POLICY BRIEF

Improving sexual and reproductive healthcare for permanent and temporary im/migrants in Canada

No. 28, February 2026
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EXECUTIVE SUMMARY

A quarter of Canadian residents are temporary or permanent migrants from diverse regions of the world. As of 2021, female im/migrants comprised 23.8% of women and girls in Canada. Despite constituting a considerable proportion of the population, many newcomer women face persistent barriers in accessing sexual and reproductive healthcare (SRH). These include cultural, gender, language, and financial barriers. Lack of insurance and discriminatory treatment from healthcare providers also lead to lower SRH usage among im/migrant women in Canada. Newcomer women are predisposed to these SRH barriers due to their migration backgrounds and journeys, settlement experiences – including delayed economic and social integration – and limited social support postmigration. This results in poor knowledge and management of sexually transmitted infections (STI), fertility, mental health and preventive care. It also leads to poorer diagnoses and treatment outcomes, unintended pregnancies, pre-term births, lower live birth rates and higher need for emergency services.

This brief highlights how some of these barriers are rooted in Canada's primary healthcare system of which many im/migrant women have limited knowledge and which is plagued by healthcare provider shortages. It also shows how provincial eligibility requirements and wait-periods for government-funded insurance further limit newcomer women's SRH access. Lastly, it outlines how insufficient cultural and gender sensitive care hinders im/migrant women's SRH access and use.

This brief shares recommendations for improving im/migrant women's SRH outcomes, including providing centralized information about SRH services, increasing supply of primary care practitioners, leveraging the knowledge and expertise of internationally-educated health professionals, and increasing cultural and gender sensitivity among health professionals. It also recommends developing cultural and linguistic interpreter systems, diversifying service provision options, and reviewing and amending policies regarding access to health insurance. Lastly, it advocates for integrated immigration, employment and health systems planning, and collecting/analyzing data to inform policy and programs on im/migrant women's SRH in Canada.

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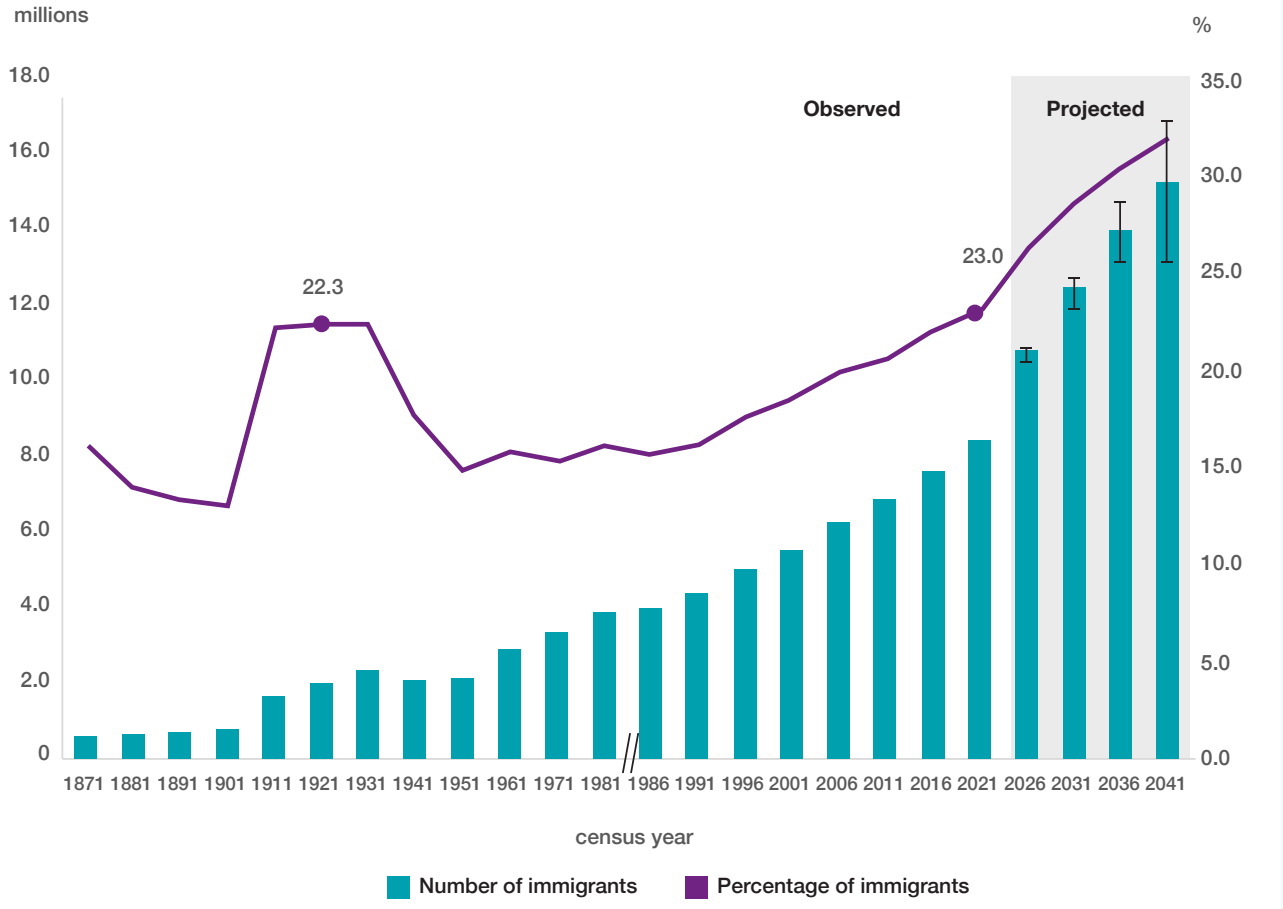
Canada Excellence Research Chair in Migration & Integration

IM/MIGRANT WOMEN IN CANADA EXPERIENCE HEALTHCARE BARRIERS

Close to one quarter of Canadian residents are im/migrants (Figure 1). As of 2023, female im/migrants comprised 48% of temporary and permanent migrants in Canada, the majority of whom are racialized and of reproductive age. This number is even higher for permanent residents (50.2% female). Despite making up a significant proportion of Canada's population, newcomer women experience barriers to accessing and using sexual and reproductive healthcare (SRH).

Figure 1: Immigrants as a proportion of the Canadian population



// denotes a break in the historical series

Note(s): The lines within the bars in the shaded area of the chart for the years 2026 to 2041 indicate the interval between the minimum and maximum values projected for all 11 scenarios combined.

Source(s): Census of Population, 1871 to 2006, 2016 and 2021 (3901); National Household Survey, 2011 (5178); Population projections on immigration and diversity for Canada and its regions, 2016 to 2041 (5126); The presented data are based on the reference scenario.

Source: Statistics Canada.

The World Health Organisation (WHO) defines sexual and reproductive health as a variety of services that encompass access to information on healthy relationships, fertility/infertility treatments, contraceptives, maternal and perinatal wellbeing, the prevention and treatment of sexually transmitted infections (STI), and safety from gender-based violence. Being of good sexual and reproductive health implies that a person experiences overall physical, mental and social wellbeing regarding their reproductive system.

Ensuring equitable access to SRH services that are affordable and timely – as well as culturally, linguistically, and gender sensitive – throughout the life course is important for improving newcomer women's wellbeing. This also enhances their labour market integration and reduces government healthcare expenditures over the long term. Research shows that when newcomer women have access to family planning, they are better positioned to pursue education and maintain stable employment, reinforcing the need for Canadian policies to better align immigration and labour market priorities with comprehensive healthcare support.

Importantly, access to SRH services is a human right that should be enjoyed by all, regardless of immigration status. Promoting im/migrant women's access to SRH services is thus critical for meeting the Sustainable Development Goals (SDGs) 3: "ensure healthy lives and promote well-being for all at all ages", and 10: "reduced inequalities".

Newcomers of all categories and durations – for example temporary and permanent residents, refugee claimants, and irregular migrants – face barriers to SRH services. However, this brief centres on SRH access and use among those with regular status whether as temporary (students or workers) or permanent residents in Canada. It briefly touches on the implications of limited SRH support for refugee claimants and undocumented women. Nonetheless, despite shared similarities, the migration background and legal standing of refugee claimants and irregular migrants open them up to unique vulnerabilities that cannot be adequately addressed here.

This brief adopts the WHO's definition of SRH, and uses the terms im/migrant or newcomer women to refer to persons who identify as women and who are currently resident in Canada with legal temporary or permanent migration status. It explores SRH barriers across the life course, from puberty to postmenopausal stages, including: contraception, abortion, birth, early infant care, pre/postpartum physical and mental health, STIs, female cancers, among others. Due to the limited and fragmented Canadian data on im/migrant women's SRH experiences across the different areas listed, some data is drawn from comparable countries (for example the US, Australia) for illustrative purposes.

This brief is directed to policymakers in the provincial/territorial Ministries of Health and Education, to federal agencies such as Health Canada and Immigration, Refugees and Citizenship Canada, and to Municipal Public Health Departments. By highlighting the diverse vulnerabilities that newcomer women face in accessing SRH in Canada, and potential avenues

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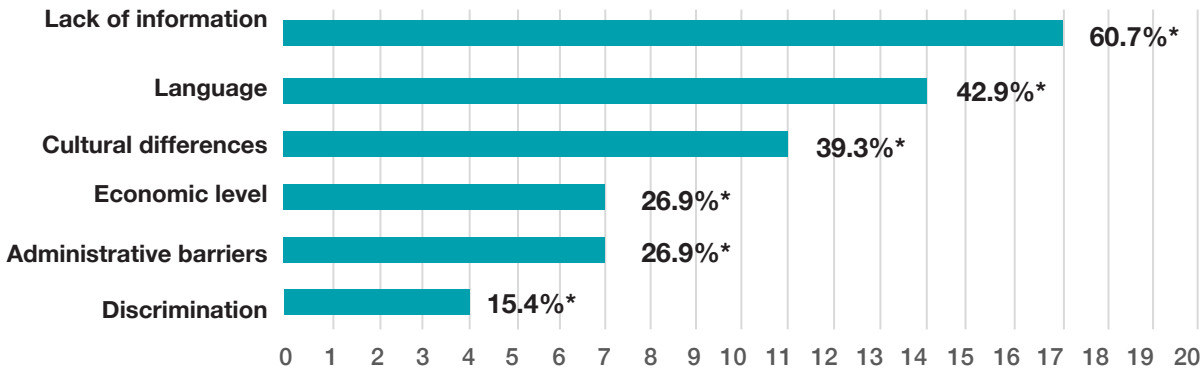
Newcomer women in Canada experience SRH barriers partly because healthcare policies are not always migrant-inclusive, leading to lower health service utilization among im/migrants compared to non-im/migrants. For example, while the general Canadian population deals with systemic healthcare challenges such as quality of care, healthcare costs and fragmented access to services, im/migrant women must navigate these hurdles in addition to ones unique to their im/migrant identities.

Documented immigrant-related SRH barriers include language obstacles, under-developed social support systems, and geographic and information inaccessibility. Others include insufficient insurance coverage, lack of knowledge of available SRH services, racial and ethnic-based healthcare provider discrimination toward patients, and limited translation/interpreter assistance (Figure 2). This often results in im/migrant women not seeking preventive care, or treatment for ailments considered minor, until their illnesses become severe.

Figure 2: Documented barriers to im/migrant women's access to SRH globally



% = percentage of the total number of studies on the research (n = 28)

Source: Pérez-Sánchez et al. (2024).

While factors such as lack of employment, low or irregular income, poor social support and racial/ethnic discrimination contribute to health deterioration of im/migrants after arrival, emerging evidence points to the role of SRH vulnerabilities in worsening health outcomes for im/migrant women and their families. Integrating and adjusting to a new country is a stressful process, and mental health among im/migrant women is especially poor. Yet, In Ontario, the highest im/migrant-receiving province, newcomer women in their first year postpartum are 40% less likely to use mental health services compared to Canadian-born women.

Relatedly, a survey of studies on women's SRH outcomes revealed that im/migrants, including those in Canada, tend to underuse gynaecological and maternal health services, resulting in unmet SRH needs such as poorer knowledge and diagnosis of STIs, and lower knowledge of sexual rights and fertility management. Other studies in Canada have also found higher rates of pre-term births, lower birth weights, and postpartum complications among im/migrant women compared to their non-im/migrant counterparts. This is concerning, as SRH is a critical indicator of long-term health.

FACTORS THAT PREDISPOSE IMMIGRANT WOMEN TO SEXUAL AND REPRODUCTIVE HEALTHCARE BARRIERS

Newcomer women's socioeconomic and cultural background, as well as their migration journeys and settlement experiences, significantly shape their SRH outcomes in Canada. Yet, despite having worse SRH outcomes than Canadian-born women, the odds of their concerns going unaddressed is higher – up to 3.2 times for recent im/migrants. Newcomer women are predisposed to sexual, reproductive, and childbirth-related health issues due to a number of factors:

- **Premigration Stressors:** For permanent and temporary im/migrants from lower-income countries, women may have pre-existing unmet healthcare needs such as access to contraception, STI testing, fertility management, care for those who experienced genital cutting, and other needs that predispose them to require greater access to culturally appropriate SRH services upon arrival in Canada.
- **Relocating to a New Country:** Despite the relative predictability and lower-precarity of regular migration, the process of relocating to another country, whether temporarily or permanently, can be stressful. For instance, transitioning from employment in the origin to the destination country may result in the loss or delay of benefits (for example, health insurance). This creates uncertainty around im/migrant women's ability to access SRH services during this transition period.
- **Economic Integration**: Although Canada recruits im/migrants for their skills, many newcomers to Canada end up in jobs that are not commensurate with their level of skill. Moreover, only 69.6% of women who landed in Canada in the last five years are employed, compared to 84.4% of women born in Canada. Some of these un(der)employed newcomer women are healthcare workers who practised in their country prior to immigrating to Canada. This downward economic integration has implications for newcomer women's ability to afford good quality SRH care in the early stages of settling. Furthermore, for those who immigrate as a family, women may forgo or postpone their labour market participation to support that of their male partners or to care for their children, thereby affecting their financial ability to independently access certain SRH services.
- **Poor Working Conditions**: While highly skilled im/migrants experience downward economic mobility, others –particularly farm workers, live-in-caregivers, and students– find themselves working under poor or hazardous conditions, for low wages. These jobs may offer migrant workers limited to no SRH insurance coverage, and migrant women themselves may lack the time or financial resources to access SRH due to long work hours or unpaid wages for time not worked.
- **Social and Cultural Support:** Pregnant newcomer women feel more vulnerable when navigating healthcare in Canada due to cultural differences around social support. In comparison to their country of origin, they might not have family or community social support during pregnancy and after delivery. This opens them up to pre- and post-partum care struggles, which may not be adequately understood within, or accommodated by, the Canadian healthcare system.
- **Post-migration/Settlement Stress:** Immigrant women's SRH services utilization is restricted by lack of familiarity with the healthcare system and financial, transportation and time barriers. For example, newcomer women may deprioritize their SRH needs because of multiple responsibilities in their household and workplace, and lack of knowledge about what services are available and how to access them. As such, it has been found that newcomer women's health-seeking behaviour is primarily driven by acute health concerns rather than preventive care.
- **Delayed Care:** Newcomer women experience poorer diagnosis and treatment outcomes due to communication and awareness barriers in accessing timely preventive SRH services like cancer screening, family planning, gynecologic wellness visits, sexually transmitted infection testing and perinatal care. These barriers are rooted in language and cultural differences, lack of health system knowledge and insufficient health care coverage. Newcomers are thus overrepresented among women with unintended pregnancies, those seeking abortions, and women with pre-term births.

PLANNING FOR THE HEALTHCARE OF IM/MIGRANTS

Between 2026-2028, Canada plans to welcome 380,000 permanent residents, with over 40% of spots reserved for those transitioning from temporary to permanent status. The country will also welcome 155,000 new international students and 230,000 new temporary workers. While these figures represent a significant drop from previous immigration levels, they still comprise a 1.8% growth in Canada's population of 41,726,794.

Yet Canada is experiencing an alarming decrease in practising doctors, including family physicians. It is predicted that by 2028, Canada will lose approximately 44,000 physicians, with family doctors comprising 72% of that decline. An important indicator of health system capacity is the number of practising physicians: with a ratio of 2.8 physicians per 1,000 population, Canada ranks lower than the OECD average of 3.7.

The mismatch in immigration growth and physician availability exacerbates access to healthcare for both im/migrants and the rest of the population, but is of particular concern for temporary migrants, including international students and temporary workers, as they do not always have the same level of access to healthcare, and face unique SRH access challenges.

To illustrate, while Canadians and permanent residents are eligible for universal public health insurance across different provinces/territories, such as the British Columbia Medical Services Plan (MSP) and Ontario Health Insurance Plan (OHIP), temporary residents may not have immediate eligibility, depending on their province of residence. For example, international students in Ontario do not have access to OHIP; their school-provided health insurance comes at an added cost and may provide limited benefits.

In British Columbia (BC), although international students are covered by the MSP, they are required to pay a $75.00 monthly fee. Moreover, the 60-90 day wait-time in BC implies that newly arrived temporary residents who are unable to afford private insurance are left without care during the transition period.

Considering that temporary migrants are already predisposed to financial precarity, these policies have far-reaching consequences.

Nonetheless, this immigration-related population growth could be leveraged to both fill Canada's healthcare worker shortage gaps and meet im/migrant women's SRH needs. For instance, by better utilizing the skills of internationally educated health professionals such as nurses, doctors, doulahs, and midwives, these immigrants could simultaneously contribute to filling healthcare worker shortage gaps and provide culturally appropriate SRH services to im/migrant women.

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STRUCTURAL BARRIERS TO SEXUAL AND REPRODUCTIVE HEALTHCARE

Canada's Primary Healthcare System

Primary care, a universally recognized component of health service delivery, serves as the first step to interacting with the Canadian healthcare system. According to the WHO, primary healthcare facilitates "first-contact, accessible, continuous, comprehensive, and coordinated person-focused care close to where people live and work". For primary care practitioners, this entails providing preventive care, diagnosing and treating medical conditions, referring patients to other physicians or specialists, and coordinating care across all facets of the patient's life, to ensure continuity of care. Primary care is aimed at promoting health equity by lowering costs and increasing accessibility for large segments of the population, regardless of socioeconomic status. It is generally delivered by family physicians. Without primary care, many people lack access to free and consistent healthcare.

Canada is experiencing a primary care crisis, where 1 in 5 people do not have access to a regular primary care provider. The situation is worsened by insufficient physician training and recruitment, and poor remuneration of family physicians. This translates to a scarcity of primary doctors and an inability to meet the needs of a growing, more diverse, and aging population.

Immigrant women in particular are less likely to access routine primary care via a physician, even after years of residence in the country. This exclusion is attributed to inequities in navigating the healthcare system, and stem from language barriers, discrimination, lack of insurance, and waiting periods. These disparities are widening among im/migrant and racialized groups, due to increasing income gaps and health policies that are unaligned with the growth of an increasingly diverse population.

The primary care structure becomes even more limiting for newcomers due to its "gatekeeper" model: where patients cannot directly access specialist care - including to reproductive health specialists if necessary- without primary physician referral. Referral pathways are central to the primary care system. Given the scarcity of family physicians, newly arrived im/migrant women who are starting from scratch must join waitlists to be assigned to a family doctor. This might result in longer wait-times to access specialist SRH care. Coupled with the long wait-times to see specialists following referral, sometimes spanning weeks/years, im/migrant patients are delayed care. This is concerning, given the established relation between long wait-times and quality of life.

Infrastructural Strain and Fragmented Healthcare Delivery

Due to sustained long-waiting times, and lack of access to consistent care from a primary physician, newcomer women who need care must use emergency services, including walk-in clinics and emergency departments. This constitutes episodic and often critical care. Unlike longitudinal care, episodic care lacks sustained provider relationships and coordination, leading to poorer health outcomes and avoidable hospital visits and medical procedures. This is particularly challenging for im/migrant women living with chronic conditions and those requiring timely interventions, such as pre/postnatal women.

Episodic care also puts a strain on emergency departments and walk-in clinics, and overwhelms the medical personnel who manage patient treatment in these settings. The consequences of this overutilization of episodic care include system inefficiencies such as the duplication of patient treatment plans, multiple and repeat testing, added paperwork, and burnout among emergency department staff.

Furthermore, programs such as hormonal contraception and contraception counselling are often run separately from one another, creating a lack of centralized SRH information and services. Consequently, although some of these services may be covered by government insurance and/or are offered without physician referrals, their fragmented nature further restricts access.

Lack of Orientation and Information Dissemination

Although primary care is aimed at supporting service continuity and coordination, im/migrants face inequitable access in a healthcare system that is new to them, and about which they have little prior knowledge. Poor understanding of a new healthcare system with referral pathways dependent

on family doctors can limit continuous care for im/migrant patients. Newcomer women are particularly vulnerable to the effects of medical gatekeeping due to their limited knowledge of the requirement to obtain a referral to reach specialist services like gynecological care.

This contributes to a lack of awareness about where and how to access critical SRH services, leading to underutilization among newcomer women. For example, in Vancouver, BC – due to poor promotion and advertisement – many im/migrant women lack knowledge about a Newcomer Women's Health Clinic that provides vital SRH services. This leads women to depend on word-of-mouth recommendations, which may be inaccurate or incomplete.

Insufficient Cultural and Gender Sensitive Care

A lack of cultural awareness and sensitivity among Canadian healthcare workers results in newcomer women facing stigma, discrimination, and miscommunication. Additionally, language remains a significant barrier. When newcomer patients cannot understand SRH medical terminology or information, they are excluded from effectively participating in their own treatment plans. Also, appointment-booking policies that rely on phone calls instead of in-person access can disadvantage newcomers with limited English proficiency, making it harder for them to obtain timely care. This reduces patient satisfaction, compromises safety, and lowers trust and the overall quality of care.

Despite their existence, Cultural Health Brokers (CHBs) remain underutilised across Canada, and their roles are often confined to peripheral or community-based programs. This means that im/migrant women must independently seek out CHB services during physician appointments.

Cultural safety is crucial for effective SRH treatments, considering the sensitive nature of SRH topics and treatments. Without culturally safe care, newcomer women may avoid available preventive services, leading to complications in treatable or avoidable health issues.

The integration of CHBs, for example as interpreters and support persons, plays a critical role in bridging linguistic and cultural barriers to SRH access. As bilingual and bicultural individuals that share similar experiences with newcomer women, CHBs can help to build trust and more effective communication with healthcare providers. This aids in facilitating SRH literacy, improving patient-provider relationships, and promoting efficient navigation of SRH services.

RECOMMENDATIONS

1. Evidence-based Legislative, Regulatory and Policy Reviews to Better Serve Needs of Im/migrant Women

- The Canadian Institute for Health Information and municipal public health departments to collect and analyze data on access to, and utilization and outcomes of SRH services for im/migrant women in Canada.
- Provinces to review eligibility and remove wait periods for provincial health coverage to ensure timely access for all residents of the province, including newcomer women.
- Federal and provincial governments to review whether employers and educational institutions are providing timely and effective healthcare coverage for temporary workers and international students or whether alternatives like the Interim Federal Health Program are necessary.

2. Increasing Access to Culturally-Sensitive Sexual and Reproductive Healthcare

- Federal and provincial governments – funded by the Sexual Health Fund – to develop a centralized database for all SRH information, resources and services, and to disseminate this information to im/migrant women in collaboration with local health units, key providers and settlement agencies, in multiple formats and languages (see for example the ACHIEVE Model).
- Provinces and municipal public health departments to establish online registries of qualified cultural and linguistic interpreters accessible to im/migrant women and health practitioners in the area of SRH.
- Post-secondary institutions and regulatory bodies to incorporate cultural and gender sensitivity training in preparatory and professional development requirements for all health professionals, including those providing SRH care, and review or modify their codes of ethics to incorporate a stronger focus on anti-discrimination.

3. Increasing Supply of Health Practitioners to Serve Im/migrant Women's Sexual and Reproductive Healthcare Needs

- Provinces to establish women's health and mobile SRH clinics in locations with significant numbers of im/migrant women (see Immigrant Women's Health Center (IWHC) in Toronto), and streamline SRH services in existing Community Health Clinics (e.g., REACH Community Health Centre in BC and Parkdale Queen West Community Health Centre in Ontario).
- Provinces to provide incentives for more physicians and nurse practitioners to choose family medicine as their area of practice and remove disincentives to practice (e.g., reduce administration, review methods of compensation), in order to boost the number of primary care practitioners available to both long-time residents and newcomers.
- Provincial governments, regulatory bodies, and employers in the health sector to streamline processes for licensure and entry to practice in their fields, and maximize the utilization of the knowledge and expertise of im/migrant and internationally-educated health professionals (e.g., physicians, nurses, midwives, doulahs), to boost SRH health system capacity. See the Alberta Labour Mobility Regulation and BC Office for International Credential Recognition programs).
- Provinces and federal government to provide financial support to post-secondary institutions and internationally educated health professionals for bridging programs, required courses for licensure, and clinical practice (e.g., residencies). The Foreign Credentials Program and BC Internationally Educated Nurses program are promising models.

CONCLUSION

Im/migrant women comprise a significant proportion of Canada's population but face barriers to SRH care. The suggested recommendations would help to facilitate efficient navigation of SRH services, and aid in the provision of timely and continuous care for im/migrant women. They would also help in the delivery of culturally and gender- safe care, while strengthening patient-provider relationships and reducing structural barriers to SRH care. Lastly, these recommendations are useful for reducing long-term costs to Canada's healthcare system. In addition to promoting women's social and economic integration, these strategies would also contribute toward mitigating health inequities and improving overall SRH outcomes for newcomer women.

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Suggested Readings

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