Walton et al., 2022). This helps to equalize the relationship and leads to a nonhierarchical approach and place from which the participant and researcher can collaborate

in creating knowledge and building a rapport. In my discussion with RI (Nigeria, 37) I shared that other women I had interviewed had expressed similar concerns and this helped encourage her to open up about her own experiences:

Researcher: OK. I was just saying that in some previous interviews, women have also mentioned similarly, that their physicians aren't necessarily hearing them or hearing their concerns. So, some approaches that they take to deal with that are advocating more for themselves and appointments. Kind of asking more questions and doing kind of research? Do you find that you've taken any approaches like that as well, with your physician?

RI: Yes, I have. I have been able to find out for myself the recent issue about my chest pain. I know, chest pain is something you don't joke with you, you have to take it serious. You might just be having a cardiac or something. So, you have to go straight up to the hospital to make sure. What - thankfully, my blood work was good. My chest X-ray was good. And then when I had my appointment with him, I found that I had to explain to him, oh, yes, because I am stressed. I am a student, I am a mom with three kids. And having all this to deal with, it can contribute. I'm not having – like it's not possible.

I think stress is a major concern for me. But he was like hey, you have to follow up with your chest X-ray. You have to like yes, I think that, but I think stress, I know myself. Stress is it - if I call them on this thing, I get my break, school breaks. And get time to rest and have time for myself. I might feel better or I will be better. Yeah, so I do things on my own to make sure yeah.

Traditional interviewing practices would argue that they should be all about the participant (Few, Stephens and Rouse-Arnett, 2003). Instead, I found that universalization had the opposite effect and helped to empower participants to share their experiences with the same topic. This approach reflects the convergent interviewing approach and was effective in fostering a safe space for participants to open up.

Barriers

Reluctant to speak of negative experiences. TA moved from Nigeria to Winnipeg and had lived in the city for about four years at the time of our conversation. While TA was initially reluctant to discuss the racism she experienced, she later opened up about the discrimination she had faced both outside and within the healthcare system. In the transcript excerpt below, she expresses that she has not experienced any racism since moving to Manitoba:

Researcher: So, as a Black woman, how has life been for you since immigrating to Manitoba?

TA: It's been, I wouldn't say it's been challenging, it's been pretty, pretty decent, a lot of changes definitely. But apart from the weather, because I come from a really warm climate, but yeah, otherwise it's been pretty good. Never once experienced racism or anything like that, so yeah, it's been a pretty OK experience apart from the weather.

Throughout the rest of the first half of the interview she continued to assert that she had not experienced any racism in Winnipeg and that race was not a factor she considered when looking for a healthcare provider. However, as the conversation continued and we built a stronger rapport, she opened up more. Later in the conversation, when discussing her experiences with healthcare providers, she offers this account of what she terms her “first racial encounter in Canada”:

TA: And so, the bad ones [healthcare experiences]. There was one time I was in the hospital; I was having an ultrasound and this female doctor walks in and she's like, we're having a chat and then she asked where are you from and I said Nigeria. And she was like, oh, I really need to check, because a lot of Nigerian women come to Canada with really big fibroids. And I'm like, why the stereotype, you checked before, I don't have fibroids, I didn't come here for complaints about fibroids, I came from something completely unrelated. And she was like, oh yeah, people walk around with huge fibroids in Nigeria, I'm like, that's not true, anyone can have fibroids, it's not just a Nigerian thing. And she was working based on that personal stereotype, I don't

know why she did that and then she also made a comment about, oh, she did ask if I'd had a pap smear in the last three years, I'm like yeah, and she said where, and I said before I came to Canada, and she's like, oh, she can't really trust that, that I'm going to have to have another one done. Like why, it was, I felt like it was a racial bias, because she was, she's white, I'm like, why, it just didn't make any sense. I was supposed to have follow-up appointments with her, but I just canceled it, because I didn't want to have to experience that again from her.

Researcher: Yeah. And then for that issue, did you just, did you go to someone else or?

TA: Yeah, I went to - I saw my personal doctor and then she referred me to someone else. And apparently, it was just something I was just worried about, it was nothing, right, but I could have gone back to her for the follow up, but I just wasn't going to.

Researcher: Yeah, you just, and how, when you had that experience and she was saying those things, how did that make you feel?

TA: It made, I would, I actually categorize that as my first racial encounter in Canada, and probably my only, because it was an unnecessary racial bias and it made me feel really uncomfortable.

As stated by Boylorn (p. 67, 2011) “talking about race is an emotionally vulnerable process” and the reasons that individuals may feel uncomfortable exploring the topic are varied and nuanced. Participants may worry about being stereotyped as angry or uneducated and unable to discuss race calmly and rationally (Boylorn, 2011). For example, Burkard (2019) details an instance when one of the participants in her study mentions experiencing racism, but when asked to elaborate further, she declines. Later she revealed that she did not want to sound uneducated or incorrect on the record. This participant was also an undocumented immigrant, contributing to her unwillingness to speak openly about her experiences. In her work with Latina colleague students Rodriguez (2010) had a similar experience with participants claiming they did not experience racism early in the interview before later opening up about their experiences. Rodriguez (2010) shared her own

experiences of racism as a PhD student to help the participant feel more comfortable sharing her story.

Gubrium & Holstein (2001) noted that a woman's "silence or speech" is impacted by her social location, including factors such as her class, cultural norms and her place in her community. For the women in this study, their social location and experiences as Black immigrant women are central to their personal narratives and contributions to the interview. Their position as immigrants in Manitoba may make them hesitant to be critical of the healthcare system especially when speaking on the record. Similar to the participant experiences mentioned by Burkhard (2019) the women in this study may want to avoid saying something incorrect about the healthcare system. Understanding why women speak or do not speak requires paying attention to speech gaps and absences in women's narratives and considering messages that may be hidden beneath the surface (Rodriguez, 2010).

Hesitant to name racism. Gubrium and Holstein (2001) noted that there are many reasons why people may not want to speak about racism. These reasons may stem from fears of being ostracized or rejected by those who are offended by what they have to say. They may explain why some participants were hesitant to discuss racism, which limited the depth of the data I could gather. Here I discuss parts of my conversations with SE, GI and FS who were all hesitant to describe the poor treatment they received in healthcare as racist. First, in my conversation with SE, a 20-year-old from Nigeria, she talked very openly about her struggles to find a Black therapist in the city. We discussed the challenge of having her troubles brushed off by a Nigerian therapist because "that's just how the culture is". In contrast, when discussing an experience she had waiting for hours at urgent care, SE said she felt "neglected" and "overlooked" but did not want to view this as an experience of racism:

Researcher: Definitely, yeah, and I think what you just said as well about kind of like gaslighting yourself almost is very interesting as well. Did you feel like you didn't want to assume that it was racial bias because – you have to get the care either way? Could you speak more to that?

SE: Yeah, I did not – once I assumed that it was racial bias because I know that would affect my mood and I would be so sad about that, if that was like the conclusion my mind came to. Yeah, so I just have to help myself to not see it as a racial bias

because I know – even if I got mad I wouldn't be able to do anything about it so it's still like I'm not sure enough for myself.

So instead of going down all that spiral it's just easier to gaslight myself because at the end of the day I will still need their help with the existence of the issue, so it's like if it's going to happen the way it's happening I might as well just close my eyes. It's like I don't notice but like I'm still going to be getting my help from them, so gaslighting myself definitely helps. It's me helping myself to not feel bad about the entire process, yeah.

Researcher: Yeah, you're kind of like trying to protect yourself?

SE: Yeah, because I don't want – I don't want to be in that scenario where I would be – I would consider myself less than my neighbour, but if that's the kind of conclusion that's like coming up after everything I have seen and experienced, and I do know that's basically [unintelligible 00:25:48] a very certain way because it's going to be a very negative emotion, I don't want to carry all of that especially when I'll be sitting by myself alone. So it's not like carrying some kind of bitterness and resentment in my heart about the entire scenario. I know I am indeed in pain so just to let it off lightly I just think about it in a way that it's not going to affect me directly, so yeah.

SE's responses offer another reason for why people are reluctant to think about or discuss racism - to protect themselves from feeling negative or painful emotions. These women have no choice but to seek medical attention when sick. It is easier for them to access this care if they believe medical professionals do not have racial biases and to interpret their negative healthcare experiences as anything other than racism. In her responses, GI, a 20-year-old university student from Ivory Coast, was similarly hesitant to call out racism in her interactions with healthcare providers. Throughout our conversation, GI and I discussed many of her interactions with healthcare providers, both positive and negative. When I asked her if she thought that any of her negative experiences were a result of the provider's racial bias, this was her response:

GI: I want to say yes and no. I'm not even too sure. Like completely if this is just like in general. Like if this is just how they would like treat - but probably honestly racial wise yeah.

Researcher: Mm-hmm I guess it's hard to know what someone's motivations are. And like you can't -- mm-hmm be inside their head yeah.

GI: You hope it's not racial. Yeah, exactly.

Similarly, during the first focus group discussion, FS (31, Nigerian) mentioned a very distressing interaction with a white nurse when she was in the hospital after having just given birth to her baby. The nurse had been rude to her, refused to hold or bathe her baby and told her shortly after she gave birth that if she did not get up and walk, she would die. Yet, despite this mistreatment she was hesitant to call the nurse racist:

FS: And there was also a comment she made. She said something like if I don't stand up and walk – because it was a surgery, it was CS [a cesarean section], and she said if I don't stand up and walk I'm going to get blood clots and I'm going to die. She said that and I was like – and my husband was like, “Wow, why would she say something like that?” And it didn't even really hit me, I didn't know if she was being racist or not, but I just didn't want to take it too personally. That was the major negative experience I've had since I've been here.

Researcher: ... And when she said that, when you heard her say that, like how did that experience make you feel would you say?

FS: Because, you know, just having a baby you have lots of like emotions and other things going on, so I didn't really, really take it too personally. It was even my husband that had to point out, “Why would she say something like that” and when he now mentioned that, then I said, “Oh, that's true. She shouldn't have said something like that.” But I really don't want to think she was being racist but, at the end of the day, maybe that was what was going on because she was a white female nurse, yeah.

Seeking healthcare puts patients in a vulnerable position that may help explain why these participants worried about being critical of the healthcare system and speaking up regarding instances of racism. Participants may not want to relive traumatic or difficult experiences (Gubrium & Holstein, 2001). Investigating silences in participants' narratives can illuminate how immigrant women navigate the healthcare system and experience racism. Their limited responses, caveats and alternative explanations for mistreatment may not necessarily indicate a genuine belief that they did not experience racism. Instead, these responses may reflect an effort to downplay their discomfort. It appears to be an attempt to distance themselves from the painful memory of the experience of racism through “gaslighting” to use SE’s words (Rodriguez, 2010). It can be an act of self-preservation to avoid being critical of a system that is supposed to serve you and provide care for an issue as intimate as your health.

Conclusion

Qualitative interviews are a dynamic process shaped by the relationship between the researcher and the participant and the social context. Interviews between Black women are not different and can become unpredictable when various personalities and situational factors agitate, energize or otherwise influence the environment (Bailey-Johnson, 1999). In this paper, I reflected on my experiences as a Black woman conducting research with Black women. I found that there were silences and breakthroughs throughout our conversations depending on the topics being discussed. As an insider, I explored conversations with the participants about gender and general issues related to seeking healthcare as a Black woman. I also used universalization and shared previous participants' experiences to open up the conversations. However, my insider status was not always enough to get participants to speak freely, especially regarding race and racism. Women were either hesitant to bring up their racist experiences or to name those encounters as instances of racism. There are many possible explanations for this, including women trying to distance themselves from painful experiences, trying to downplay them or wanting to give the healthcare provider the benefit of the doubt. When addressing sensitive topics such as racism in the healthcare system, it is clear that insider status is not enough to guarantee trust and depth in the participants' responses.

The findings of this paper inform several recommendations for future qualitative research with Black women. First, participants occasionally exhibited greater willingness to

discuss sensitive topics when that were brought up later in the interview. Therefore, researchers should not hesitate to ask questions about the same subject multiple times within a single interview. Modifying the wording or approach of the question allows participants to reflect on different aspects of their experiences and potentially provide different responses. Few et al. (2004) argue that posing the same question in multiple ways grants participants more time for contemplation. Second, researchers should employ an intersectional approach when conducting research with Black women. By incorporating intersecting identities such as, race, gender and class into the interview process, researchers can develop a more nuanced understanding of the experiences and perspectives of Black women, avoiding oversimplification or generalization. Further, researchers should consider their own standpoint, in relation to participants - as insiders or outsider or both - and how this affects the effects process. Finally, researchers should focus on establishing rapport and when appropriate, share the experiences of other Black women through universalization, or their own experiences through self-disclosure. This can help equalize the participant and researcher relationship and contribute to making it a non hierarchical one (Few et al., 2004). Shared vulnerability can help facilitate engagement from participants.

Further research is needed to expand the knowledge base in this area. As future researchers undertake health research studies involving Black women across Canada, they should adopt a reflexive stance and consider how the social context influences their work. Engaging in such reflections would undoubtedly offer fresh insights and contribute to the expansion of the limited literature in this domain. Additionally, the available publications providing recommendations for qualitative interviews with Black women primarily focus on African American women (Few et al., 2004; Walton et al., 2022). It is crucial for future researchers to investigate the impact of implementing these recommendations when conducting research with Black women in Canada. Ultimately, researchers who conduct studies with Black women are responsible for their interpretations and presentations of these women's experiences. By embracing critical reflection and culturally informed methods, researchers can conduct studies that more accurately reflect the complexity and intersectionality of the lives of Black women.

Chapter 4: Conclusion

Research Summary

As the number of Africans immigrating to Canada has increased, the research literature and healthcare policy have not kept pace and do not reflect immigrants' voices and experiences. Persistent gaps in healthcare outcomes and healthcare service use among immigrant communities suggest unmet healthcare needs (Fuller-Thomson et al., 2011; Ahmed et al., 2016). Informed by feminist standpoint theory and intersectionality, this research study focused on 22 African immigrant women living in Manitoba. I aimed to better understand their lived experiences and how those experiences impacted their trust in the healthcare system and providers. Moreover, I sought to identify how the participants preferred to communicate with their providers when making decisions regarding healthcare for themselves and their families.

African immigrant women face many barriers when accessing healthcare services in Manitoba. Participants discussed their challenges juggling work and childcare and finding a sense of community in their new home. Navigating the healthcare system was a common struggle for participants who had trouble finding a doctor, getting their health card and health insurance. Feeling unheard during healthcare interactions and encountering communication breakdowns led some participants to avoid the healthcare system or seek new providers. Experiences of discrimination and racism further compounded these challenges. Facilitators having a positive healthcare experience included having a strong social support network. Women relied on their friends and family to find doctors, for transportation, childcare and emotional support. Women who had strong relationships with their healthcare providers mentioned that they experienced clear communication, active participation in their care and felt heard.

The interview process provided insights for a reflexive paper that discussed my challenges when conducting the interviews and focus groups. Despite my shared identities with the participants - as a Black woman and child of African immigrants - I noticed that topics such as gender were easier to discuss with participants. In contrast, I encountered silences and friction in other areas, such as discussions of race and racism. In some instances, I was able to use my insider status, sharing the experiences of others and approaching the same topic multiple times to overcome participant hesitations when discussing race. I also explored the limited available literature regarding interviews with Black women and

highlighted the methods that previous researchers found to be effective. These included self-disclosure and vulnerability, reflexivity, and attention to the research context (Walton et al., 2022; Few et al., 2003). This manuscript and the existing literature can inform and improve how researchers conduct research with African immigrant women.

Contributions to the Literature

This thesis contributes to the research in two distinct areas, healthcare experiences and research methodology. Despite the rise in research on immigrant experiences, this is the first qualitative study in Manitoba and all of Canada that focuses primarily on the experiences of African immigrant women. Collecting race-based data and centering the voices of Black immigrants is essential in making evidence-based policy changes (Dryden, & Nnorom, 2021). The experiences that participants shared in their interviews and focus group conversations provide insight into the nuances of moving through the healthcare system as a Black woman and an immigrant, among other intersecting identities. Further, the study highlights how the women display resilience and resourcefulness and lean on the community to overcome challenges. The participants also discussed their experiences beyond encounters with healthcare providers that impacted their health and well-being. They discussed their struggles with finding employment, healthcare insurance - especially as university students - and childcare. Recognizing that barriers beyond the healthcare system need to be addressed emphasises the importance of creating better services for immigrants across sectors.

Secondly, this study found that many participants felt unheard or understood in their healthcare encounters, suggesting communication barriers exist between patients and providers. These barriers are harmful, considering doctors have such a strong influence on their patients' access to specialist care and overall well being. Doctors should be actively engaging patients and empathising and listening to their concerns. By discussing participants' trust in their providers, their comfort in asking questions and their feelings regarding whether or not they felt like their concerns were being addressed, I was able to look into where communication was breaking down and could be improved. Further, the participants' experiences also provide insight that could be helpful to future immigrants. Their accounts stress the importance of leaning on social support and community and advocating for yourself. This manuscript and the existing literature can inform and improve how researchers conduct research with African immigrant women.

Thirdly, my research experience provides further evidence that a thoughtful and feminist-grounded approach is needed for qualitative research with Black women. This approach is critical in health research where the discussion of experiences of healthcare discrimination and racism is needed to provide information for evidence-based care and achieve health equity. However, much of the research on qualitative interviewing with Black has been conducted in other fields (Johnson-Bailey, 1999; Walton et al., 2022). Research informed by a Black feminist standpoint and intersectionality can ensure that researchers approach their work from a reflexive and informed position and minimise discomfort and distress for participants.

Recommendations

The findings of this study have important implications for immigrant-serving organisations, healthcare providers and healthcare policy in Manitoba, as well as qualitative interview researchers working with Black women. As mentioned above, participants were often hesitant to speak directly regarding experiences of racism and discrimination. Therefore, the recommendations presented here may not fully address all the challenges that African immigrant women face, especially regarding those issues. These recommendations are informed by the experiences participants shared and the suggestions they mentioned in the focus groups and interviews. While it is important to remember that not all immigrants have the same experience, these recommendations are relevant to healthcare providers, policymakers across Canada, and qualitative researchers working with other marginalised groups.

Recommendations for Healthcare Providers and Immigrant Service Organisations:

1. Participants expressed they felt that there is a lack of awareness among doctors regarding the issues they face as Black women. It is crucial to enhance cultural competency and sensitivity among healthcare providers. Training for doctors and medical students should be developed to increase awareness and understanding of African immigrant women's cultural backgrounds, beliefs, and healthcare practices. This will help foster better communication, trust, and stronger patient-provider relationships.
2. Participants' responses indicate that African immigrant women would benefit from greater access to interpreter and language services in healthcare. The study revealed

that limited English proficiency often hindered effective communication and access to quality care for their community members. By ensuring the availability of professional interpreters or utilising technology-based translation services, healthcare providers can facilitate clearer communication and ensure that African immigrant women understand their medical conditions, treatments, and rights.

3. Immigrant service organisations should develop workshops that focus on helping navigate the healthcare system. These programs should focus on raising awareness about available healthcare resources, preventive care, and how to get a health card and insurance. Organisations such as Manitoba Start which already provide workshops for immigrants, should consider developing one focusing exclusively on healthcare.
4. Many participants mentioned their social support networks as the primary place they got healthcare information. Immigrant service organisations should collaborate with community organisations, faith-based institutions, and cultural leaders to help build trust, disseminate accurate health information, and facilitate the utilisation of healthcare services.
5. Finally, African immigrant women faced a significant challenge: a lack of transportation. Immigrant serving agencies could provide a means of transportation for women to get to and from their medical appointments, such as a community van or bus fare and taxi vouchers. This would help women without driver's licences, vehicles or community members who can give them rides to access healthcare services.
6. To address the issue of healthcare provider accessibility I would also recommend that clinics be established in places immigrants are already accessing, such as immigrant serving organizations. These clinics could be set up on a short term basis - i.e. during flu season - and offer immunizations and other preventive health measures. Though immunizations are not the focus of this study, this one aspect of preventive healthcare that could be managed through outreach.

Recommendations Policy-makers:

1. Many participants had difficulties finding a primary care doctor and faced long waits when booking appointments. To address the lack of primary care physicians, especially culturally and linguistically diverse ones the provincial and federal government and the relevant regulatory bodies (i.e. the College of Physicians and Surgeons of Manitoba) should review their policies regarding internationally trained medical graduates and make it easier for them to practise in Manitoba. Possible

changes could include accelerating the process of assessing the qualifications of internationally trained healthcare providers.

2. The lack of culturally appropriate care could also be addressed by focusing on accepting more Black students into medical school. Efforts at Ontario medical schools have contributed to increased admissions in the provinces (Walji, 2015), and similar attempts can be made in Manitoba. More Black doctors can help increase equitable access to healthcare for African immigrants, especially those who stated they would be more comfortable with a doctor who shares their background.
3. Finally, this study identified that some immigrants, especially international students, have limited health insurance coverage. Reinstating full healthcare coverage for international students would relieve them of a significant cost burden and make it easier for them to access critical healthcare services.

Recommendations for Qualitative Researchers:

My research experience and the published literature suggest that researchers face challenges when conducting qualitative interviews with Black women. Researchers should also be aware of the potential barriers when discussing sensitive topics like race and work to establish a safe and open research environment. Given these challenges, I would make the following recommendations for future qualitative researchers:

1. Reflexivity should guide the collection, analysis and interpretation of interview data. Even when researchers share identities with the research participants, they must critically reflect on their positionality and biases throughout the analysis process. Insider status is not an unchallenged location and can be challenged as other differences create distance between the researcher and the participant during the interview process. As a Black woman interviewing Black women I had to be mindful to not assume I always understood what participants were trying to say just because we had a similar background. Maintaining the participants' voice throughout the research process is essential, ensuring that their narratives are accurately represented.
2. Participants in this study were sometimes more open to discussing sensitive topics when asked about them later in the interview. Researchers should not hesitate to ask questions about the same topic multiple times throughout one interview. Changing the question's wording or approach to the topic may give the participant a chance to reflect on different aspects of the experience and respond differently. As argued by

Few et al., (2003), asking the same question in multiple ways gives the participant more time to reflect upon their experience.

3. Researchers should focus on building rapport over time and be aware that they may need to be vulnerable with participants for them to be vulnerable in return. Sharing one's own experiences or the experiences of other participants can contribute to creating a safe space in which the participants feel comfortable sharing. Finding common ground and building trust is especially important when working with Black women or other marginalized groups who may be suspicious of the research process (Walton et al., 2022). It is important to establish this rapport without leading the participant towards a certain answer or perspective.
4. Researchers should employ a Black feminist standpoint and intersectional framework when interviewing Black women. Intersectionality recognizes the interconnected nature of various social identities and how they shape people's experiences. Researchers should be mindful of the multiple dimensions of identity that intersect with race and gender, such as class, sexuality, and disability. By incorporating these intersecting identities into the interview process, researchers can gain a more nuanced understanding of the experiences and perspectives of Black women, avoiding oversimplification or generalisation.

Future Research

Further research to expand the healthcare literature focusing on the barriers that Black women face is needed. This study focused on the experiences of immigrants who have lived in Manitoba for 10 years or less. This was done to include only accounts of the current immigration process in Canada. This also allowed for the focus on early settlement experiences, with people who may still be getting settled. However, this did not allow for assessing the immigrant experience over time. As immigrants settle in their new communities, their experiences of the healthcare system change, as does their health status. Further longitudinal research could be conducted to examine African immigrant women's healthcare experiences over time. Additionally, the recommendations suggested here should be implemented and evaluated. The benefits of interventions such as healthcare information workshops, providing transportation to appointments and increasing the use of interpreters should be investigated to see how they affect immigrants' ability to navigate the healthcare system. This would help provide further evidence-based solutions to immigrants' challenges.

As stated throughout the thesis, the experiences of African immigrant women are complex and intersectional. The participants in this study were predominantly under the age of 35 and in heterosexual relationships. Future studies should delve into women's experiences within this population with different experiences, such as older women and women in the LGBTQIA+ community. Women with chronic illnesses who have more interaction with the healthcare system may also have different experiences. Similarly, it would be advisable for future research to discuss the experiences of linguistically diverse immigrants who likely face barriers in accessing care beyond the ones described here. Exploring these experiences can provide more nuanced insights into this population's unique challenges and healthcare needs.

Future research should also focus on the experiences of healthcare providers and community organizations that work with immigrants. Studies should focus on identifying what healthcare providers feel they need to know/the resources they need in order to work with diverse patient populations. Researchers should explore the experiences of community organizations that are currently working with immigrant organizations. It would be helpful to understand the strategies that are working well and the challenges they have encountered. These perspectives are needed in order to support providers and organizations in providing services and improving care. The findings of this thesis may be relevant to multiple stakeholders. I aim to create an executive summary of the main study and with the findings and recommendations and share it with immigrant service organizations, such as Manitoba Start. Additionally, by writing these manuscripts and publishing them for an audience of public health experts, healthcare providers and qualitative researchers I hope to inform positive change in the healthcare system. I will also be sharing the executive summary with the study participants to get their feedback and make any needed changes before I submit the papers for publication.

The reflexive methodology paper also raises potential areas of concern for future research. My research experience and the literature make it clear that there are limited texts available that focus on how Black women and other communities who have been historically underrepresented as researchers and research participants can effectively and safely conduct qualitative research. The publications containing recommendations for conducting qualitative interviews with Black women were developed in the context of working with African American women (Few et al., 2003; Walton et al., 2022). Future researchers should explore the impact of implementing these recommendations when conducting research with racialised participants in Canada. This would help further validate the recommendations with other communities or develop more useful ones in this context. Finally, as future researchers

conduct health research with Black women across Canada, they should practise reflexivity and consider how social context impacts their work. These reflections would inevitably provide a new perspective and contribute to expanding the limited literature in this area.

In conclusion, this thesis underscores the pressing need to improve the healthcare experiences of African immigrant women living in Manitoba. The barriers these women face are multifaceted, and addressing them will require action at many levels, including community organisations, healthcare providers and government bodies. Further research is needed to explore people's experiences with other intersecting identities within this community. As future researchers conduct studies with African women in Manitoba and across Canada, they should intentionally design their research process. They should take an intersectional approach that centres on the participants' voices. Critically, this study highlights how participants managed the challenges of immigration and navigating the healthcare system by relying on their communities and their strength. However, African immigrant women can not break down all the barriers they face alone, nor should they have to. By recognizing and addressing their barriers, Canada can work towards a healthcare system that embraces health equity for African immigrant women and their families.

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