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Gender-Based Violence in a Migration Context: Health Impacts and Barriers to Healthcare Access and Help Seeking for Migrant and Refugee Women in Canada

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Abstract: This article focuses on the health impacts of the gender-based violence (GBV) experienced by migrant and refugee women (MRW) survivors in their migration/settlement journeys in Canada, and their challenges in accessing healthcare. Adopting a feminist and intersectional lens, I draw upon qualitative in-depth interviews with 48 migrant women conducted between 2020 and 2022. GBV is a frequent experience in the migration and (re)settlement journey and has wide-ranging and cross-secting emotional-psychological, socio-economic, physical, as well as sexual and reproductive health consequences which, in turn, impact settlement and integration and may increase vulnerability to further GBV as a result. Drawing upon a "social determinants of health" approach, I aim to understand the workings of barriers to healthcare access and help seeking for MRW survivors of GBV in Canada. The social determinants of health involve structural (e.g., legal, financial, linguistic, knowledge, healthcare access) barriers, mediated by gender, intersecting with various positionalities and identities. GBV unambiguously impacts on the health and well-being of all survivors, but the extent of harm varies significantly depending on the intersections of positions and identities of survivors. The migration context entails unique barriers to MRW help seeking and healthcare access as well as aggravates the impacts of other barriers on MRW. My objective is to show how GBV affects the health status of MRW survivors in Canada in the specific context of healthcare access and help-seeking barriers MRW face, conceptualized as risk factors for reproducing GBV.

Keywords: gender-based violence; migrant and refugee women; health impacts; healthcare accessibility; feminist and intersectional approach; social determinants of health; barriers to healthcare access; barriers to help seeking; Canada; physical; sexual; reproductive; emotional health

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Academic Editors: Valerie Zawilski, Ana Ning and Jordan Fairbairn

Received: 21 August 2024
Revised: 21 February 2025
Accepted: 24 February 2025
Published: 12 March 2025

Citation: Tastsoglou, E. Gender-Based Violence in a Migration Context: Health Impacts and Barriers to Healthcare Access and Help Seeking for Migrant and Refugee Women in Canada. *Societies* **2025**, *15*, 68. https://doi.org/10.3390/soc15030068

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1. Introduction

This article focuses on the diverse health impacts of the gender-based violence (GBV) experienced by migrant and refugee women (MRW) survivors in their migration and settlement in Canada, their challenges in seeking help, and barriers to accessing healthcare. Adopting a feminist and intersectional perspective, I draw upon qualitative in-depth interviews with 48 migrant women conducted between 2020 and 2022 as part of a large, pan-Canadian research project[1].

Gender-based violence is a frequent experience in the migration and (re)settlement journey. As this research and other studies document, GBV has wide-ranging and cross-secting emotional-psychological, socio-economic, physical, as well as sexual and reproductive health consequences. In this article, health is conceptualized "as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" [1].

This definition makes it clear that health is not merely based on biological or behavioral factors but also social ones. Drawing upon a social determinants of health approach, I aim to understand the social barriers to health for MRW survivors of GBV in Canada. More specifically, the focus of this paper is on how interacting social barriers impact MRW's healthcare accessibility and help seeking. The latter are conceptualized as essential steps to restoring health. Moreover, healthcare accessibility and help seeking are mediated by the intersectional positionalities and identities of MRW in Canada. Thus, the objective of this article is to examine how GBV affects the health status of MRW in the specific context of the barriers to accessing healthcare and help seeking in Canada they face, as women, migrants of diverse origins and legal/migration statuses, and GBV victims/survivors. These barriers are conceptualized as risk factors for (re)producing GBV. The migration context entails unique barriers to MRW help seeking and healthcare access, as well as aggravates the impacts of other barriers on MRW. To understand the nature of barriers and how they impede healthcare access, ultimately reproducing GBV, a feminist contextual and intersectional approach is necessary (see argument flow chart (Supplementary Materials) at article's end).

The article is organized in four substantive sections. A theoretical framework section follows this introduction, focusing on outlining the key concepts and ideas framing this article. A methodological section comes next, describing the research process and introducing a brief profile of the 48 interviewees. The findings are presented in the following section, which consists of two sub-sections organized along the lines of the two key themes: the diverse health impacts of GBV on MRW; and the barriers to MRW survivors accessing healthcare and help seeking in Canada. The concrete barriers to healthcare accessibility and help seeking experienced by MRW are traced to law and policy frameworks, i.e., institutions and systems. This understanding is critical for effective policy interventions to overcome GBV, specifically for migrant and refugee populations. The last section draws the conclusions of this study and discusses limitations and directions for further research.

2. Theoretical Framework

2.1. Gender-Based Violence

GBV is generally understood as violence directed towards a person or a group on account of their perceived gender. Gender is a fundamental analytic concept for understanding how the social world is ordered and the hierarchies of power in it. Violence (or its threat) is at the core of the construction of gender, reinforcing and (re)producing the gendered order. Gender constructions are underlying structural and institutional inequalities [2] and intersect with race, sexuality, nation, class, and other context-specific social divisions and processes [3]. Consequently, GBV can be understood as emerging from structural gender inequalities rather than individual or group perpetrator dynamics [4]. Following the intersectionality approach, GBV is not solely the result of patriarchy but is also influenced by other intersecting structures.

According to UNHCR [5], GBV "is rooted in gender inequality, the abuse of power and harmful norms…It also includes threats of violence, coercion and manipulation". Moreover, the broader definition of "sexual and gender-based violence" (SGBV) makes explicit reference to the state and institutions "perpetrating" or "condoning" this form of violence [6] (p. 11) and clarifies that SGBV can take the form of a "denial of resources or access to services" [7] (p. 1). While structurally based unequal gender power can affect individuals across genders and sexual orientations, this article focuses on women as a variety of studies and statistical measurements globally indicate that women/girls are, disproportionately, the principal victims of such forms of violence (e.g., [6,8]). Women are

understood in positional and non-essentialist terms, including individuals with female gender expression, gender identity, or perceived gender.

2.2. Gender-Based Violence in Migration

In the broader migration and refugee context, GBV is understood as a fundamentally structural form of violence, appearing "as unequal power and consequently as unequal life chances" [9] (p. 171). This violence is exerted by institutions, laws, policies, and practices relating to migration governance and migrant reception/settlement, either directly generating violence or failing to provide protection from it, thus (re)producing the social and political vulnerability of victims [10]. Individuals, whether citizens or others, also perpetrate this violence against those with precarious migration status, the undocumented or insufficiently protected "others" [11]. Nevertheless, it is not only structural violence in the form of specific migration governance and migrant reception/settlement policies and practices that generate vulnerability to GBV, but also intersecting gender and other inequality-producing divisions in specific migration and refugee contexts that feed into and amplify this vulnerability and GBV. While recognizing that such intersecting oppressions produce distinct forms of GBV, I use the terms "migrants" and "refugees" in a deliberate attempt to break down rigid classifications of different forms of migration and to capture a broad spectrum of non-citizens and foreign-born, set apart from Canadian-born non-Indigenous citizens, by different entitlements, protections, and socio-cultural capital [11] (p. 2).

2.3. Intersectionality

Important as the broad spectrum of migrants and refugees may be when contrasted to citizens, the differences between specific categories within the MRW spectrum and associated hierarchies are equally significant to understand. In particular, legal/ migration status intersecting with various forms of social division forms unique positionalities that impact vulnerability/experience of GBV as well as healthcare accessibility. Gender structures and hierarchies intersect with those of race, class, age, sexuality, religion, migration status, and other inequality-producing divisions and processes, as a rich tradition of feminist intersectionality in the social sciences has demonstrated (e.g., [3,4,12]). These intersections of structures and hierarchies create unique positions or positionalities for individuals and groups where the effects of cross-secting inequalities and vulnerabilities are multiplied [13,14]. Such positionalities shape individuals' experiences of disempowerment and marginalization [15,16]. For instance, Okeke-Ihejirika et al. [17] showed in their scoping review that within Canadian immigrant groups, there are crucial differences in perceptions, experiences, responses, and coping mechanisms among female intimate partner violence (IPV) survivors. In this article, drawing broadly upon intersectional understandings of identity, positionality, and structure, I focus on how the particular social, legal, and material contexts of MRW in Canada dynamically restrict their access to healthcare resources, and, by so doing, (re)produce GBV.

2.4. Health and Healthcare Accessibility

With respect to "health", I start with a benchmark definition of health as being a "structural, functional and emotional state that is compatible with effective life as an individual and as a member of society" [18]. This definition is generally acceptable in the scholarly, state, and policy sectors at various levels [19–21]. In the case of migrants and refugees, the above definition of health suggests equitable and effective life as individuals and as members of Canadian society. Following the Ottawa Charter for Health Promotion [20], I conceptualize "health" as a "resource" that helps us lead "effectively" our everyday lives. To achieve "effective life", however, it is clear that beyond individual physical status and behavioral factors, social factors play a role, the so-called "social determinants of health".

The latter factors are unevenly distributed and in a dynamic interplay among themselves. This approach recognizes that intersecting social inequalities impact health status.

McIntyre et al. [19] identified five measurable features that have a great impact on the health of individuals and communities, such as the physical features of the environment, healthy environment at home or work, services, socio-cultural features, and reputation of an area. Focusing specifically on migrant women's health, Hyman's critical synthesis of diverse studies [22] conceptualizes the social determinants as operating on macro (legal, policy, economic, physical and social environments), community (institutions, networks, neighborhoods, amenities), and family and individual levels (family status, education, employment, economic dependency, religion, health behaviors, migration status). There is a complex interplay between these levels of determinants and the concrete life course of the individual migrant woman. Furthermore, Hyman [22] identifies the key features having a health impact on migrant women in Canada as intimate partner violence, female genital mutilation, reproductive health, and access to healthcare. Drawing broadly upon McIntyre et al. [19] and Hyman [22], I focus on help seeking and healthcare accessibility for MRW of various legal statuses and social positionalities who are GBV survivors/victims in Canada. Healthcare accessibility is one of the social determinants enabling participants on their path to restoring health so that they can function effectively in their everyday life in Canada.

2.5. Migrant and Refugee GBV Survivors' Help Seeking

A significant portion of the literature on MRW's experiences of GBV focuses on challenges and barriers to help seeking and identifies unique barriers that prevent MRW from disclosing their experiences. Cultural and religious norms and practices; lacking adequate information regarding entitlements and services; distrust of state authorities; isolation/alienation/lack of social belonging; loss of informal support due to migration; migration/acculturation distress; linguistic barriers; lacking interpretation and cultural mediation services; inadequate coordination between services; precarious migration status; fear of deportation; fear of social and family sanctions and stigmatization; and economic dependence on spouses are cited among the obstacles to women's disclosure of violence and help seeking [17,23–30].

In light of the multiplicity and complexity of the barriers that MRW experience, scholars underscore the difficulties in conceptualizing the relationship between culture and GBV in research and practice (e.g., [10,16,31–33]). There is often a tendency in academic, policy, and media discourses to provide cultural "explanations" for MRW's experiences of GBV and lack of help seeking. Cultural approaches, reducing GBV in migrant communities to a cultural problem of specific ethnic communities, result in reproducing stereotypical representations, blaming immigrants for the values they bring to Canada, further marginalizing survivors, and, ultimately, diverting attention from the "fundamental causes of gender-based violence rooted in unequal, racialized and gendered structures of domination and control in host countries" [10,17]. Thus, government policies that create conditions furthering the systemic inequalities and discrimination experienced by migrant groups (e.g., poverty/unemployment, economic exploitation, service gaps, accessibility issues, social exclusion, racism/sexism) remain invisible [31]. This article locates the causes of limited help seeking and healthcare access by MRW survivors of GBV squarely within the realm of legal and policy institutions and systems of protection and addresses the interface of the latter with "cultural" and family-level barriers.

2.6. The Canadian Context of GBV and Barriers/Risks for MRW

Canada is home to a large immigrant population, with 23% of the Canadian population born outside the country [34]. More than one-quarter (27%) of the female population

reported as migrants in 2021 [35], with a majority of them coming from Asia, the Middle East, and Africa. While GBV continues to be a crucial problem in Canada, disproportionately affecting all women and girls, based on an analysis of 2018 national data on DIPV, 30% of immigrant women had experienced some form of GBV at the hands of an intimate partner in their lifetime [36] (p. 20). In particular, vulnerability to GBV is three times higher for racialized women as compared to non-racialized and non-Indigenous women [37]. Research in specific contexts and among immigrant groups in Canada indicates that migrant and refugee women (MRW) face unique risk factors for D/IPV due to structural inequalities at the intersection of immigrant identity/status, gender, ethnicity/race, and class [38–40]. As a result, it is of great importance to understand how the specific risks/barriers and vulnerabilities of MRW survivors/victims of GBV in Canada impact their health, well-being, and settlement in Canada. In agreement with long-standing and contemporary scholarship (e.g., [41]) identifying at the macro level sexism, racism, xenophobia, and class discrimination at the roots of GBV experienced by MRW and intersecting with various MRW identities [42], I argue here that the same social hierarchies and their interplay are reflected in institutional barriers of legal and policy frameworks, identifiable either as concrete policies creating/increasing vulnerabilities, or as absence from protection.

While Canada has legislation and policies both addressing GBV and protecting all migrants (e.g., "It's Time: Canada's Strategy to Address and Prevent GBV", [43]; and "Immigration and Refugee Protection Act", [44]), it is argued in the literature that existing state strategies remain limited in successfully responding to GBV, particularly for women and girls in marginalized communities, including migrants and refugees. This limitation is contributing to the further (re)production of GBV experiences [45]. The limited successful response to GBV by the state is broadly generated by the overdependence on criminal justice frameworks in centrally shaping state responses to violence; lack of intersectional understanding of GBV in legislation and policy documents; lack of intersectoral collaboration; conceptual gaps in GBV and human rights; policy issues of eligibility and access to protection; and neoliberal tendencies in current migration and service provision policies [17,29,31,32,45,46].

Federal/provincial legislation and policies in Canada are generally criticized for not efficiently recognizing and addressing the social, economic, and political determinants of GBV and their interlocking relations. This is argued to result in "tunnel vision" [32] (p. 576), whereby the problem of violence is individualized, depoliticized, and/or culturalized. For instance, many migrant women in Canada are shown to experience a downward socioeconomic mobility (e.g., not being able to practice their profession, remaining unemployed or underemployed for an extended period after resettlement, or experiencing increasing economic dependence on their spouses) [29,31,46]. The degree of vulnerability and particular experiences vary by the intersectional positionalities of various groups and individual women. Overall, while **economic vulnerability** is a crucial factor that would increase women's susceptibility to GBV and limit their chances to disclose violence and seek help [25,29,30], such challenges are often overlooked **under neoliberal migration policies** [31] (p. 340).

Intersecting with the class-based barriers, other systemic inequalities and discriminations are in place that significantly affect accessibility to support and services in Canada for MRW [29,45,46]. **Inadequate language translation/interpretation** services, for instance, are considered as a major example of unequal treatment of MRW with limited linguistic communication skills, making the existing services inaccessible and unavailable to them [27,37,45]. **Limited cultural competency** in service provision is highlighted as another crucial structural barrier contributing to migrant women's further marginalization while seeking support [27,37,45]. **Depending on legal/migration status, there is a lack**

of or limited eligibility for services, such as healthcare access, income assistance, or settlement services. For example, while permanent residents and sponsored partners have overall access to healthcare (even with some time limitations at the beginning, variable by province; [47]), resettled refugees have immediate access only to the "Interim Federal Health Program" (IFHP) and refugee claimants have access to the IFHP only for essential care services [48]. Those without legal status or on Temporary Resident Permits (TRPs) do not have access to healthcare, unless it is privately paid. The 2-year condition for healthcare eligibility for new PRs sponsored by spouses was only lifted in 2017 [49]. The significance of policy/policy gaps is illustrated in a recent study demonstrating a lack of eligibility for GBV protection for migrant women in precarious employment and for migrant women of dependent migration status seeking protection from abusive employers and spouses, respectively [50]. **Previous experiences and/or fear of discrimination and racism** primarily prevent racial-ethnic minority migrant women from accessing services [17,45,46,51]. **One-size-fits-all solutions primarily based on Westernized "rescue and prosecute"** [17] (p. 789) strategies without considering diversities in women's experiences, perspectives, and needs contribute to decreasing MRW's likelihood of accessing and benefiting from the available services [32].

More recently, the "National Action Plan to End Gender-Based Violence" [52] announced in 2023 attempts to seriously address earlier shortcomings by clarifying conceptual ambiguities and introducing clear and structural strategies of building social-economic infrastructure and enabling an environment for the support of victims and families, transformative change, and prevention. The Action Plan is supported by (i) a significant federal financial investment and bilateral agreements with each province aiming at addressing challenges specific in each province, and (ii) monitoring mechanisms over the short, medium, and long term. Although the Action Plan has generated a great deal of enthusiasm and commitment, it remains to be seen how effective it will be in reducing GBV.

3. Methodological Considerations

This article draws upon data from the Canadian research program, associated with the international project *Violence Against Women Migrants and Refugees: Analyzing Causes and Effective Policy Response*. The Canadian research team included four co-investigators from four different institutions in four provinces, two post-doctoral fellows, and a number of research associates and graduate students over a four-year period. A pan-Canadian Expert Advisory Group (EAG) was established at the beginning to advise, comment on, and respond to plans for research and knowledge mobilization activities. Research instruments were developed at the international level but then were adapted to the contexts of each particular country, and additional methodologies were introduced depending on research needs. The objective of the international study was not to compare but to develop parallel contextual analyses of GBV causes, manifestations, and effective policy responses to address it in specific migration contexts.

In Canada, the research team utilized four different data sets, three produced by this project and one for which permission was obtained from another project and institution to utilize for secondary data analysis. Research ethics approval was obtained from all four institutions. Members of the EAG provided the research team with critical contact information for recruitment purposes in different regions. We recruited research participants by sharing information about the project with staff working in immigrant settlement and domestic violence agencies, non-governmental organizations (NGOs), as well as provincial and federal government departments across Canada. A number of articles and book chapters were written in various authorship configurations depending on participation in the analysis and writing of each. Any faults of the present article belong to this author alone.

The data analyzed in this paper derives from semi-structured interviews with 48 migrant and refugee women (MRW) survivors of GBV. Upon completion of these interviews, it was felt that a saturation point was reached. Recruitment was conducted primarily through the encouragement of suitable individuals to participate by partnering community organizations, and through interviewer personal contacts and snowball sampling in diverse communities. Recruitment consisted of a two-step process in which names were first collected, and then the interviewer contacted candidates by phone. Candidates were MRW of various legal/migration statuses; they were either GBV survivors or had acquired experience from witnessing victims/survivors. A number of MRW spoke about GBV experiences they "knew" other women in their circumstances went through and without referring to themselves[2]. This was understood by the research team as a self-protection strategy to avoid possible re-traumatization by speaking about personal GBV experiences. The MRW being recruited and connected to community organizations provided an additional safety valve in case re-traumatization from the interview process occurred[3]. Finally, MRW had to be willing and ready to talk about their experiences. The utmost ethical considerations to ensure the safety of participants and informed consent were observed, following the Government of Canada Tri-Council Policy Statement [53] and the recommendations of the four respective REBs. The interviews were conducted across Canada in person or by videoconference, between the spring of 2020 and the summer of 2022, by a post-doctoral fellow, a research associate, and four other graduate student researchers trained by the co-investigators for this purpose. The decision for remote interviews was made partially to facilitate the recruitment of participants from varied geographic locations, but also because most of the interviews were conducted during pandemic restrictions. The interviews' duration varied from 30 to 150 min.

The interview guide included questions covering a range of themes such as experiences of the migratory journey, life experiences, gendered experiences, and safety in Canada. The interviews were mostly audio recorded, transcribed verbatim with identifying information removed from the transcripts, coded with QDA Miner software, and thematically analyzed [54]. They were conducted in English/French—with a few interviews in a South Asian language that were then translated/transcribed by the interviewer, who was a research associate of the project and a native speaker of that language. There is no claim of representation of the experiences of this sample to MRW in Canada, as the present study is qualitative and, furthermore, despite our best efforts, the interviewers were mostly able to reach out to English/French-speaking immigrants—that is, those MRW not speaking any of these languages were left out. From the coded themes, this paper focuses on the themes of health situation and health services; GBV experiences; and contact/experience with police, immigration, and GBV services. Based on the analysis of these themes, the findings were grouped in terms of the health impacts of GBV on MRW and barriers to help seeking and healthcare accessibility.

This[4] study's participants came from across Canada with about half from the Western provinces (Manitoba, Saskatchewan Alberta, and British Columbia). The majority (n = 29) were newcomers in the last 0–5 years in Canada; a smaller number (n = 10) had arrived in the last 5–10 years, and the last 9 had been to Canada for over 10 years. The overwhelming majority came from urban areas. More than one third were of various Christian denominations, nine were Sikhs, nine were Muslim, while the rest either had no religious affiliation or followed other religions (Buddhism, Hinduism). In addition, 24 participants were permanent residents, 8 were citizens, 3 were asylum-seekers, and 4 were waiting for a decision on their legal status. Fewer were on student visas or work permits. Less than one third worked full time, some were working part time, but the majority were unemployed. More than one fifth had a grade 12 education, about one third (n = 14) had a BA obtained

mostly outside of Canada, and another fifth (n = 10) had a graduate degree (9 MAs and 1 PhD). More than one third had a European mother tongue (with 10 of them speaking English at home), while the rest spoke Arabic or a variety of Asian and African languages. In terms of ethnicity, only 2 identified as of European origin while the rest came from various continents and countries. More than half were separated or divorced, while the rest were either married (9) or single (13). Participants had 1–6 children, with the majority having 2 to 4. Moreover, 25 participants were in their thirties, another 11 in their forties, and the rest in their twenties and a few in their fifties.

The focus, perspective, and analysis of the data in this article are informed by the author's positionality as a feminist academic and migration scholar, an immigrant woman, and a White settler of European origins in Canada, with multiple, ongoing transnational links and a family history of refugee movements and global multi-generational mobility. While acknowledging the limits and dangers of my knowledge, I am committed to identifying power relations and dissecting oppressive structures, clarifying their complex workings and interactions, and advocating for compassionate and just social responses. I live and work in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq People.

4. The Findings

This section includes the findings of the two key themes, serving as similarly titled subheadings, namely "Migrant and Refugee Women GBV Survivors and Health Impacts" and "Barriers in Accessing Healthcare Services". The findings are presented and analyzed in some detail as follows:

4.1. Migrant and Refugee Women GBV Survivors and Health Impacts

GBV, in various forms and levels, is a frequent experience at various stages in the migration journey, often continuing upon settlement in Canada. In many cases, in this study, GBV had occurred prior to arriving in Canada and might even have been the cause for leaving the country of origin. MRW continued to live with the consequences of such GBV upon arriving, and sought help whenever possible. The participants in this study faced diverse health impacts as Canadian women survivors of GBV, but also health impacts that were uniquely related to their specific legal/migration status as MRW, which resulted in exclusion from or limitations in accessing healthcare; in greater susceptibility to threats by abusive partners; and in non-receiving timely care for previously experienced severe GBV and PTSD. Although outcomes varied depending on particular intersectional identities and individual life courses, the dimension of legal/migration status was a key factor impacting their help seeking, healthcare accessibility, and ultimately, health status. The latter, in turn, affected their ability to rebuild their lives and settle in Canada [17]. Furthermore, as Hyman has argued, failure to integrate in Canada socially and economically can adversely influence health outcomes for MRW (2020). This suggests (i) that health status itself is in a complex interplay with socio-economic integration, where there is a mutually reinforcing effect between the ability to rebuild one's life and health status, and (ii) that healthcare accessibility is one of the social determinants of health.

4.1.1. Physical Health

Physical violence caused bodily harm or physical injuries, often requiring medical attention. Monica, a university-educated permanent resident at the time of arrival and a citizen at the time of the interview, originating in a West European country, had to go to the hospital for the injuries she sustained from her ex-husband. She described her experiences as a survivor as follows:

> So anyways, the abuse went on for quite a while, I had a few admittances to the hospital. . . one time I had an open wound on my head bleeding, so I had to go to the hospital to get it dressed. . . And at the hospital they gave me stiches, and it was a holiday, and that time I had a blue eye, was swollen and all that[5].

Physical harm and emotional/psychological harm are inextricably connected, leading to physical manifestations of stress. Existing research [55] reveals that migrant women who had experienced and reported GBV were more likely to also report more depression, anxiety, somatization, and post-traumatic stress disorder (PTSD). In this study, Mayari, a mother of two young children from a Middle Eastern country, who had become a citizen by the time of the interview and was studying in college, described how her experience with GBV profoundly affected her mental health, leading to the manifestation of physical health problems:

> I've been bleeding for 11 months nonstop every day, and sometimes severe, like I have to go to urgent care. I have to stay there, they tried many different types of medication like shot, hormone is the medication to just stop the bleeding, and they were testing for pre-cancer, whatever, but it was all because of the pressure, because of the stress.

Mayari, in comparison to Monica, was a recent migrant to Canada. Her experience confirms previous research findings that migrant women are at an increased risk of GBV if they have migrated less than two years ago [55]. If being a more recent immigrant increased the risk of GBV for Mayari, Monica had sustained these injuries three decades before the interview and at a time when there was much less sensitivity to domestic violence in the law and society and, subsequently, fewer resources for women survivors. Both women were highly educated and permanent residents upon arriving.

4.1.2. Sexual and Reproductive Health

Experiences with GBV can also have impacts on sexual and reproductive health. Many women described the sexual violence they faced, but fewer mentioned the sexual and reproductive health consequences resulting from such violence. Zoro, a woman in her early 40s who arrived as a refugee from an East African country about six years before the interview, described how multiple forms of GBV including rape and FGM, in the country of origin, had created complications for her sexual and reproductive health. For Tani, a 32-year-old woman who had arrived from a South Asian country at about the same time as Zoro, as a permanent resident but had achieved citizenship at the time of the interview, ongoing GBV in Canada by her spouse brought about severe reproductive and mental health consequences:

> And my husband every single night came late night in the apartment and he always raped me. . . One day he said I want to make a video. I said no, you can't do it when I'm your wife, not like a girlfriend or something else, I don't want, but we fought very badly and he, again, had picked my knife. . . My injury, they [the doctors] gave me medication. . . You know, I tried two times to kill myself.

The physical abuse and coercive control another immigrant, Sunita, faced by her spouse, especially in pregnancy and at the post-partum period, impacted her reproductive health through blocking her access to much needed healthcare services. Sunita was a 28-year-old woman from a South Asian country who had arrived as a dependent of her spouse five years before the interview, but had obtained permanent residency by the time of the interview, in which she divulged the following:

> One time, when the baby was crying, I said it's OK, uh, hurry up we have to go to the doctor, right? Moms always very much conscious about the health of their

> children, every mom, right? Then he slapped me. Oh, you are making drama. Oh my God, I was so confused why he, I'm just crying because of my baby, right?

Withholding access to essential services and healthcare was commonly noted as a form of GBV among the women in this study. Blocking access to such services during prenatal, intrapartum, and postnatal periods of maternity posed serious health risks for MRW. Khanlou et al. [56], in a scoping review on maternal health among immigrant and refugee women in Canada, found that barriers to accessing healthcare services during these periods increased maternal health risks for immigrant and refugee women. Additionally, the scoping review of Stirling-Cameron et al. [24] showed that refugee and asylum-seeking women in high-income countries faced greater unmet healthcare needs for contraception and cervical cancer screening when compared to women born in the resettlement country. As far as the intersectional identities affecting healthcare access by the women in this group is concerned, some striking commonalities among the three women in this group consisted of them being racialized minorities, recent arrivals in Canada, and having a precarious status at the time of arrival.

4.1.3. Emotional-Psychological Health

Physical, verbal, sexual, and economic abuse as well as blackmail seem, understandably, to have emotional and psychological health consequences. In the present study, these ranged from prolonged episodes of stress to more severe or complex mental health impacts such as depression, post-traumatic stress disorder (PTSD), and even suicidal ideation. Priscilla, a recently arrived immigrant with PR status from a Latin American country, explained that despite the reduced immediacy of the threat of GBV by her ex-spouse's family due to geographical distance, the emotional-psychological impacts persisted:

> I think they still have power over me, although they don't. . . But I feel like if I tell them where I am, they would destroy me. . . And that was a big fear. And so, I still think that if they know where I am, they will come here. . . because of the threats they had made to my family, because of the messages of pure rage.

Amidst the generalized violence of the Syrian Civil War, Zainab experienced abduction and horrific sexual violence in her native country. She continued to live with the ramifications of that violence in the form of complex PTSD. In Canada, where she arrived as a Convention Refugee four years before the interview, she sought therapy and was still struggling, as seen in the following: "Ah, I've had therapy, for two years, I have complex PTSD". Zoro, a recently arrived Convention Refugee from East Africa and survivor of multiple forms of GBV, described the harrowing journey of her survival, which is common among her fellow countrymen and women, focusing on the atrocities women faced at home and throughout her journey. Both Zainab and Zoro spoke about past violence and their PTSD from it. The present GBV in their case refers to the unaddressed or inadequately addressed consequences of the past. Their unique life trajectories in migration contexts and the GBV experiences of these women's past set them apart from Canadian-born, non-Indigenous women. Zoro, in particular, did not speak about herself but rather about the "common" experiences of women from the part of the world she came from. She concluded by stating that visible and invisible scars in minds are the outcome of such experiences:

> It's really common nowadays especially, like if you go to the Sahara Desert in Africa, like my people, they always because we do have a dictatorial government and non-stopping people from [Eastern African country name] fleeing out of the country every day and. . . the smugglers preying on them and. . . every woman thinks they will escape from their country of origin, where they suffer violence, every kind of violence psychological, emotional, sexual, . . .and even

> for men. . .they [all] escape towards [Libya], that way, that's the main route to go to the Mediterranean Sea to escape to go to EU, Italy. . . A lot of physical and emotional things are happening to them, and rape is a main, common thing, gang rape, individuals do have a lot of visible and in- invisible scars in their mind.

Other MRW described less acute challenges with their emotional and psychological health upon arriving to Canada. These challenges were still quite unique as they had to do with cultural and social navigation issues related to the migration context. Most had no prior experience with the country and, upon arrival, had difficulties navigating a new culture. This challenge caused them to feel isolated as they had no community or family to turn to for support. Being isolated proved especially challenging following experiences with GBV. These difficulties were compounded by an inability to receive professional support due to barriers to accessing healthcare. As previous research has shown, racialized women in particular, suffering three times higher vulnerability to GBV because of gender inequalities and racism within health and social care institutions, "disproportionately experience GBV-related health concerns and psychosocial sequelae, such as mental health and a decrease in quality of life, social capital and employment opportunities" [37]. Mariam, a student with permanent residency who had arrived as a Convention Refugee from Afghanistan two years before the interview, described how she had struggled with her mental health upon arriving in Canada and to this day:

> But when I came here, I heard it's natural for people when they are going to a new society. . . I was feeling like, to be honest, at some point I decided ok life doesn't mean anything. . . and I decided that I'm going to commit suicide. I literally googled how to kill myself. . .. . . Then I tried to find a doctor to help me. . . It was at that time I was also going through a relationship break up and it was a really emotional situation. . . Until now I have not been able to get a psychiatrist or a doctor to help me out. . . I still feel depressed.

The three MRW survivors of GBV in this category of impacts had all recently arrived to Canada (<6 years) with a precarious status and/or little understanding of how to access services and navigate the Canadian legal system.

4.1.4. Economic Health and Well-Being

Economic impacts on health and well-being can not be separated from physical and emotional health impacts. To illustrate this category of health impacts, I highlight Andy's story. Andy was a young immigrant from South Asia who had arrived in Canada as a dependent spouse, about two and a half years before the interview. When living with her spouse became impossible, the financial pressure and threat that Andy's dependent PR status would be revoked if she did not leave the spousal house created huge uncertainty and stress in her life. Here, the immigration context is catalytic, as this is the sort of threat that can only target a precarious-status immigrant, especially in the absence of clearly explained rights and services. In the end, it was the advice of her own family and ethnic network (not professional help seeking) that enabled her to understand the Canadian legal system, showing her a pathway out of the spousal abuse:

> He took the money from my account and he's trying to kick me out from my house. And the house is on both our names and he's thinking that I don't know about Canada's laws and regulations. And he said, "if you don't go to X [South Asian country] or to your relatives in Vancouver, I'll cancel your permanent residency". But I know that he can't, right. . . But then his friend is living across the street from us. He is working with an MP here in Manitoba and my husband was just telling me, he said "I can cancel your permanent residence, I know MLAs

> and MPs here and we can do that" and we know that [people] like [that] back home have power, right? . . . I said "OK, I'll go to X [South Asian country]". . . Then I talked to my relatives in England and Vancouver. Everybody said, don't go, it's your house too.

4.2. Barriers to Accessing Healthcare Services

While the right to health is protected by various international instruments, migrants and refugees—especially those awaiting clarification of their status—often fall into cracks at the national and regional levels [18]. In this section, I focus on barriers that impact healthcare accessibility and help seeking for MRW. Several women in this research identified serious barriers to accessing healthcare and described a negative experience overall. Research on migrant healthcare accessibility confirms many of the findings of this research. For example, Machado et al. [57] in their comprehensive review of determinants and inequities in sexual and reproductive healthcare among im/migrant women in Canada identify health system navigation and service information; experiences with health personnel; culturally safe and language-specific care; social isolation and support; immigration-specific factors; discrimination and racialization; and gender and power relations. Kalich and Ghahari [58], in their scoping review of immigrant experience of healthcare access barriers, identify language barriers, barriers to information, and cultural differences in conjunction with low cultural competency reported by healthcare workers.

Nevertheless, this research contributes to a more nuanced understanding of barriers to healthcare accessibility. The latter are grouped here under two categories: 1. Barriers affecting MRW specifically: Several of these barriers were linked to MRW legal/migration status, resulting in financial repercussions for health services accessible only through payment. Other barriers related to accessing services in their spoken language, cultural barriers, or being able to navigate services in Canada. All of these barriers to healthcare are systemic and constitute either inequalities or gaps in policies and services that can only be detected through an intersectional lens. 2. Barriers affecting other Canadian population groups but having compounding or aggravated effects on MRW because of their specific positionalities, associated vulnerabilities, and life trajectories. This category of barriers related to general, systemic problems in Canadian healthcare, including long wait times and not having access to a family doctor.

4.2.1. Legal/Migration Status Barriers

As has been documented in research [59–61], immigration, social, and health policies—that is, the social and political context of immigration and health—create or aggravate barriers to healthcare through the regulation of immigrants' access to services. These policy barriers dynamically interact with one another and with the intersectional positionalities/identities of MRW to undermine equitable access to health. One of the direct systemic barriers to accessing healthcare services pertains to legal/immigration status. Depending on their legal status, some MRW in this study had no healthcare coverage and were unable to afford the high costs for services that were otherwise free to Canadian-born individuals. When faced with this barrier, the affected women would often forgo medical assistance. As already argued, resettled refugees have immediate access only to the "Interim Federal Health Program" (IFHP) while refugee claimants have access to IFHP for essential care services only [48]. Those without legal status or on Temporary Resident Permits (TRPs) do not have access to healthcare. The 2-year condition for healthcare eligibility for new PRs sponsored by spouses was only lifted in 2017 [49]. However, some of the migrant women of this study who had arrived earlier as sponsored spouses had lived for a while under

conditions of a lack of eligibility and under spousal dependence. Similar problems were reported in Australian research [62,63].

Not being able to access healthcare due to legal status was often the case following graduation for immigrants who were formerly international students. Ginny, a young, university-educated immigrant from Taiwan, explained that students have health insurance through their educational institution, but once they graduate, and for a period of time while searching for employment, they can no longer access healthcare:

> I didn't have a health card, so I was very scared to go to the doctor because I didn't have money to pay for the services and it was very expensive. I got sick sometime for a week and I couldn't go to the hospital and I really got serious, so I had to go the community clinic to see a nurse practitioner because they do attend to people without health card.

4.2.2. Financial Barriers

Although poverty, the non-recognition of foreign credentials, and downward mobility are systemic issues affecting migrants and refugees overall, as documented in a plethora of studies, I am examining here their direct impact on healthcare accessibility. This category of barriers may be a corollary of legal/migration status or may act independently of status in terms of preventing healthcare access. In either case, financial barriers made healthcare access problematic for many women in this study. Financial barriers are especially prohibitive of access to healthcare services that are not covered under the *Canada Health Act* and require independent insurance that many migrant women do not have upon arrival, such as dental care. Although this may be a challenge for Canadian-born women as well, for MRW it was a compounded problem. Other studies (e.g., [62,64])have documented this absence of non-basic healthcare. Jessica, a 34-year-old permanent resident from Southern Africa, explained how she had to make sacrifices to her health because she could not afford the costly price:

> I woke up in the morning and my tooth had broken off in my mouth. I started grinding my teeth... from all the stress... And to go in for an emergency dental appointment, $1300 to crown my tooth. Oh my goodness. I don't have that money. So, I have to get them to patch my tooth. For me, they took the broken piece and they glued it onto my tooth. And then they say, and I try to touch it up a little bit.

One of the healthcare services most identified as inaccessible due to the high costs was professional psychological help. This was problematic for migrant women GBV survivors, as it was also identified as one of the most needed forms of healthcare for their recovery from past trauma. Jessica, a young, highly educated professional from Southern Africa who had arrived as a skilled worker in Canada, explained that, even with having health insurance, the cost of the psychologist was beyond her finances:

> And it's absolutely crazy because even though I have medical coverage through my company, it's $150 cost and they only cover half of that. ... Then we reach out to someone and gave them all my details and everything. And then they send me the bill afterwards for $70 just to have an hour's talk to someone over zoom because of COVID... And I feel that's also wrong because, you know what I mean? ... I lost my job. I don't have $70 a time to pay, to speak to someone. I have to try and do this on my own. And some days I can, and then other days I have a complete block, a stress attack, and this is why the migraines have started on.

4.2.3. Knowledge Barriers

A lack of knowledge of the available resources, support services, and understanding of the Canadian healthcare system was identified as a barrier for many women seeking healthcare. This barrier has been confirmed by other studies (e.g., [62,65]). Machado [66] found that not having knowledge about the existence of resources and support related to health services created a barrier that was associated with poorer health outcomes. This type of barrier is, to a large extent, structural, as it requires specific, ongoing effort on the side of individual MRW to overcome it through networking and ongoing inquiry into available resources and access pathways. Indeed, Mayari, a young, university student at the time of the interview, from the Middle East, told us the following:

> The most difficult part of my life here, was lack of information. I didn't know anything about my rights, about resources. . . So, I was kind of facing a lot, but I could stop it if I knew my rights. And I didn't have any support, like you see they're saying here women. . . have their rights, they are protected, but I didn't see that because no one, like, reach out to me, and give me information or help me out. So, I suffered a lot.

4.2.4. Cultural Barriers

Cultural differences between migrant women and Canadian-born service providers proved to make accessing healthcare more challenging, as the MRW often felt as though the service provider could not understand their perspective. In their scoping review, Allen-Leap et al. [51] documented that sociocultural and sociopolitical factors were compounding barriers for migrant and refugee women in seeking help for domestic violence. Cultural differences have been routinely identified as a barrier to accessing primary healthcare and to seeking help from GBV in other studies too (e.g., [32,64,65,67]). Culturally sensitive practices have been assessed as critical in accessing health services and help [9,68]. In the present study, MRW were especially astute in picking up on cultural differences and cultural perspectives in seeking help, especially when they were coming from countries and cultures where such services or discourses on GBV or mental health were considered "taboo". Salamat, a Palestinian-born woman who lived in a Gulf country before coming to Canada, explained that although there is abundant accessible mental health information in Canada, in the Gulf country she came from, mental health was not something openly discussed, and women often opted to suffer alone:

> Yes, here I know that like, people are announcing about mental health care providers and sometimes on Facebook also I find some of these messages from the government or whomever, or the Newcomer Center sometimes provided us with some links about these centers so in case any of these situations happened. . . Back in Dubai these things were not really accepted to talk about.

Salamat's case suggests avoiding stereotypical thinking about cultural differences. Awareness of different ways of thinking between cultures may not necessarily be an obstacle to seeking help for MRW in Canada. Culturally different, more individual human-rights-oriented ways of understanding abuse and dealing with it may be welcome news for many MRW fleeing violence. These types of "cultural differences" may act as facilitators in seeking help for MRW.

4.2.5. Linguistic Barriers

Being unable to speak one of the official languages in Canada has been widely documented in research to be a challenge for many migrant women not only in accessing health services but also in employment and social integration in Canada. It is a structural barrier,

as the primary responsibility for translation and interpretation services as well as linguistic skills lies with the receiving state. Linguistic barriers are in a dynamic interplay with gender as well as race, education/social class, age, and other forms of social division, i.e., linguistic barriers are inflected with social positionalities and identities. Guruge et al. [69] identified linguistic but also cultural and gender barriers to healthcare service provision as major factors associated with poor health outcomes for Syrian refugee women in Toronto. Canadian and international researchers have commonly identified linguistic barriers to disclosing GBV and to accessing healthcare (e.g., [62,63,70–73]). But linguistic barriers and limitations are also internalized, leading individuals to avoid circumstances where linguistic skills of various levels are required. In this research, Meet is a permanent resident from a South Asian country who had arrived to Canada as a dependent spouse and was abused by her spouse until she left him. Despite her two postgraduate degrees from her native country and her Canadian professional education, Meet avoided counseling despite her doctor's recommendation, as she felt that the language barrier would affect her ability to effectively communicate:

> I went through depression, he [family doctor] suggested to go for sessions. But I couldn't, because of the language barrier it would have been nearly impossible to share my experiences with the counsellor. So, my family doctor prescribed medicine, which helped me.

4.2.6. Long Wait Times

Although not specific to GBV survivors or MRW, long wait times were identified as a significant systemic barrier to timely healthcare. This finding confirms other research findings, such as Woodgate et al. [64] and Pandey et al. [70]. Because of the urgency for healthcare in MRW cases, the long wait may have a more significant impact on MRW survivors. Accessing healthcare in a reasonable amount of time is especially crucial for those struggling with mental health and trauma. The latter may be more likely for certain categories of migrant GBV survivors. Hope, a young, university-educated woman from Central America, of a precarious legal status and financial situation, explained how important seeking support was for her well-being. Unfortunately, she noted that the time it took for her to receive psychological support was too long, and in her case, it took over a year:

> When I arrived, I was at my worst moment "emotionally" because of the violence that I went through. So, my lawyer suggested psychological support. . . I had to wait almost a year and 2 months.

4.2.7. No Family Doctor and Less than Adequate Healthcare

Not having a family doctor was frequently mentioned as a barrier to healthcare access [64]. Although this, too, is a systemic problem, its impact may be greater for MRW survivors of GBV. Obtaining necessary referrals to specialists from a family doctor often made seeking professionals, such as gynecologists or psychologists, who are instrumental in healthcare related to GBV, harder to access. Mariam, a young professional from Afghanistan who came to Canada as a UNHCR Convention Refugee, explained how the lack of a family doctor not only made gynecological healthcare a challenge for her, but aggravated her psychological state of anxiety, as follows:

> It's at the worst situation like I feel like um it's a very serious problem that I'm having since I arrived here and I'm looking for a gynecologist but I cannot get an appointment for it, and month by month, when I have my monthly period, I feel that I'm having a very serious problem that might be cancer, might be anything.

Zoro, a woman from an East African country who arrived in Canada as a refugee, highlighted that the support available to newcomers often is *not enough* and not adequate. Despite being able to overcome the barriers to healthcare and finding the support she needed on her own, she had the nagging feeling that, if it were not for her own persistence in finding additional support, she would have only had very limited access to counseling. This finding confirms other research about inadequate or "less than ideal" healthcare in Canada (e.g., [64]). The broader barrier is, of course, systemic, affecting everyone living in Canada. However, in various degrees depending on intersectional positionality/identity, it has particularly acute impacts in the case of MRW often fleeing horrific forms of GBV and structural, generalized violence in conflict situations.

> I was depressed and feeling alone. So, I wanted to do the same thing and talk to somebody but here you have to go through CLSC ["Centre local de services Communautaire", in Quebec] to get that. And the other thing too, is that you get only 10 sessions. How can 10 sessions help you? One day I went to Côte-des-Neiges. . . .don't know how I ended up to Femmes du Monde [Femmes du Monde in Côte-des-Neiges]. . . I've seen so many organizations, but they are so rude. But this organization was super helpful and very nice. . . They made me go see a counsellor and I'm moving on (Zoro).

4.2.8. Access During the COVID-19 Pandemic

Another structural constraint affecting all women living with GBV but with especially aggravated consequences for MRW survivors was the COVID-19 pandemic restrictions that were strong enough to create a "pandemic within the pandemic" [74] and a "heightened vulnerability" of GBV survivors [75]. With the interviews occurring during the COVID-19 pandemic, many MRW described how the pandemic had aggravated barriers for them. Accessing healthcare during the pandemic proved to be challenging for most, but especially for MRW single mothers. The significance of this barrier for MRW can only be understood through an intersectional lens that focuses not only on single parenting and the pandemic mobility restrictions but also on MRW's increased social isolation associated with the pandemic, marginalization, unemployment, and poverty. It was this intersectional disadvantage which made finding childcare a difficult and costly proposition for many MRW. Mayari described this challenge, where, in order to take care of her own health, she was forced to rely on her unsupportive spouse, as follows:

> I have to go to lab a lot to do the tests. No one is there to take care of my kids. . . And I have to go to the lab, I cannot bring my kids to hospital because of the Corona. You cannot have someone with you. So, what I have to do, my ex was kind of bothering me. He didn't want to take them, and I have to plead with him. I have to cry, I have to even send him pictures from bleeding, to show him it's serious, please take them for two hours, so I can go and do the test, blood tests or I can go to urgent care. . . If I cannot, like, if something happened to me, what's going to happen to the kids at home?

5. Conclusions

Utilizing an intersectional feminist perspective and a contextual analysis of barriers to healthcare accessibility for MRW, I examine the health impacts of GBV on MRW in the Canadian context. Although GBV entails health risks and impacts for all women, it has compounded the health consequences for MRW survivors in Canada. Following a qualitative, semi-structured interview research design, 48 MRW were interviewed between 2020 and 2022. Drawing upon the social science literature on health and healthcare access, my understanding of health includes biological but also social factors. Health is a key resource

enabling individual well-being and, in the case of migrants, facilitating settlement and integration. As a resource, health is unevenly distributed and populations have differential access to it, depending on the social factors that determine this distribution. These factors are the social determinants of health which can act as barriers to accessing healthcare.

My findings on the GBV affecting MRW include physical, sexual/reproductive, and emotional/psychological impacts and their complex, mutually reinforcing interactions. These impacts are mediated by the intersectional positionalities/identities of the women survivors/victims, with a very important one being that of legal/migration status. The health impacts are ultimately shaped by the challenges and barriers that the MRW encounter in their journeys of survival from GBV and health restoration while striving to settle in Canada. From all the barriers that MRW encounter in these journeys, I focus in the present article in particular on the barriers to healthcare accessibility and argue that they are institutional and systemic in nature. On the one hand, there are general barriers to healthcare access affecting the overall population, including Canadian-born GBV survivors. Long wait times, a lack of family doctors, less than adequate care, as well as the COVID-19 pandemic restrictions have been named by the interviewees in this regard. Serious as these barriers are for everyone, they affect MRW in more pressing and aggravated ways due to past trauma or intersectional positionalities. On the other hand, there are more specific challenges that affect only MRW's accessibility to healthcare; legal/migration status, financial, linguistic, knowledge, and cultural obstacles to access have been identified in this regard. These specific barriers can be traced to the state and society's failure to provide appropriate support and services (policy gaps) to MRW survivors of GBV. All systemic barriers speak ultimately to institutional/policy decisions—or lack thereof—to provide equitable protection and support and are, consequently, political in nature. To understand these barriers, it is critical to utilize a feminist intersectional lens, foregrounding the circumstances of migration, life trajectories, and the intersectional positionalities/identities of survivors.

At the **conceptual level,** this article contributes to the following: 1. identifying the health status effects of barriers to healthcare accessibility in Canada for MRW who are survivors of GBV, as these are mediated by the intersectional positionalities and identities of the latter; 2. identifying the concrete barriers to healthcare access and recognizing these barriers as structural impediments (related to inadequate law/policy protection) to healthcare access and to improving health status for MRW in Canada. At the **policy level**, the identification of institutional barriers points to the direction of addressing them by making policy changes, enhancing protection and taking into account the needs of MRW groups as these emerge from their intersectional positionalities.

There are several limitations of this analysis. At the **conceptual level, the limitations are the following**: 1. Besides healthcare accessibility as a social determinant of health for MRW survivors of GBV, there are other socio-structural factors (e.g., housing, income assistance) with a direct impact on the health of MRW that have been cited in research but are not examined by this article. 2. While I recognize that there are links between the specific barriers identified in this article for healthcare access by MRW survivors of GBV and the broader systemic forms of discrimination and disadvantage, such as racism, sexism, capitalism, and xenophobia, that are at the root of the institutional barriers to healthcare access, such links are not explicitly addressed in the present article. At the **methodological level**, the usual caveats for qualitative studies apply, with the main one being the inability to generalize beyond the sample. Finally, a systematic parsing out of the effects of other hierarchies of power, positionalities, and identities will be needed to flesh out the picture of their workings in affecting the health and well-being of MRW.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/soc15030068/s1, "Argument Flow Chart" and "Socio-Demographic Data Table".

Funding: This research was funded by the Canadian Institutes of Health Research, CIHR/GenderNet Plus Initiative, grant FRN 161903.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Institutional Ethics Review Board of Saint Mary's University, Halifax, Nova Scotia, Canada (REB File # 19-092-2019; with annual renewals till July 2023). Additionally, the study was approved by the REB of the University of Guelph, Guelph, Ontario, Canada (# 19-08-004); the REB of the University of New Brunswick, Fredericton, New Brunswick, Canada (REB # 2019-113); and the REB of the University of Manitoba, Winnipeg, Manitoba, Canada (Protocol # P2019:099 (HS23173)).

Informed Consent Statement: Informed consent was obtained from all subjects involved in this study.

Data Availability Statement: Interview data is unavailable due to privacy and ethical restrictions. Selective, deattributed interview data and summary table of socio-demographic data is contained in this article. Further inquiries can be directed to the author.

Conflicts of Interest: The author declares no conflict of interest.

Notes

1 The Canadian GBV program (https://www.smu.ca/gendernet/welcome.html, accessed on 23 February 2025) includes collaborating researchers at four institutions (i) Saint Mary's University, (ii) University of New Brunswick, (iii) University of Guelph, (iv) University of Manitoba. The research program has been approved by the Research Ethics Board at each of the four institutions. The Canadian program, funded by Canadian Institutes of Health Research (grant FRN 161903), is part of the international project on *Violence Against Women Migrants and Refugees: Analyzing Causes and Effective Policy Response (GBV-MIG)*, a winning project of the Gender-Net Plus Consortium (https://gbvmigration.cnrs.fr/, accessed on 23 February 2025). I gratefully acknowledge my co-investigators in the project design, data collection and co-authorship of other articles from the University of Guelph (Dr. Myrna Dawson), the University of New Brunswick (Dr. Catherine Holtmann) and the University of Manitoba (Dr. Lori Wilkinson), as well as the entire Canadian and international GBV-MIG research teams. Beyond them a huge thank-you to all the community partners and research participants.

2 No attempt was made in the interviews to get the MRW to "own" their narratives, in order not to exacerbate potentially traumatic memories.

3 This risk never materialized, to the best of the team's knowledge.

4 See complete socio-demographic data table (Supplementary Materials) at end of this article.

5 Quotations have been minimally edited for readability. The names of interviewees are all pseudonyms, almost always selected by themselves.

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